

Audit, Risk and Assurance Committee Main Meeting

Thu 18 September 2025, 09:30 - 12:00

Agenda

1. PRELIMINARY MATTERS

 1.0 ARAC 20250918 Agenda.pdf (4 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 24 June 2025

Attached Chair

 ARAC 20250624 1.4 Main Meeting Minutes - Chair Approved.pdf (9 pages)

1.5. Committee Action Log and Matters Arising

Attached Chair

 ARAC 20250624 1.5 Action Log - Chair Approved.pdf (3 pages)

1.5.1. To Receive update report in relation to the checklist for future projects

Attached Director of Strategy, Planning and Partnerships

-  ARAC 20250918 1.5.1 ARAC Capital Audits SBAR Sept 25.pdf (4 pages)
-  ARAC 20250918 1.5.1a1 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a2 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a3 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a4 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a5 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a6 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1a7 App 1 Capital Project Dashboard.pdf (1 pages)
-  ARAC 20250918 1.5.1b App2 Capital Projects Checklist.pdf (2 pages)

1.5.2. To Receive Job Planning Progress update report

Attached Interim Medical Director

-  ARAC 20250918 1.5.2 ARAC 2025 09 - Job Planning Assurance Note.pdf (4 pages)
-  ARAC 20250918 1.5.2a The 2025 plan for job planning aims to meet comply with the recommendations of the 2024.pdf (8 pages)
-  ARAC 20250918 1.5.2b Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2c Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2d Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2e Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2f Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2g Worksheet.pdf (1 pages)

-  ARAC 20250918 1.5.2h Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2i Worksheet.pdf (1 pages)
-  ARAC 20250918 1.5.2j Worksheet.pdf (6 pages)

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. To Approve Reviewed and Updated Financial Control Procedures.

Attached *Director of Finance and procurement*

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

-  ARAC 20250918 2.1 Finance Governance Report - 18.09.2025.pdf (10 pages)
-  ARAC 20250918 2.1a Appendix 1 ABUHB_Finance_0241 Budgetary Control_Issue DRAFT.pdf (28 pages)
-  ARAC 20250918 2.1b Appendix 2 ABUHB_Finance_0240 Losses and Special Payments_DRAFT.pdf (45 pages)
-  ARAC 20250918 2.1c Appendix 3 ABUHB_Finance_0249 Stores and Stocks_DRAFT.pdf (24 pages)

2.2. Financial Standing Financial Instruction (SFI) Self-Assessment

Attached *Director of Finance and procurement*

-  ARAC 20250918 2.2 SFI Self-Assessment Report - 18.09.25.pdf (6 pages)
-  ARAC 20250918 2.2a Appendix 1 - SFI Self Assessment Document.pdf (9 pages)

2.3. To Receive Q1 Audit Recommendation Tracking Report

Attached *Director of Corporate Governance*

-  ARAC 20250918 2.3 Internal_External Audit Recommendations Cover Report.pdf (8 pages)
-  ARAC 20250918 2.3a Audit Tracking Appendix A Completed Recommendations.pdf (12 pages)
-  ARAC 20250918 2.3b Audit Tracking Appendix B Revised Timescale Requests pdf.pdf (8 pages)
-  ARAC 20250918 2.3c Audit Tracking Appendix C Remaining Overdue Recommendations.pdf (1 pages)
-  ARAC 20250918 2.3d Audit Tracking Appendix D Recommendations Exceeding Threshold pdf.pdf (3 pages)

3. ITEMS FOR DISCUSSION

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

Attached *Director of Finance and Procurement*

-  ARAC 20250918 3.1 Single Tender Action Report - 01.04.2025 - 01.09.2025 (004) (1).pdf (4 pages)
-  ARAC 20250918 3.1a Appendix A STA.pdf (2 pages)

3.2. To Receive a Quarterly Report on Counter Fraud Activity

Attached *Director of Finance and Procurement*

-  ARAC 20250918 3.2 ARAC Counter Fraud Progress Report Sept 25 (002) (003).pdf (25 pages)

3.2.1. Risk Fraud Process

Attached *Director of Finance and Procurement*

-  ARAC 20250918 3.2.1 SBAR for ARAC re Fraud Risk Process.pdf (5 pages)
-  ARAC 20250918 3.2.1a FRAUD RISK ASSESSMENT PROCESS.pdf (13 pages)
-  ARAC 20250918 3.2.1b Risk Assessment Flow Chart.pdf (1 pages)

3.3. To Review Compliance with Welsh Health Circulars (WHCs)

Attached *Director of Corporate Governance*

-  ARAC 20250918 3.3 ARAC WHC and Min Dir Exec Update september 2025.pdf (5 pages)
-  ARAC 20250918 3.3a Ministerial Directions 2025.pdf (2 pages)

- 📎 ARAC 20250918 3.3b WHC 2023.pdf (6 pages)
- 📎 ARAC 20250918 3.3c WHC 2024.pdf (10 pages)
- 📎 ARAC 20250918 3.3d WHC 2025.pdf (3 pages)

3.4. ABUHB Audit Handbook

Attached *Director of Corporate Governance*

- 📎 ARAC 20250918 3.4 Introduction of the Health Board's Audit Handbook.pdf (3 pages)
- 📎 ARAC 20250918 3.4a ARAC_3.4_Appendix A_ABUHB Audit Process and Reporting Handbook_Final Draft.pdf (27 pages)

3.5. To Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.5 ABUHB Sept 2025 Audit Committee Progress Report FINAL.pdf (11 pages)

3.6. To Receive Internal Audit Review Reports

Attached *Head of Internal Audit*

3.6.1. Health and Safety - Limited Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.1 ABUHB 2024.25 Final Health & Safety Internal Audit Report Updated & Reissued.pdf (18 pages)

3.6.2. Medical Equipment and devices - Reasonable Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.2 ABU-2425-15 MED FINAL Internal Audit Report for Client.pdf (11 pages)

3.6.3. Newport East (19 Hills) HWBC - Reasonable Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.3 ABU SSU 2425 28 Newport East Health and Wellbeing Centre - Final Audit Report.pdf (21 pages)

3.6.4. Waiting List Management - Reasonable Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.4 ABUHB-2425-13 Waiting List Management Final Report issued to client.pdf (11 pages)

3.6.5. Electronic Document and Records Management Solution - Reasonable Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.5 ABUHB 2425-24 EDRMS Final Internal Audit Report for Client.pdf (10 pages)

3.6.6. Financial Sustainability - Reasonable Assurance

Attached *Head of Internal Audit*

- 📎 ARAC 20250918 3.6.6 ABUHB Financial Sustainability Final Internal Audit Report for Client.pdf (9 pages)

3.7. To Receive Internal Audit briefs of audits underway

Attached *Head of Internal Audit*

- Development of a Regional Radiotherapy Satellite Centre at NHH
- Business Continuity Plan
- GUH Emergency Department Extension
- Space Utilisation
- Subject Access Requests

- Welsh Intensive Care Information System
- Cyber Security
- Safeguarding
- Shadow IT

- 📄 ARAC 20250918 3.7.a ABUHB_2425_ RSC_ Final Audit Brief issued June 2025_.pdf (7 pages)
- 📄 ARAC 20250918 3.7.b ABUHB-2526-06 BCP final audit brief.pdf (3 pages)
- 📄 ARAC 20250918 3.7.c ABU-SSU-2526 Grange ED Final Audit Brief.pdf (4 pages)
- 📄 ARAC 20250918 3.7.d ABU-SSU-2526-26 Space Utilisation Final Internal Audit Brief.pdf (4 pages)
- 📄 ARAC 20250918 3.7.e Final Internal Audit Brief 2526 04 Subject Access Requests.pdf (3 pages)
- 📄 ARAC 20250918 3.7.f ABU 2526 24 wics final Audit Brief.pdf (3 pages)
- 📄 ARAC 20250918 3.7.g ABU-2526-22 Cyber Security - Final Audit Brief.pdf (3 pages)
- 📄 ARAC 20250918 3.7.h ABUHB 2526 16 Final Safeguarding Audit Brief.pdf (3 pages)
- 📄 ARAC 20250918 3.7.i ABUHB 2526-13 Shadow IT final IA Brief.pdf (3 pages)

3.8. Receive External Audit Progress Report 2025-26

Attached Audit Wales

- 📄 ARAC 20250918 3.8 3997A2024 Audit Risk and Assurance Committee Update - September 2025.pdf (12 pages)

3.9. Review of Urgent and Emergency Care services Aneurin Bevan University Health Board

Attached Audit Wales

- 📄 ARAC 20250918 3.9 ABUHB Managing Urgent and Emergency Care Demand Report.pdf (50 pages)

4. ITEMS FOR INFORMATION

4.1. All Wales NHS Audit Committee Chairs Group Report

Attached Chair

- 📄 ARAC 20240918 4.1 Annual report AWACC 24025 pdf.pdf (10 pages)

4.2. Committee Programme of Business 2025/26

Attached Director of Corporate Governance

- 📄 ARAC 20250624 4.2 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- 📄 ARAC 20250624 4.2a ARA Committee Work Programme 2025-26 Final - Copy.pdf (7 pages)

5. OTHER MATTERS

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

Oral Chair

5.2. Any Other Urgent Business

Oral Chair

5.3. Date of the Next Meeting: Tuesday 21st October 2025

Oral Chair

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time

Thursday 18th September 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 24 June 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
1.5.1	To Receive update report in relation to the checklist for future projects	Attached	Director of Strategy, Planning and Partnerships
1.5.2	To Receive Job Planning Progress update report	Attached	Interim Medical Director
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
2.1	To Approve Reviewed and Updated Financial Control Procedures. - Budgetary Control - Losses and Special Payments - Stores and Stocks	Attached	Director of Finance and procurement
2.2	Financial Standing Financial Instruction (SFI) Self-Assessment	Attached	
2.3	To Receive Q1 Audit Recommendation Tracking Report	Attached	Director of Corporate Governance
3	ITEMS FOR DISCUSSION		



3.1	To Receive Report of the use of Single Tender Action	Attached	Director of Finance and Procurement
3.2	To Receive a Quarterly Report on Counter Fraud Activity	Attached	
3.2.1	Risk Fraud Process	Attached	
3.3	To Review Compliance with Welsh Health Circulars (WHCs)	Attached	Director of Corporate Governance
3.4	ABUHB Audit Handbook	Attached	
3.5	To Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.6	To Receive Internal Audit Review Reports Limited Assurance: - Health and Safety Reasonable Assurance - Medical Equipment and devices - Newport East (19 Hills) HWBC - Waiting List Management - Electronic Document and Records Management Solution - Financial Sustainability	Attached	

3.7	To Receive Internal Audit briefs of audits underway • Development of a Regional Radiotherapy Satellite Centre at NHH • Business Continuity Plan • GUH Emergency Department Extension • Space Utilisation • Subject Access Requests • Welsh Intensive Care Information System • Cyber Security • Safeguarding • Shadow IT	Attached	
3.8	Receive External Audit Progress Report 2025-26	Attached	Audit Wales
3.9	Review of Urgent and Emergency Care services Aneurin Bevan University Health Board	Attached	
4	ITEMS FOR INFORMATION		
4.1	All Wales NHS Audit Committee Chairs Group Report	Attached	Chair
4.2	Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
5	OTHER MATTERS		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: Tuesday 21 st October 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





**GIG
CYMRU
NHS
WALES**

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DATE OF MEETING	Tuesday 24 June 2025
VENUE	Microsoft Teams

PRESENT	Iwan Jones Richard Clark Dafydd Vaughan Neil Patrick	Independent Member (Committee Chair) Independent Member (Committee Vice Chair) Independent Member Independent Member
IN ATTENDANCE	Rani Dash Rob Holcombe Robert Jones Lucy Windsor Stephen Chaney Efion Jones Sara Utle Julie Rees Bryony Codd Gareth Lewis Angharad Clements Gareth Lavington Amanda Legge Sue Tilman James Calvert Steve Edwards Richard Morgan-Evans Leeanne Lewis Danielle Jackson	Director of Corporate Governance Director of Finance and Procurement Assistant Finance Director Head of Corporate Risk and Assurance Head of Internal Audit, NWSSP Deputy Head of Internal Audit, NWSSP Performance Audit Lead, Audit Wales Finance Audit Lead, Audit Wales Head of Corporate Governance (<i>Items 3.1 & 3.2</i>) Head of Financial Services & Accounting (<i>Item 3.3</i>) Senior Auditor, Audit Wales (<i>Item 3.4</i>) Head of Counter Fraud (<i>Item 3.6</i>) Post Payment Verification Manager (<i>Item 3.8</i>) Post Payment Verification Manager (<i>Item 3.8</i>) Medical Director (<i>Items 3.12.1</i>) Deputy Medical Director (<i>Items 3.12.1</i>) Deputy Chief Operating Officer (<i>Item 3.14</i>) Assistant Director for Quality and Patient Safety (<i>Items 3.15</i>) Secretariat
OBSERVING	None to note	
APOLOGIES	None to note	



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Minute Reference	Preliminary Matters
ARAC 2406/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
ARAC 2406/02	Apologies for Absence Apologies were noted.
ARAC 2406/03	Declarations of Interest There were no declarations of interest raised to record.
ARAC 2406/04	Minutes of the previous meeting The minutes of the meeting held on the 20 May 2025 were agreed as a true and accurate record.
ARAC 2406/05	Committee Action Log The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. The Committee AGREED that completed actions could be removed from the Action Log.
	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 2406/06	Update on Financial Control Procedures (FCPs) Robert Jones (RJ), Assistant Finance Director, provided an update on the status of the Health Boards FCPs. It was noted that no FCPs were due for review in Q1 (April – June); however, three would be presented at the next Committee meeting. The Committee NOTED the report.
	ITEMS FOR DISCUSSION
ARAC 2406/07	Health Board's Annual Report (Overview & Performance Section) (Part 1) Rani Dash (RD), Director of Corporate Governance, advised that the Annual Accounts must be submitted to Welsh Government (WG) as a single consolidated document. The final reports were scheduled for Board approval on 25 June 2025. RD confirmed that Parts 1 and 2 of the 2024/25 Annual Report had been shared with Audit Wales and WG, with no material changes identified. Iwan Jones (IJ), Committee Chair, raised concerns regarding reported absence figures, particularly the calculation method for absence percentage and days lost. RD agreed to convene a meeting with the Committee Chair, Director of Finance and Procurement, and Director and OD to review the data. ACTION: Director of Corporate Governance



	The Committee NOTED the report for assurance.
ARAC 2406/08	Final 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, confirming that all amendments and changes raised during the meeting in relation to the draft accounts had been actioned and were reflected in the Appendices of the report. The committee NOTED the report for assurance.
ARAC 2406/09	Final Annual Accounts and Financial Statements (Part 3) Robert Holcombe (RH), Director of Finance and Procurement, presented Part 3 of the Health Board's 2024/25 Annual Report, noting the accounts had been prepared in accordance with national financial reporting standards and no material changes had been made since the draft accounts. The committee NOTED the report for assurance
ARAC 2406/10	Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation Julie Rees (JR), Finance Audit Lead, Audit Wales, provided an overview of the Audit of Accounts, noting Audit Wales intended to issue an unqualified opinion on the financial statements, but noted, a qualified regularity opinion would be issued due to the Health Board's failure to meet the three-year break-even target. The adjusted three-year deficit stood at £93.793m. It was noted that, due to identified financial risks, a broader programme of substantive testing had been undertaken, with no material misstatements found The Committee NOTED the report.
ARAC 2406/11	Recommendation to the Board in respect of the audited Annual Report and Accounts The Audit, Risk and Assurance Committee recommended that the Board: • RECEIVE the Audit Wales Audit of Accounts Report (2024/25) • APPROVE the Annual Report and Accounts 2024/25, comprising: 1. The Performance Report;



2. The Annual Accountability Report; and
3. The Financial Statements

- **APPROVE** the Letter of Representation; and
- **AUTHORISE** the Chair, Chief Executive Officer, and Director of Finance & Procurement, to sign the documents where required.

ARAC 2406/12

Counter Fraud Functional Standard Return Declaration

Gareth Lavington (GL), Head of Counter Fraud, presented the Declaration, and reported that the Health Board was fully compliant with all twelve components of the required self-assessment.

It was also noted that the ABUHB Counter Fraud team would not be subject to an engagement visit this year

The Committee **NOTED** the report for Assurance.

ARAC 2406/13

Counter Fraud Services in NHS Wales Operational Performance Report for Q4 of 2024/25

Gareth Lavington (GL), Head of Counter Fraud presented the Q4 report, noting the report contained an overview of all NHS Wales health bodies. The content of the report was noted as a useful tool for benchmarking and identifying areas for improvement.

The Committee **NOTED** the report for Assurance.

ARAC 2406/14

Post Payment Verification 2024/25 Annual Report, including, the Annual Workplan for 2025-26

Amanda Legge (AL), Post Payment Verification Manager, presented the 2024/5 Annual Report and proposed work programme for 2025/26.

Key updates included:

- 62 General Medical Services (GMS) visits were planned and completed during 2024/25: 20 routine and 42 revisits.
- Welsh Government requested additional verification of Covid and RSV vaccines, to begin in 2025/26.
- 18 of 20 General Ophthalmic Services (GOS) visits were completed; 2 would carry over to 2025/26.
- New services (WGOS 4 and IPOS5) would also be verified in 2025/26.
- All 42 planned General Pharmacy Services visits were in progress.



	The Committee NOTED the Post Payment Verification Annual Report 2024/25 and the proposed workplan for 2025/26.
ARAC 2406/15	Committee Risk and Assurance Report Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided an update on the Health Board's strategic risks. It was noted that six risks remained outside the Board's risk appetite and were subject to ongoing review with executive leads to identify additional measures for mitigating potential threats. The Committee NOTED the report for assurance.
ARAC 2406/16	Head of Internal Audit Opinion and Annual Report (2024/25) Stephen Chaney (SC), Head of Internal Audit, presented the final opinion for 2024/25. The overall conclusion was Reasonable Assurance. The opinion was formed following a review of the 26 completed audits, which comprised the following outcomes: • 1 Substantial Assurance • 20 Reasonable Assurance • 4 had Limited Assurance • 2 Advisory Reports The committee NOTED the report for assurance
ARAC 2406/17	Internal Audit Progress Report Stephen Chaney (SC), Head of Internal Audit, reported on the progress of the Internal Audit Plan for 2024/25, noting all audits been completed and work on the 2025/26 plan had commenced. It was proposed to defer the Medical E-Rostering Audit to 2026/27 to align with Job Planning compliance improvements. The Committee NOTED the report for assurance and AGREED the deferral of the Medical E-Rostering Audit to 2026/27.
ARAC 2406/18	Internal Audit Review Reports Stephen Chaney (SC), Head of Internal Audit, provided the Committee with an overview of the following audit reports. Job Planning – Limited Assurance



	The review aimed to provide assurance that appropriate arrangements were in place and operating effectively for consultant job planning. However, despite significant efforts by the Health Board, no substantial improvements in compliance were identified. James Calvert (JC), Medical Director, welcomed the report and reassured the Committee that all efforts were being made to improve job planning compliance. He acknowledged that while a robust process was in place, the main challenge lay in the uptake and completion of job plans. JC further advised that 40 grievances had been raised as a result of increased scrutiny and the expectation for consultants to hold a job plan. He suggested that divisional directors from areas with low or no compliance be invited to the next Committee meeting to address the report's findings and respond to the Committee's concerns. ACTION: Medical Director and Secretariat Contract Management – Advisory The review assessed whether appropriate contract management arrangements were in place within the Health Board following the 2023/24 Betsi Cadwaladr University Health Board (BCUHB) review. Rob Holcombe (RH), Director of Finance and Procurement clarified contact ownership under Standing Financial Instructions (SFIs) and noted ongoing work to develop a Contracts Register as part of the governance improvement work. Performance Management Framework – Reasonable The review examined the adequacy of the Performance and Accountability Framework arrangements. The review assessed the appropriateness of the Framework implemented, rather than the associated performance recorded. Follow Up of Previous Audit Recommendations – Advisory The review sought to assess whether a sample of high and medium priority internal audit recommendations had been implemented as per the standards The Committee NOTED the reports for assurance.
ARAC 2406/19	External Audit Progress Report Sara Utleý (SA), Performance Lead, Audit Wales, presented the Committee with an overview of the 2024/25 External Audit progress report.



	The committee NOTED the report for assurance.
ARAC 2406/20	Audit Wales Planned Care report Sara Utleý (SA), Audit Wales, presented the Planned Care Report, which summarised findings from a national thematic review undertaken across all Health Boards in Wales. The report was part of a wider piece of work that would result in a national briefing report, based on individual findings from each local report. SA summarised the key findings for the Health Board: • The Health Board had made positive progress in reducing 104-week waits; however, overall patient waiting numbers remained high. • While short-term plans were in place, there was a need to develop a more sustainable long-term improvement plan to meet future demand. • The Health Board was advised to accelerate the implementation of the “Three Ps” service (Prevent, Promote, and Prepare) to better support patients awaiting care. • Improvements were needed in how harm resulting from delays in planned care was reported. • Barriers to improvement had been acknowledged by the Health Board, with plans already in place to address them. • Audit Wales also identified opportunities to enhance productivity and efficiency, including expanded use of virtual appointments, preoperative assessments, and increased day surgery activity. Richard Morgan Evans (RME), Deputy Chief Operating Officer, welcomed the report and confirmed that the Health Board was committed to implementing all recommendations, as outlined in its formal response. Iwan Jones (IJ), Committee Chair, queried Recommendation 2, which had already been marked as completed in relation to the outcomes linked to the additional funding. Rob Holcombe (RH), Director of Finance and Procurement, acknowledged the challenge in demonstrating outcomes, noting it was easier to evidence outputs from the investment. However, he highlighted mechanisms such as PROMs, PREMs, and CIVICA could provide evidence of patient outcomes, and, suggested incorporating the data captured into future reporting could help demonstrate both the outputs and outcomes of the funding.



	RH also raised significant concerns regarding the recent national insourcing proposal. While the ambitions of the proposal were acknowledged as positive, RH cautioned that the process posed substantial risks and emphasised that the risks were being flagged consistently and should not be viewed as a failure of NHS organisations, but rather as systemic challenges in implementation. The Committee NOTED the report for assurance.
ARAC 2406/21	Clinical Audit Activity Annual Report 2024/25 and Clinical Audit Plan 2025/26 Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, presented the Clinical Audit Annual Report 2024/25 and the Clinical Audit Annual Plan 2025/26, reporting that the Health Board had maintained its focus on ensuring full participation in the Welsh National Clinical Audit and Outcomes Review Plan. Key developments included: • introduction of standardised audit reporting templates, which improved consistency and the scrutiny of action plans, • further embedding of the Audit Management and Tracking system (AMaT) across the organisation to enable more controlled tracking of audit outcomes and actions. LL also highlighted progress in strengthening the governance of clinical audit, with clearer reporting structures now in place through the Clinical Standards and Effectiveness Group (CSEG), the Patient Quality and Safety Outcomes Committee (PQSOC), and the Audit, Risk and Assurance (ARA) Committee. Looking ahead to 2025/26, the focus would shift towards strengthening divisional ownership of audits, supporting the development of divisional audit plans, and establishing a more sustainable funding model for the AMaT system, which was currently funded on a biennial basis. Iwan Jones (IJ), Committee Chair, questioned how the Health Board could be assured that divisions were actively participating in audit activity and that non-participation was being appropriately managed. LL confirmed that work was ongoing to strengthen improved data monitoring, enabling earlier identification of non-participation and reassured the Committee that only one instance of non-participation had been identified in 2024/25, specifically within respiratory services, and that targeted support had been provided to ensure full data submission for 2025/26.



	The Committee acknowledged the Health Board’s commitment to enhancing its clinical audit activity. However, it also recognised the ongoing challenges, particularly in relation to the development of local audit plans and the resources required. As a result, the Committee was unable to take sufficient assurance that the Health Board had an effective plan in place to demonstrate delivery and the impact of clinical audit in driving improvements in the safety and quality of care. The Committee NOTED the 2024/25 Annual Report and APPROVED the 2025/26 Clinical Audit Annual Workplan.
	ITEMS FOR INFORMATION
ARAC 2406/22	Committee Programme of Business 2025/26 The Committee NOTED the report for information.
	Other Matters
ARAC 2406/23	Items to be Brought to the Attention of the Board and Other Committees • Recommendation to the Board in respect of the audited Annual Report and Accounts
ARAC 2406/24	Any Other Urgent Business • Nothing reported.
ARAC 2406/25	Date of the next meeting • Thursday 18th September 2025



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	Completed Included in Septembers Agenda
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
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	September 2025	Completed Included in Septembers Agenda



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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
May 2025	ARAC 2005/05 Action Log	Review and update the management responses to ensure they accurately reflect the scope of the recommendations and return the updated Records Management audit report to the Committee for assurance.	Director of Corporate Governance/Director of Digital and Head of Internal Audit	September 2025	In progress Updated paper is scheduled to be presented to Executive Committee in October 2025, suggested that an update is brought to ARA Committee in December 2025.
June 2025	ARAC 0624/07 To Review the Health Board's Annual Report Part 1	Schedule a meeting with the Committee Chair, Director of Finance and Procurement and the Director of Workforce and OD to discuss the figures/calculation used to determine staff absence and days lost.	Director of Corporate Governance	September 2025	Completed Meeting took place 10 th September 2025.



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2025	ARAC 0624/18 To Receive Internal Audit Review Reports	Invite directors from divisions of particular non or low Job Planning compliance to attend the next scheduled Committee to provide assurance.	Medical Director	September 2025	Completed Included in Septembers Agenda

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.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Capital Audit Update in Relation to Themes and Checklist
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Hannah Capel, Assistant Director of Capital

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Following a number of internal audits on major capital schemes over the last 24 months, a range of themes have been identified in the reports on areas common to all projects. The following paper draws out the themes identified and the work which has been undertaken to address the areas of concern across all projects.

Cefndir / Background

During 2023/24 and into 24/25 there were 5 capital project schemes which were in construction phase of delivery. These were:

- The Bevan Health and Well Being Centre – Tredegar
- 19 Hills Health and Well Being Centre – Newport
- Satellite Radiotherapy Centre – Nevill Hall Hospital
- Unified Breast Unit – Ysbyty Ystrad Fawr
- Emergency Department Extension – Grange University Hospital



As part of the assurance process for capital schemes, internal audits were undertaken to review and provide assurance to the Health Board of the processes which are undertaken in the management and delivery of such projects. The table below summarises the rating of the audits:

SCHEME	DATE	RATING
The Bevan Health and Well Being Centre	March 23	Limited
19 Hills Health and Well Being Centre	Jan 23	Reasonable
Satellite Radiotherapy Centre	May 23	Reasonable
Unified Breast Unit	Dec 22	Reasonable
Emergency Department Extension	April 25	Reasonable

Whilst the audits identified areas for review and improvement for each project, there were some common themes which were identified, predominantly around project governance. These are:

- Project Board arrangements, e.g.
 - Terms of Reference
 - Agendas (declaration of Interest)
 - Risk Management (financial and non-financial)
- Alignment to Project Execution Plan (PEP)
 - Roles and Responsibilities
- Performance Monitoring, e.g.
 - KPI's
 - Reporting through to Project Board, specifically on financial issues
- Change Control, e.g.
 - Appropriate completion of documentation
- Project Bank Accounts

Asesiad / Assessment

As a result of the audit findings, a number of actions have been undertaken to ensure consistency and application of best practice across projects. These are:

- Development and roll out of Project Dashboard (Appendix 1)
The dashboard is a live document and is used as the basis of discussion at each Project Board. It covers both construction and service aspects of the project as well as the following:
 - Construction Highlight Report
 - Service Highlight Report
 - Risk Log (Service and Construction)
 - Decision Log
 - Issues Log
 - Change Control Log



- Development and roll out of Project Checklist (Appendix 2)
The Project Checklist has been developed by the Capital Team to ensure consistency in projects and that key areas are being covered and addressed. Each project will have its own checklist and is tailored to meet the specific scope of the individual project.

The checklist is and will continue to be added to following any lessons learnt which have been identified as the capital team work through each scheme.

- Standardisation of Documentation
Documentation such as agenda templates, Terms of Reference, etc have been standardised for all projects.

Whilst it is acknowledged that each project will have a specific scope and set of parameters, the measures which have been put in place have and will continue to benefit and support the delivery of schemes, which is evident through recent audits where the same themes are no longer being raised as areas of concern.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **Note** the progress made in the standardisation of approach to capital projects.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.3 Quality Improvement, Research and Innovation 3.4 Information Governance and Communications Technology 3.5 Record Keeping
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.



Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Enabling Estate
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 prioritise 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 Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



Monitoring & Reporting Dashboard



Croeso and Welcome to the SISU Project Monitoring & Reporting Dashboard. Here you can input and view the workstream's highlight reports, risks, issues as well as other logs. **Please do not remove this Excel file from its location or make offline copies.** Additionally **please do not edit the formatting.** This is all to ensure the information can be pulled through up to Programme level seamlessly. If there are any problems then please get in touch with the Capital Estates Team. **Diolch yn fawr!**

Please ensure this dashboard is utilised at workstream / team meetings in order to support monitoring and control activities.

Please click on the tabs below to begin

Project Highlight Report

Exec Sponsor / SRO:					Delivery Confidence Assessment			
UBU building lead:					Green	Successful delivery of the project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.		
Service Lead:								
Reporting period:								
Overall Status Summary		Achievements - What went well this period?			☒ Amber/Red	Green Successful delivery of the project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.		
						Amber/Green	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening delivery.	
						Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.	
						Amber/Red	Successful delivery of the project is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.	
						Red	Successful delivery of the project appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The project may need re-baselining and/or overall viability re-assessed.	
Set backs - The latest & biggest issues facing the project				How are we dealing with the issues - The 'Path to Green'		Planning - What's ahead for the workstream over the next reporting period		
						1		
						2		
						3		
Risk Management - Summary of the top 3 risks								
Summary of Risk		Likelihood	Impact	RAG	Mitigating Actions			
							4	
							5	

Project Highlight Report

Exec Sponsor / SRO					Delivery Confidence Assessment	
UBU building lead:					Green	Successful delivery of the project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Service Lead:					Amber/Green	Successful delivery appears probable. However, constant attention will be needed to ensure risks do not materialise into major issues threatening
Reporting period:					☒ Amber	Successful delivery appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
Overall Status Summary		Achievements - What went well this period?			Amber/Red	Successful delivery of the project is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and establish whether resolution is feasible.
					Red	Successful delivery of the project appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The project may need re-baselining and/or overall viability re-assessed.
Set backs - The latest & biggest issues facing the project				How are we dealing with the issues - The 'Path to Green'		Planning - What's ahead for the workstream over the next reporting period
						1
						2
						3
Risk Management - Summary of the top 3 risks						
Summary of Risk	Likelihood	Impact	RAG	Mitigating Actions		4
			Red			
			Red			
			Yellow			
			Red			
			Yellow			

Here is a selection of other useful logs you can use if you feel it would aid the workstreams organisation / ability to track different aspects.

Decisions Log

ID	Decision required	Raised by	Date	Decision Outcome	Made by

Issues Log

Sponsor:						Lead:		
Please do not adjust the formatting / layout of this log								
Status	Issue ID	Priority - High, Medium or Low	Description & Impact of Issue	Mitigating Response	Issue Owner	Est. Resolution Date	Escalation required?	Comments & Updates
Resolved issues								

Change Control Log

Please ensure that this log captures all change requests as they arrive within the project. This should reflect the change control log within the GUH Change Control folder on the X drive

[illegible]

Capital Projects Checklist

This checklist provides a framework for projects. Some steps will be essential for all projects, while others should be tailored to the specific scale, complexity, and governance. A checklist should be completed for each project and will be continue to added to/ edited throughout the cycle of projects.

Project Name	
Senior Responsible Officer	
Project Director	
Capital Project Manager	

Item	Complete
Governance (throughout Project)	
Project Dashboard set up	
Confirmation of SRO	
Project Meetings – frequency monthly • Board • Project Team • Other relevant sub groups	
Terms of Reference • Project Board • Project Team • Relevant Sub Groups (inc Finance)	
Set Standard Agenda inc. • Declaration of Interest • Highlight Reports ○ Construction ○ Service • Finance • Risks and Issues	
Risk Register • Costed Construction Risk Register	

• Service Risk Log	
Change Control • CC Form inc signatures • CC Log	
Pre-Construction	
Project Execution Plan (To be reviewed at regular intervals)	
Agreed derogation schedule (to form part of the Works Information)	
Agreement of Pre-Construction/ SLA Contracts • Ensure Contracts are dated • Review liability levels	
Project Bank Account – confirm implementation	
Sign-off of each Stage RIBA 1 -4	
Construction	
Agreement of Construction/ SLA Contracts • Ensure Contracts are dated • Review liability levels	
Project Progress Returns (WG)	
Construction Programme	
Project Progress Meetings	
Commercial Meetings	
Set up of KPI's (including Supervisor)	

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Item	Job Planning Progress Update
Date scheduled on Action Log	April - July 2025
Executive Lead	Medical Director
Reporting to:	Audit, Risk & Assurance (ARA) Committee
Summary	
This assurance note provides an update on the implementation of Consultant Job Planning. At its February 2025 meeting the Committee noted that the compliance target had increased from 85% to 90% within the Welsh Government's new IMTP framework. The Health Board's compliance rate at February's meeting was noted as 33.54%. This has increased to 59% (as of 1st August 2025) for consultants only. The Health Board has identified service areas where progress was slow and the deep dive approach has shown to improve compliance. It is believed that achieving 90% compliance by the end of September will be challenging to achieve. This is due to a number of factors including staff absence (sickness, maternity etc) and the "legal" challenges posed by several groups of staff.	
Background	
An update report was received by the ARA Committee in February 2025. The Committee requested a further update at its September meeting. An overview of job planning performance and compliance is included in this report up to 1st August 2025 and a fuller report will be included in the monthly Workforce Performance report of 18th September 2025.	
Assessment	
<i>Audit Action Plan (highlights):</i> A fuller update to the action plan is included as Appendix 1 (Action Plan). - Ten (10) of the eighteen (18) actions are considered complete. - Outstanding actions are centred around the completion of the Job Planning process and achieving the 90% completion target set by Welsh Government. - The e-Systems team is focusing on the roll out. Previously the support from the central Medical e-Systems team was prioritised to those areas first on the rostering implementation plan. This was agreed to reduce delays from a rostering implementation perspective. However, this approach has been revised to ensure	

- that all of the Medical e-Systems staff are focused on the roll out of job planning and achieving 90% completion by September 2025.
- Additional training sessions are being conducted and targeted bespoke training where needed.
 - Drop-in workshops have been undertaken from Spring 2025
 - Monthly compliance reports continue to be provided to the Divisional management teams
 - The Deputy Medical Director has informed Divisional Directors to remind Consultants to utilise their core SPA time to undertake Job Planning.

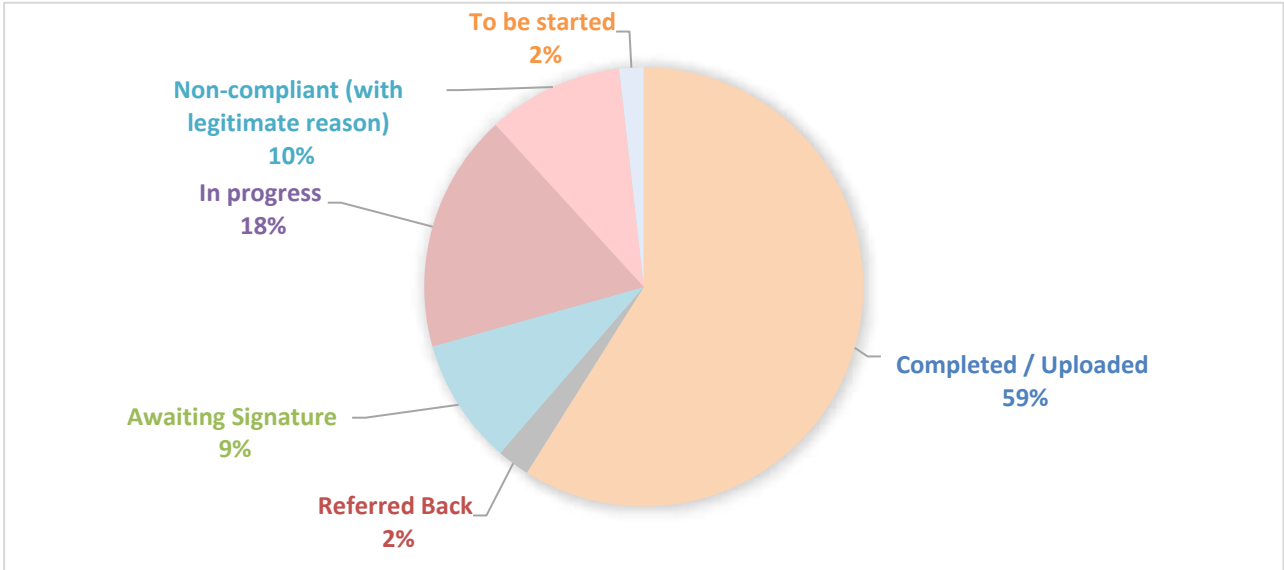
Electronic Job Planning system configuration & training:

The L2P job planning system has been configured to the Amendment to the Consultant Contract (Wales (2003)) and the Health Board’s Job Planning Procedure. Training sessions on the system continue to be delivered. The total trained is 493 staff which equates to 66% of the total 749 staff. Of these, 342 consultants have been trained – 69% of those trained. The totals for each Division vary:

	Total Required	No trained	% Trained	No consultants
Surgery	189	132	70	90
Family & Therapies	109	98	90	70
Medicine	137	46	34	29
Clinical Support Services	174	110	63	94
MH & LD	53	41	77	28
Urgent Care	36	23	64	19
Primary & Community Care	51	43	84	12
Total	749	493	66	342

Job Planning:

As at 1st August 2025 there were 419 job plans completed or uploaded out of a total of 708 at a rate of 59.2%. This total includes Consultants, SAS drs etc.



Of these, the number of completed Consultant job plans were 325 out of a total of 551 at a rate of 59%.

The following table provides a breakdown of each of the categories:

Category	Total	%	Cons only	%
Completed / Uploaded The job plan has been completed and signed by all required signatories in the L2P system / compliant paper job plan has been uploaded and is compliant until the expiry date of that job plan.	419	59.2	325	59.0
Referred Back The job plan has been signed by the Clinician and or the Clinical Manager but one of the signatories has reverted the job plan back as changes needed to be made	13	1.8	13	2.4
Awaiting Signature The job plan has been signed by the Clinician and or the Clinical Manager but not the final signatory (non-medical manager).	61	8.6	51	9.3
In progress A new job plan has been started in the L2P system	127	17.9	97	17.6
Non-compliant (with legitimate reason) Reasons include maternity, long term sickness absence, grievance	72	10.2	55	10.0
To be started New job plans to be started in the L2P system	16	2.3	10	1.8
Total	708	100	551	100

The completion plan has been reviewed in an attempt to meet the target compliance level, however, given that the non-compliant level is, with what is seen as legitimate reasons, currently at 10% then this is going to be challenging to achieve.

It is believed that other Health Boards have included the non-compliant (with legitimate reasons) figure in their "completed" statistics and if ABUHB also took this view then we would currently be achieving 69% compliance and it's strongly believed that we would then we would be close to achieving the 90% target by the end of September.

The following table shows the monthly levels of completion and the target level of completion to enable compliance with the Welsh Government target.

Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	13	33	11	21	19	11	37	27	-
Target	52	49	49	49	49	49	49	102	102
Job plans expiring or carried over	8	49	67	106	149	196	246	9	31

Further details for each Division can be found as Appendix 2 (Job Planning Data by Division as at 1st September 2025).

Deep Dive:

Service areas requiring a deep dive have been identified by the Medical e-Systems Team. Deep Dives have been undertaken with Medicine; Family & Therapies; Mental Health and Urgent Care. Dates are being confirmed for Clinical Support Services & Primary Care / Community. There is a focused agenda and presentation for each Division, agreed actions are captured and monitored.

The following provide some detail of the deep dive in the Division of Medicine as a priority area – the first meeting was held on 6th May 2025. The Deputy Medical also attended the assurance meeting for the Division of Medicine with the Chief Operating Officer where actions and sequencing were discussed. The work enabled the starting of job plans where previously over 70% were not started.

Division of Medicine Dept	Complete / Uploaded	% Compliance	Referred Back	Awaiting Signature	In Progress	To be Started	Non-compliant with reason
Acute Medicine	4	36.4	1	1	1	4	0
COTE	1	5.0	1	3	13	0	2
COTE YYF	1	16.7	0	0	5	0	0
Cardiology	3	23.1	0	2	8	0	0
Endocrinology Diabetes	0	0	0	2	8	0	0
Gastroenterology	3	17.6	0	1	13	0	0
Nephrology	0	0	0	0	1	0	0
Neurology	4	36.4	0	1	6	0	0
Respiratory	0	0	1	0	14	0	0
Stroke	0	0	0	0	6	0	0
Total	16	14.5	3	10	73	4	2
%	14.8%		2.8%	9.3%	67.6%	3.7%	1.8%

Once all job plans have been completed i.e., those in progress completed, those awaiting signature signed off etc. then this should mean that over 94% will be complete.

The size of some service areas means that the number of staff in the department may be small and show a disproportionate level of completion e.g., Nephrology shows as 0% complete but requires only one to be completed to achieve 100%.

Further Information about each Division status is available as Appendix 3 (Job Plan In-Progress Status Summary by Division as at 1st September 2025).

Recommendation

The Committee is asked to receive the report as assurance that the implementation of Job Planning is progressing, although not at the speed that we would wish and that there are challenges to implementation across the Health Board.



ACTION PLAN FOR JOB PLANNING – Updated August 2025

The 2025 plan for job planning aims to meet comply with the recommendations of the 2024/2025 Internal Audit report by : -

- Supporting the effective delivery of annual job planning
- Improving compliance
- Ensuring job planning is aligned to service delivery and outcomes for both individual and service objectives are included in the job plan.
- Job planned session and payment via ESR are aligned
- Promoting a change, the focus and culture of job planning within the Health Board to support demand capacity planning and delivery of service objectives
- Ensuring that risks associated with job planning compliance are identified within the appropriate risk registered and reviewed and monitored regularly

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
REF IA/25	1. JOB PLANNING COMPLIANCE				
R1/A1	1.1	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	Immediate & on-going	Chief Operating Officer	<u>Update August 2025</u>

ACTION PLAN FOR JOB PLANNING – Updated August 2025

R1/A2	1.2	The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with Medicine.	July 2025	Medical Director Deputy Medical Director (SE)	<u>Update August 2025</u> Deep Dives have ben undertaken with Medicine; Family& Therapies; Mental Health and urgent care. Dates are being confirmed for Clinical Support Services & Primary Care /Community. There is a focused agenda and presentation for each division, agreed actions are captured and monitored.
R1/A3	1.3	Vacant consultant posts will not be replaced until the whole team have an up-to-date job plan.	Process in place June 2025 On-going	Finance Director/Director of Workforce & OD	<u>Update August 2025</u> This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. The Job planning e-systems project officer has been added to the authorisation process in trac such that the job planning status of the team can be established before sign off. Where the requirement for the whole team to have an up- to- date job plan has not been met this will be escalated to the MD/DMD Medical for discussion with the DD/GM.
R1/A4	1.4	No positive pay impacting changes will be made unless accompanied by an up-to-date- job plan.	June 2025	Finance Director/Director of Workforce & OD	<u>Update August 2025</u> This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. Monthly retrospective reports are being analysed to ensure compliance with the requirements and action will taken if breaches are identified.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD



ACTION PLAN FOR JOB PLANNING – Updated August 2025

R1/A5	1.5	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.	June 2025	Finance Director/Director of Workforce & OD	<u>Update August 2025</u> This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. Monthly retrospective reports are being analysed to ensure compliance with the requirements and action will taken if breaches are identified.
R1/A6		Accountability arrangements will be strengthened to ensure the Directorate Manager has oversight and is responsible for ensuring job planning takes place within the directorate.	June 2025	Medical Director/Chief Operating Officer	<u>Update August 2025</u> This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7.
R1/A7		A 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 to achieving 90% compliance.	May 2025	Medical Director/Chief Operating Officer	<u>Update August 2025</u> The Medical Director has sent a letter to all consultants. In addition the Medical Director, Director of Workforce and Chief Operating Officer have sent a communication jointly to all General Managers and Divisional Director to share with their management team. Both communications explain the organisational approach and the actions that need to be taken to improve compliance. This has been reinforced at the divisional deep dives.

ACTION PLAN FOR JOB PLANNING – Updated August 2025

	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
	2. QUALITY OF APPROVED JOB PLANS				
R2/A1	2.1	The e-systems team will 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.	Dependent on ability of the L2P system and any additional cost, review October 2025	Director of Workforce & OD	<u>Update August 2025</u> This requirement was not part of our original contract with L2P however they have agreed in principle to include this in the systems development. The timescales for this are unclear at present due to other priorities. The Medical E systems team will provide updates following their regular meetings with L2P
R2/A2	2.2	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	Review October 2025	Medical Director/Director or of Workforce & OD	<u>Update August 2025</u> 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. The service outcomes in the L2P system can be activated with minimal notice once all consultants have an up-to-date-job plan in preparation for the next round of job planning. Preparatory work will need to be undertaken with divisions and corporate team to identify the outcomes that need to be included in the system.



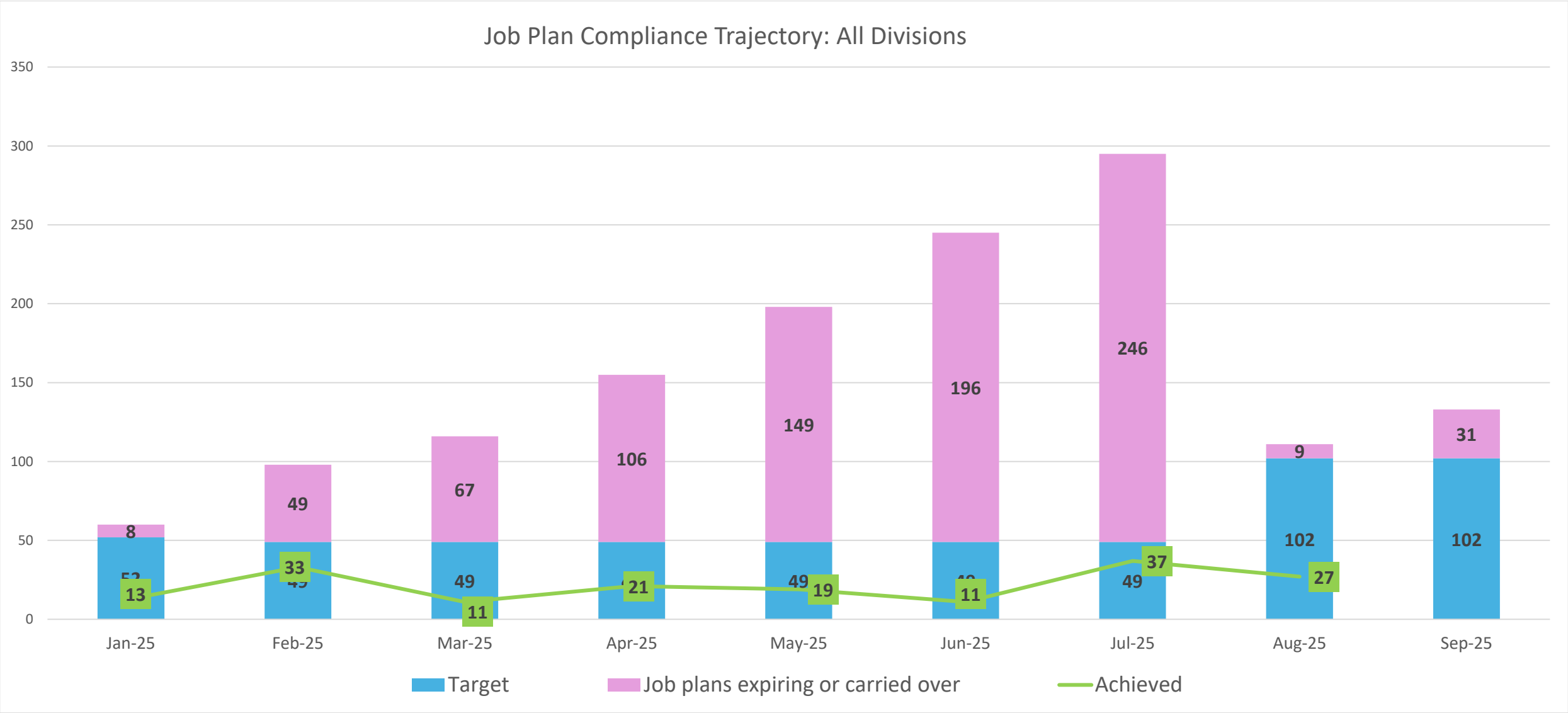
ACTION PLAN FOR JOB PLANNING – Updated August 2025

R2/A3		A reminder to complete the outcome section with SMART objectives will be included in the communication referred to in action R1/A7, to the consultant and the Directorate Managers.	June 2025	Medical Director/Chief Operating Officer	Update August 2025 The requirement is included in the job planning training which all consultants have been asked to undertake previously. It has also been included in the communication to all consultants, and management teams referenced in R1/A7.

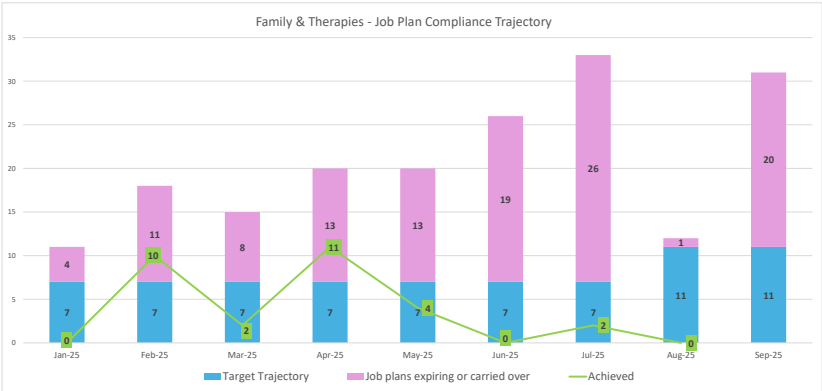
	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR LOCAL LEAD	STATUS AND MILESTONES
	3. ESR RECONCILIATION				
R3/A1	3.1	The Medical Systems team will work with L2P to establish whether the current alert can be used to provide a reminder that a change form needs to be completed and submitted to pay roll. It may also be possible to add a link to the Change form.	Dependent on ability of the L2P system and any additional cost. Review June 2025	Director of Workforce & OD	<u>Update June 2025</u> There is already an alert icon in the L2P system that identifies a sessional change in the job plan. L2P however have agreed in principle to include this in the systems development. The timescales for this are unclear at present due to other priorities. However the requirement may vary when SMA is rolled out for Medical staff.
R3/A2	3.2	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.	Review June 2025	Chief Operating Officer/Director of Finance	<u>Update August 2025</u> Awaiting 90% compliance with Job planning in the system. Review September 2025
R3/A3	3.3	The reminder to complete change forms to ensure sessions in job plans are paid accurately will be included in the communication to Directorate Managers	June 2025	Chief Operating Officer/Director of Finance	<u>Update August 2025</u> This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7.

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
4. OPERATIONAL FORUMS					
R4/A1	4.1	The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor.	July 2025	Medical Director Deputy Medical Director	<u>Update August 2025</u> Deep Dives have been undertaken with Medicine; Family& Therapies; Mental Health and urgent care. Dates are being confirmed for Clinical Support Services & Primary Care /Community. There is a focused agenda and presentation for each division, agreed actions are captured and monitored.
R4/A2	4.2	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.	July 2025	Medical Director Deputy Medical Director	<u>Update August 2025</u> The Terms of reference have been reviewed and agreed with the Job Planning Consistency Group. The decision to stand down a meeting will be the Deputy Medical Director's based on representation by the relevant clinical leaders. Lack of representation from the divisions is being addressed. Key issue highlighted from the job planning process and good practice sharing have been established as core agenda items.
R4/A3	4.3	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.	July 2025	Chief Operating Officer Divisional Directors	<u>Update August 2025</u>

R4/A4	4.4	Regular performance reports will be submitted to Performance Oversight Committee section of the Executive Committee.	Bi- Annually	Medical Director/Director of Workforce & OD	<u>Update August 2025</u> Job planning performance and compliance will be included in the monthly Workforce Performance report. Next report 18 th September.
	OBJECTIVES		ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
	5.RISK REGISTER				
R5/A1	5.1	In discussion with the Director of Corporate Governance the appropriate risk register for job planning compliance to be included in will be identified	June 2025	Medical Director/Chief Operating Officer	<u>Update August 2025</u> Non compliance with 90% target has been included in the corporate risk register in the workforce & culture section.
R5/A2	5.2	Risk related to compliance will be included in divisional risk registers	June 2025	Chief Operating Officer	<u>Update August 2025</u>

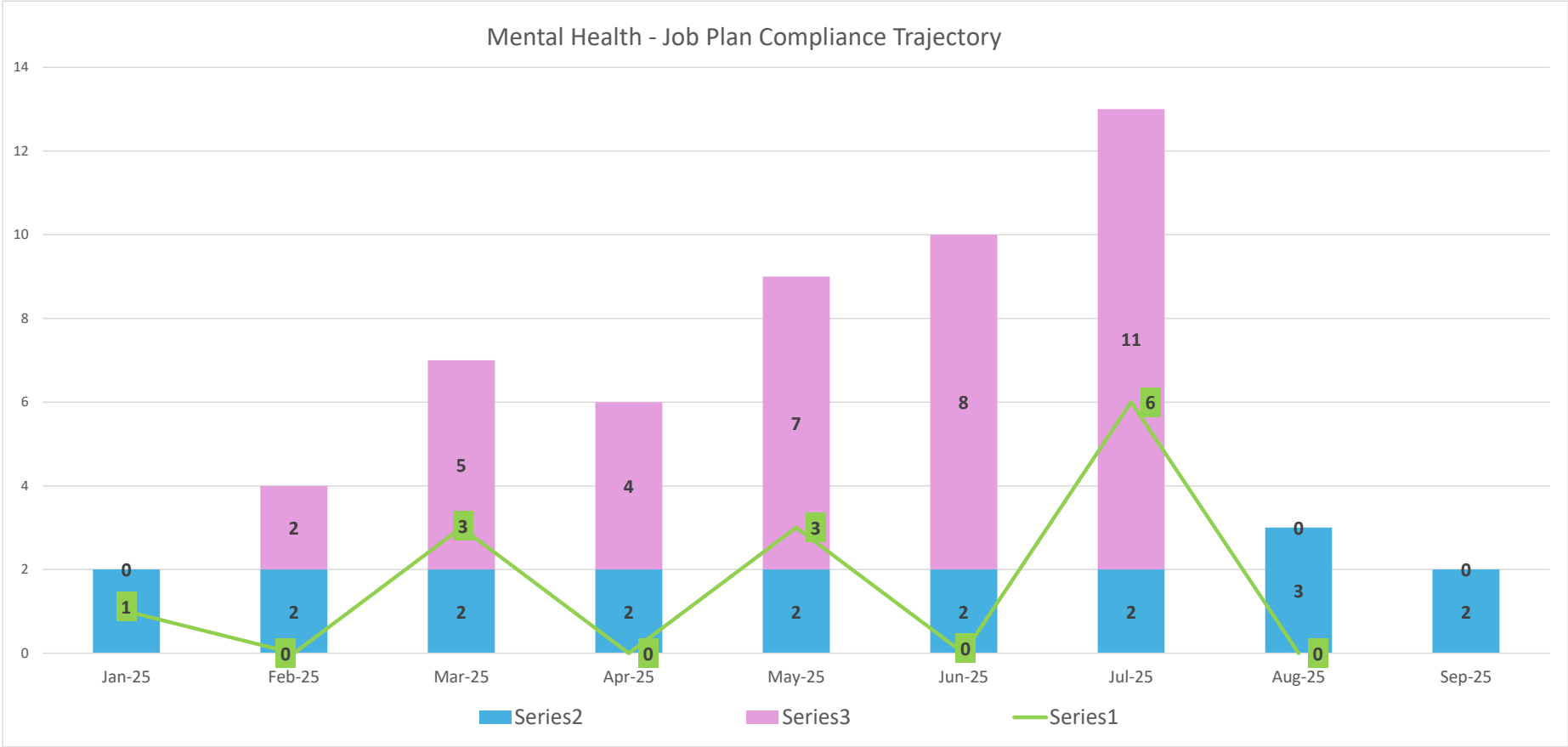


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	13	33	11	21	19	11	37	27	
Target	52	49	49	49	49	49	49	102	102
Job plans expiring or carried over	8	49	67	106	149	196	246	9	31



Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	0	10	2	11	4	0	2	0	
Target Trajectory	7	7	7	7	7	7	7	11	11
Job plans expiring or carried over	4	11	8	13	13	19	26	1	20

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July. This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September. Job plans expiring or carried over will change each month depending on what is achieved the previous months.

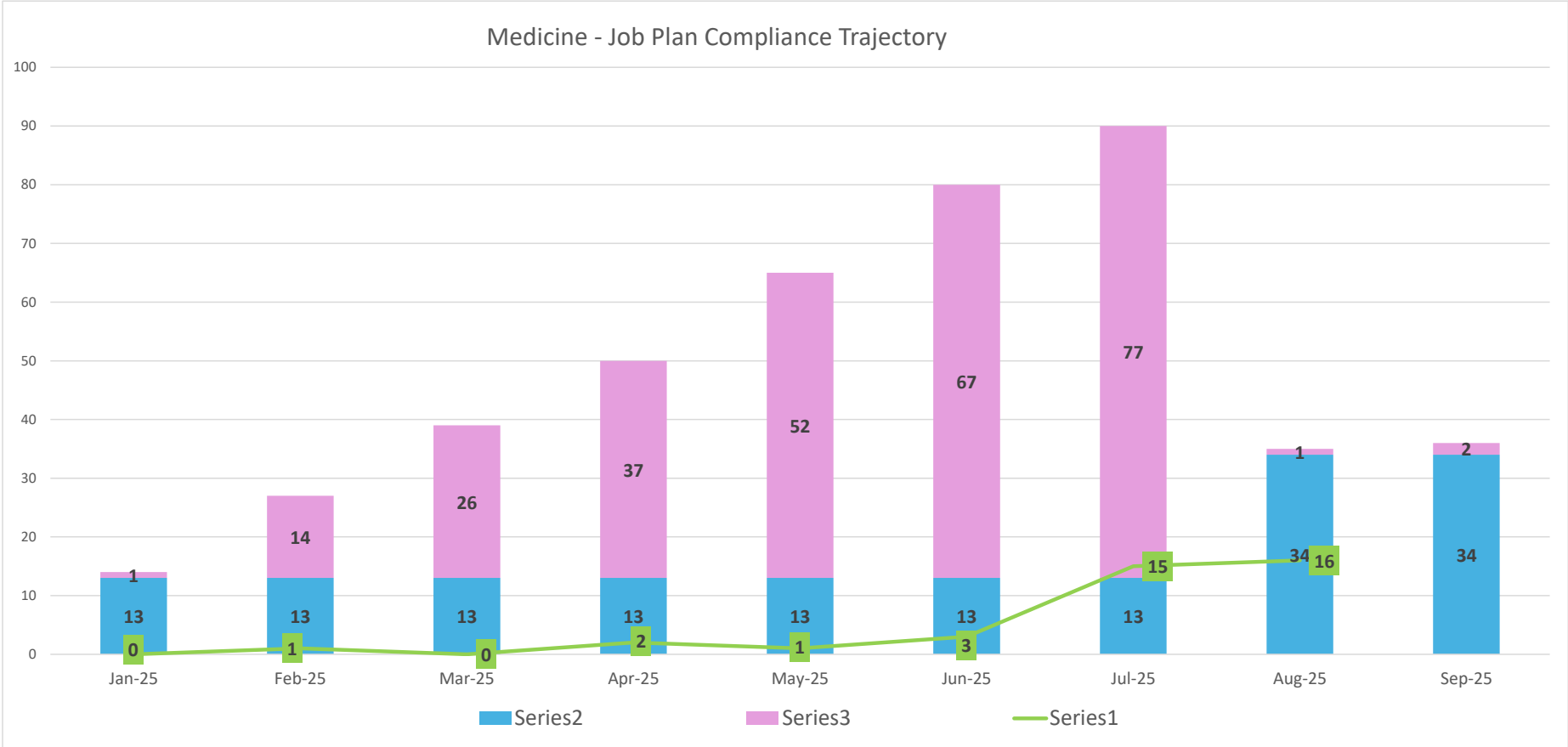


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	1	0	3	0	3	0	6	0	
Target Planned Trajectory	2	2	2	2	2	2	2	3	2
Job plans expiring or carried over	0	2	5	4	7	8	11	0	0

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.

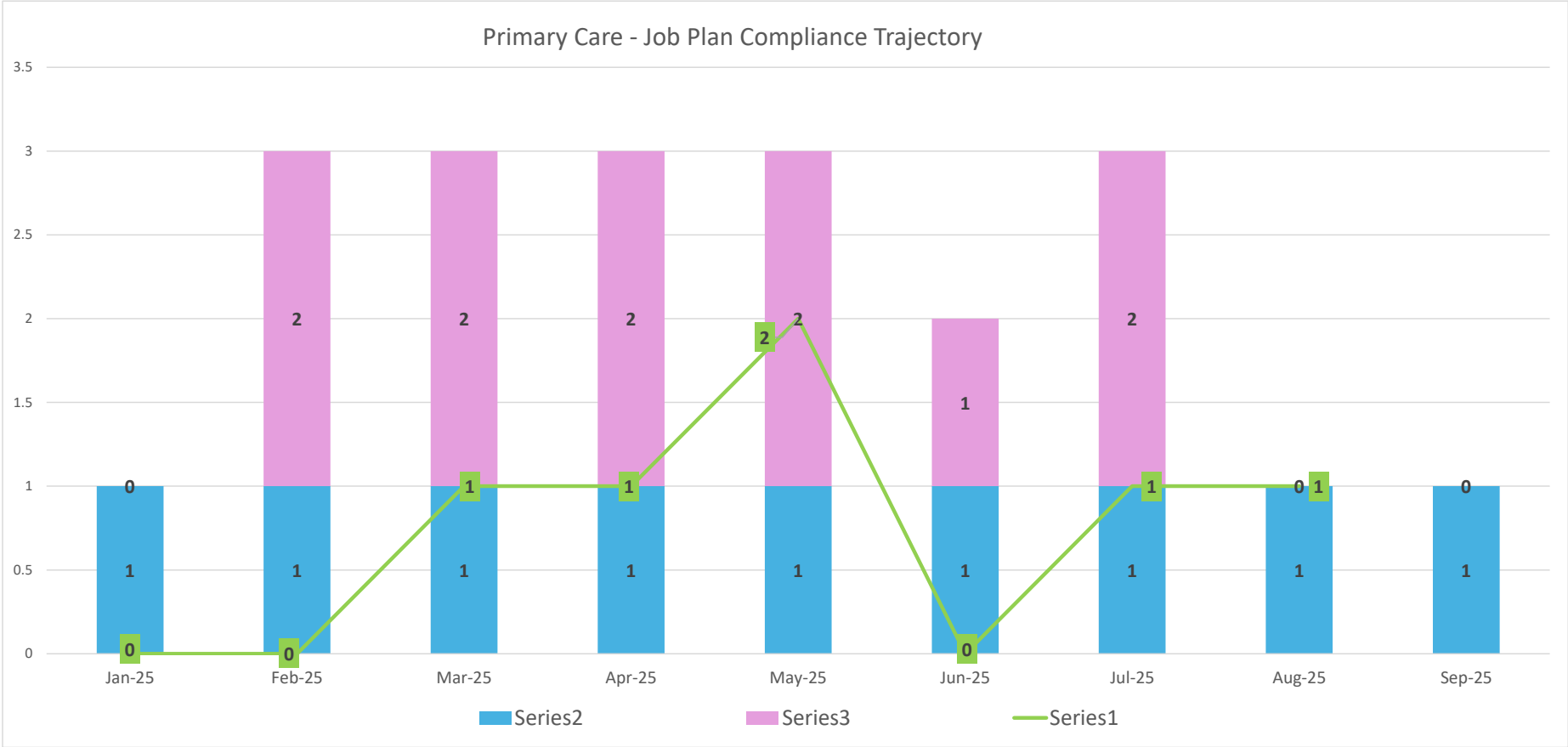


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	0	1	0	2	1	3	15	16	
Target Planned Trajectory	13	13	13	13	13	13	13	34	34
Job plans exipring or carried over	1	14	26	37	52	67	77	1	2

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.

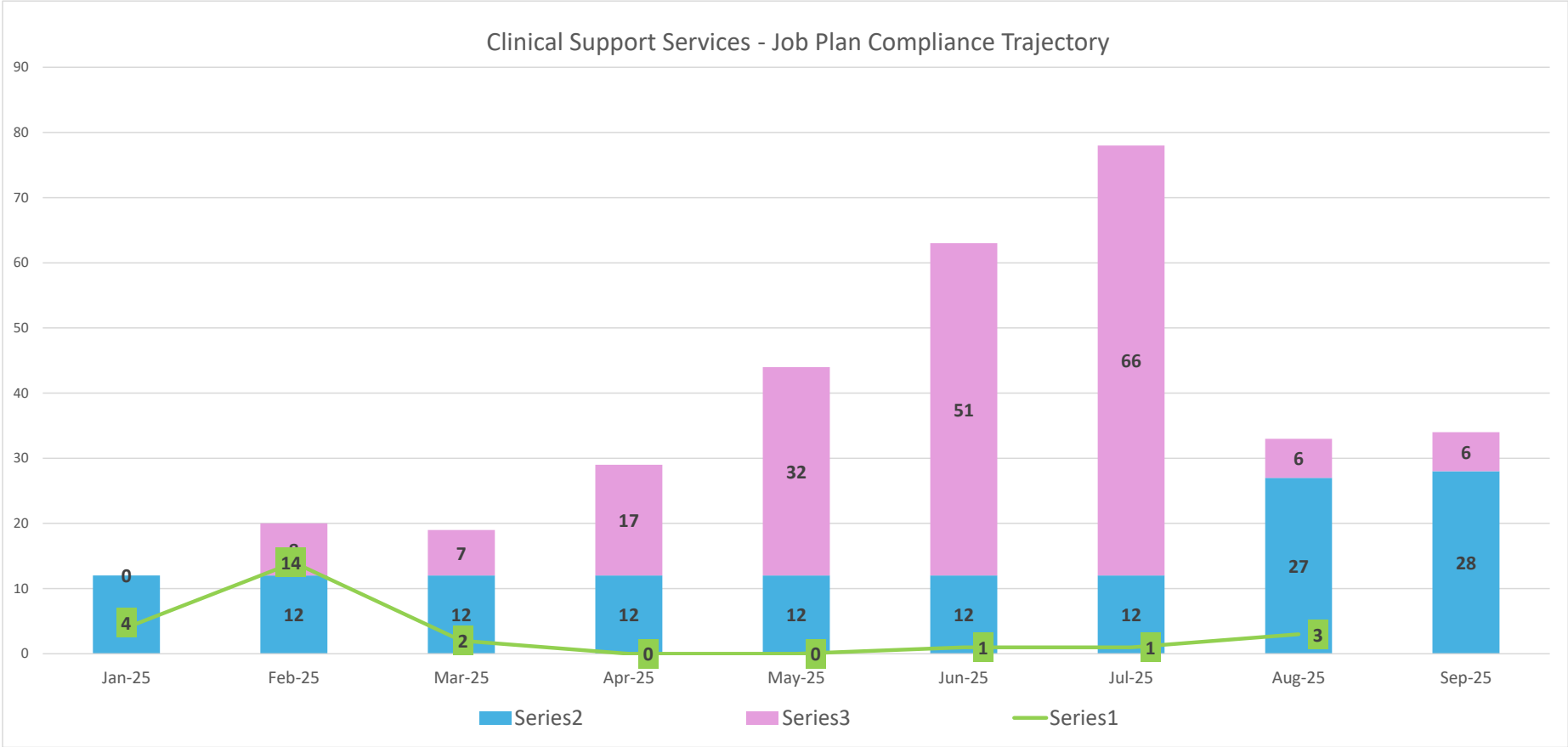


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	0	0	1	1	2	0	1	1	
Target Planned Trajectory	1	1	1	1	1	1	1	1	1
Job plans expiring or carried over	0	2	2	2	2	1	2	0	0

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.

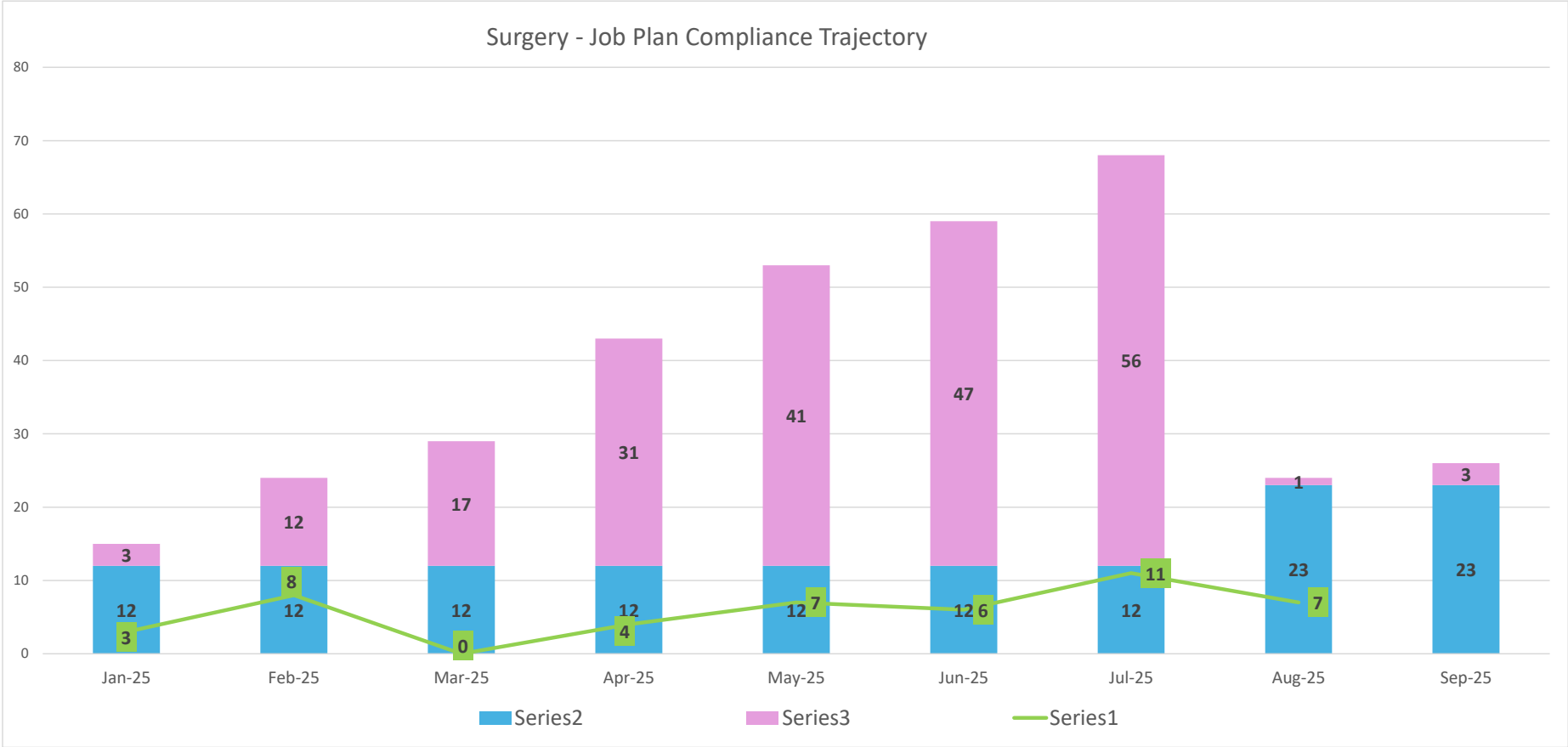


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	4	14	2	0	0	1	1	3	
Target Planned Trajectory	12	12	12	12	12	12	12	27	28
Job plans expiring or carried over	0	8	7	17	32	51	66	6	6

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.

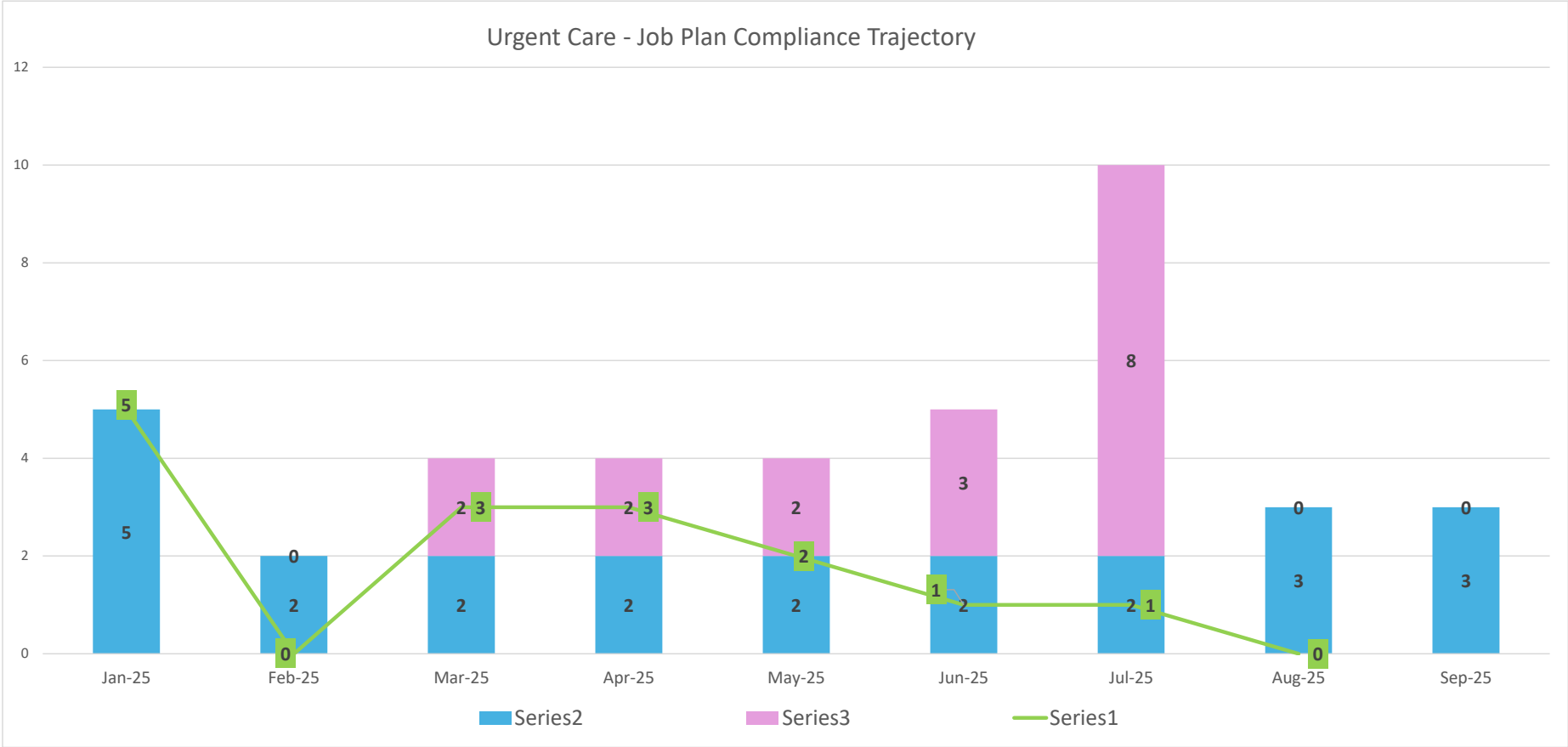


Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	3	8	0	4	7	6	11	7	
Target Planned Trajectory	12	12	12	12	12	12	12	23	23
Job plans exipring or carried over	3	12	17	31	41	47	56	1	3

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.



Status	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Achieved	5	0	3	3	2	1	1	0	
Target Planned Trajectory	5	2	2	2	2	2	2	3	3
Job plans expiring or carried over	0	0	2	2	2	3	8	0	0

This graph originally showed the trajectory of job plans required to be completed each month to achieve 90% by end of July.

This has now been re-set for August and September to achieved the Welsh Government Target of 90% by the end of September.

Job plans expiring or carried over will change each month depending on what is achieved the previous months.

Job Plan 'In Progress' by Division/Directorate Status Summary													
Division/Directorate	01/09/2025	05/08/2025	04/07/2025	05/06/2025	02/05/2025	05/04/2025	05/03/2025	05/02/2025	05/01/2025	05/12/2024	05/11/024	05/10/2024	Job Plan Status as at 10/09/02024
Family & Therapies													
Obs and Gynae	Action with directorate to complete job plans expiring in September. Directorate has advised this is unachievable.	If 2 job plans awaiting signatures are signed they would have achieved 90% compliance, action with directorate to organise job plan meetings ready for 20 job plans expiring in September.	2 Consultants remaining to sign thier job plans from 2024. Job plans are now expiring, action with directorate to complete.	2 Consultants remaining to sign thier job plans from 2024. Job plans continue to be completed as they expire.	Same as previous month	3 consultants remaining to sign their job plans from 2024.	5 job plans are remaining to be signed by clinicians since October 24. This has improved from last month since GM has chased sign off.	Job plans have been completed and ready to be signed by clinicians since October 24. 12 job plans are still waiting to be signed.	Job plans have been completed and ready to be signed by clinicians since October 24. 15 job plans are still waiting to be signed. 18 have been signed and completed since October.	6 further job plans have been signed and completed.	3 Job plans have been signed and completed. Directorate manager has chased clinicians to sign off job plans.	A few amendments have needed to be made within the job plans by the directorate, this may delay the signing of job plans by 1 week.	Admin staff in the directorate have been inputting the data of the job plans agreed into the L2P with help from the MWES team, which are now finalised. DM will be notifying the Dr's the job plans are ready to be agreeded and asking them to sign these in the system by 4th Oct 2024.
Paediatrics	Issues with regards to OOH rate and admin time raised in the deep dive meeting. Papers are being submitted for agreement before job planning can commence. 90% compliance by end of Sept will not be achieved.	Deep dive meeting to be held on 12/08/2025 where directorate will be raising issues for discussion and advice with regards to consistency.	A few issues with job calculations and historic agreements have been escalated to DD. Meeting arranged 04/07/2025 with CD to create a job plan template to ensure all calulations are as per the procedure.	Some amendments were made to clinics and admin times in job plans, action with directorate to complete job plans.	2 job plans completed this month. There has been a new CD appointed and a meeting will be arranged to discuss job plan completion along with training.	MWES met with CD and DM and agreed on job plan content. MWES have been working on applying the content to all other consultant job plans. CD has agreed and signed their job plan and job plans will be progressing this month.	MWES team have a meeting with CD and DM on 12/03/2025 to discuss job plans entered and progress with job plan meetings	MWES team have entered the data of the majority of the activites into the job plan, they will be ready this month to pass to the directorate to finalise.	MWES team are working with rostering to input job plans as per rotas.	No change on previous month	MWES team are working with rostering to input job plans as per rotas.	Meeting set up with CD, DM, MWES & L2P on 4th October to query a few calculation differences that were highlighted in the meeting held on 30/09/2024. Once these have been approved/amended MWES team can input the job plan data to system for the remaining consultants and job plan meetings can be held by the directorate.	Action with CD to approve master job plan template for Directorate. On approval job plan meetings can be scheduled in diaries and job plans completed. Meeting arranged with CD to answer some queries on 30/09/2024
Community Paediatrics	Action with directorate to complete job plans.	Action with directorate to complete job plans.	2 job plans awaiting signatures, one from October 2024 and the other from May 2025. Action with directorate to complete job plans.	Same as previous month	Job plans are being undertaken.	3 job plans awaiting DM's signature. Spoke to DM on 12/03/2025 who advised there were some queries that she needed to deal with before signing the job plans.	Further communication sent to CD and DM with no response as yet. Also chased those awaiting signatories, still no reponse as yet.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Action with directorate to schedule job plan meetings and complete job plans within the eSystem.	No change on previous month	No change from previous month	No change from previous month	Action with directorate to schedule job plan meetings in diaries and complete job plans.
Neonates	100% Compliant for consultants	100% Compliance for consultants has been achieved	90.9% Compliance with consultants has been achieved. Action with directorate to complete remaining Consultant and SAS Dr job plans.	Job plans are being undertaken.	7 Job plans have been completed. At least 3 more job plans should be completed this month.	7 Job plan meetings have being held and 5 job plans are awaiting signatures.	MWES team spoke with CD on 17/02/2025 who advised no meetings were booked in yet but would ensure job plans are completed by May 25.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. CD has responded and meeting date is being agreed.	Team Job planning meeting held with SAS Dr's 21/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	Team Job planning meeting held with SAS Dr's 21/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	Team Job planning meeting held with consultants 04/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	No change from previous month	Team job planning sessions arranged for 04/11/2024 (consultants) 21/11/2024 (SAS) - Job plan meetings will be held after this date.
Sexual Health	100% Compliant for consultants	100% Compliant for consultants	100% Compliance has been achieved.	Only 1 job plan remaining to be signed by Leanne Watkins	1 of the 4 job plans have been completed.	No longer 100% compliant as job plans have expired. 4 job plan meetings need to be arranged.	100% compliant, 1 job plan coming out of compliance on 1st April that now need to be scheduled.	4 job plans remaining to be compelted, CD is working on getting these resolved ASAP.	3 Job plans remaining to complete to achieve 100% compliance.	No change on previous month	No change from previous month	No change from previous month	CD competent on L2P system. Action is with directorate to schedule job plan meetings and complete job plans.
CAMHS	3 Job Plans still awaiting signatures. Action with directorate to complete all job plans.	3 Job plans now awaiting signatures for consultants.	No change from previous month.	4 Job plans awaiting signatures to significantly improve compliance	4 Job plans awaiting signatures - 1 job plan meeting to be arranged.	Meeting to be held on 10/04/2025 with CD for more training on the system.	Meeting held on 06/02/2025 with CD and GM. Went through remaining job plans and actions were agreed for each one. Some actions have resulted in more completed job plans, some are actions still outstanding to ensure compliance.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 06/02/2025.	Job plans have been completed in the eSystem, some since spring 2024 and are still awaiting clinician and manager sign off. MWES team have chased on multiple occations.	There is a hold on one job plan while the Core and OOH's are amended. No success in progressing signatures for the other job plans.	MWES team have been assisting CD chase signatures on outstanding job plans. However job plan meetings still need to be arranged for some job plans.	No change from previous month	Directorate competent on L2P system. Action is with CD to schedule job plan meetings in diaries and complete job plans.
Mental Health													

General Adult Psychiatry	1 Consultant job plan to be completed to reach 90% compliant next month.	1 x consultant vacancy being held until consultant job plans are complete. Action with directorate to complete job plans.	5 Job plans are awaiting signatures, action with directorate to complete remaining job plans.	Same as previous month	Although no contact has been made with directorate, 5 job plans are awaiting signatures	No change from previous months	MWES team have had unsuccessful attempts of communication with directorate.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	5 Job plans are completed in the eSystem. 6 job plans are awaiting sign off. Action with directorate to complete remaining job plans.	No change from previous month	No change from previous month	No change from previous month	DM competent on L2P system. Action is with CD to arrange job plan meetings in diaries and complete job plans.
Learning Disabilities	100% Compliance for consultants has been achieved	Action with directorate to complete 1 remaining job plan.	1 Job plan awaiting signatures, action with directorate to complete remaining 2 job plans.	3 job plans have now expired and need to be completed.	100% compliant in April although 3 Job plan meetings need to be arranged for May.	1 Job plan still needs to be completed.	MWES team continue to chase 2 remaining job plans, one job plan has now changed to awaiting signatures.	2 Job plans to complete, 1 job plan meeting is booked for February.	1 Job plan to be completed to achieve 100% compliance.	No change from previous month	1 Job plan now outstanding.	No Action required from this Directorate, 100% compliant.	No Action required from this Directorate, 100% compliant.
Older Adult Psychiatry	97.7% compliant with consultants	91.7% Consultant compliance achieved	1 Job plans meeting needs to be arranged, 2 job plans need to be agreed after meetings were held.	4 Job plan meetings need to be arranged.	2 Job plan meetings need to be arranged.	1 Job plan needs to be completed this month. 1 job plan due to expire in May.	Directorate has achieved 100% compliance. 1 job plan coming out of compliance on 1st April that now needs to be scheduled.	Directorate has achieved 92% compliance with consultant job planning.	3 Job plans to be completed to achieve 100% compliance.	Have made good progress, only 5 job plans left to complete.	CD has 3 job plan meetings booked in November.	4th Oct 24 New CD attended managers training. Meeting also held to discuss progress of job plans. Meeting dates have been provided to MWES team who will enter these on the system. 5 job plans have been completed by previous CD. DM will chase clinicians to sign these job plans and will escalate if necessary. CD now competent on system and	Directorate competent on L2P system. Action with directorate to schedule job meetings in diaries and complete job plans.
Medicine													
Acute Med	Job plan content has been added to the job plan with the detail we need for the roster. Action with directorate to continue job plan completion in line with the agreed monthly trajectory to achieve compliance by the end of September.	1x consultant vacancy being held until consultant job plans are complete. Medicine Deep Dive held 22/07/2025 - Action - Maintain regular bi weekly meetings with the Workforce and Organisational Development (WOD) team Continue job plan completion in line with the agreed monthly trajectory to achieve compliance by the end of September	No change from previous month.	Regular meetings have taken place with DM this month, Action with directorate to provide clinic detail to be added into the job plans.	2 Job plans awaiting signatures and 4 job plan meetings need to be arranged.	No improvements seen in March.	CD and DM have been in touch with MWES team and have made a small improvement this month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	MWES team have been assisting directorate with amending job plans ready for sign off. Action with directorate to complete and sign 7 remaining job plans.	MWES team have been assisting directorate with amending job plans ready for sign off.	MWES team have been in touch with CD and DM and progress is being made to complete job plans. Some job plan meetings have been held, but the job plans are waiting for signatures by all parties before they are compliant.	2nd Oct 24 a meeting was scheduled with DM to discuss job plan progress, meeting cancelled due to service pressures. Directorate competent on L2P system. Action with directorate to schedule job plan meetings and complete job plans.	Directorate competent on L2P system. Action with directorate to schedule job plan meetings and complete job plans.
Cardiology	Continue progressing with job plan completion in alignment with the monthly trajectory to ensure full compliance by the end of September.	Medicine Deep Dive held 22/07/2025 - Action - Continue progressing with job plan completion in alignment with the monthly trajectory to ensure full compliance by the end of September.	3 further job plans have been completed this month.	2 job plans completed this month	No progress on 6 job plans ready for sign off.	6 job plans are ready for sign off and should be completed in April	MWES team have given access to Business support manager in the area who will help with the job plan data in the system.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Directorate have had a team meeting to agree job plan template and can start individual job plans.	Directorate have had a team meeting to agree job plan template and can start individual job plans.	No change from previous month	No change from previous month	CD and DM competent on L2P system. Action is with directorate to complete job plans.
COTE	Maintain progress with job planning in accordance with the monthly trajectory to achieve full compliance by the end of September.	2 x consultant vacancies being held until consultant job plans are completed. Medicine Deep Dive held 22/07/2025 - Action - Rhys Monk to arrange for Natalie Brooks to attend meetings and MDTs to support consultants in finalising and signing off job plans in L2P. Maintain progress with job planning in accordance with the monthly trajectory to achieve full compliance by the end of September.	5 job plans are awaiting signatures, meeting held with the DM and CD to assist in completing job plans, action with directorate to complete job plans.	4 Job plans awaiting signatures, meeting arranged with DM to work through some issues but meeting was cancelled by DM. MWES had a meeting with CD to resolve some on-call queries for SAS on-call calculations within L2P.	2 Job plans awaiting signatures and 4 job plans entered onto L2P by the MWES team for sign off.	CD did not attend scheduled meeting. No response with regards to re-scheduling meeting. DM advised no meeting was required however no progress being made.	Meeting set up with CD and ADM for 20/03/2025	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	4 Job plans have been signed by consultants and are still awaiting CD's sign off. Action is with directorate to complete job planning.	3 job plans have been signed by consultants and are now awaiting CD's sign off.	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	4th Oct 24 DM has requested help from MWES team to add 11 job plans onto the system, this will be completed by MWES team by 11th Oct 24. Job plans will be expected to be signed after this date	DM competent on L2P system. Action is with directorate to schedule job plan meetings in diaries and complete job plans.
COTE YF	Continue with job plan completion in line with the monthly trajectory to ensure compliance by the end of September	Medicine Deep Dive held 22/07/2025 - Action - Continue with job plan completion in line with the monthly trajectory to ensure compliance by the end of September	Same as previous month	Action with directorate to complete job plans	MWES team have provided further training for DM who is working on completing job plans.	Same as previous months	Same as previous month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	2 Job plans have been signed by clinicians and are still awaiting CD's sign off. Action is with directorate to complete job planning.	2 Job plans have been signed by clinicians and are awaiting CD's sign off.	No change from previous month	No change from previous month	DM competent on L2P system. Action is with directorate to schedule job plan meetings in diaries and complete job plans.

Endo Diabetes	Sustain regular Monday meetings with the MWES team and ensure job plan completion remains on track with the monthly trajectory to meet the end of September compliance target.	Medicine Deep Dive held 22/07/2025 - Action - Sustain regular Monday meetings with the MWES team and ensure job plan completion remains on track with the monthly trajectory to meet the end of September compliance target.	2 job plans awaiting signatures, MWES team are in regular contact with CD to assist with completing job plans.	1 Job plan completed this month. Regular weekly meeting being held with CD to help input job plans on the system ready for meetings to be held.	1 Job plan meeting was held in April. Meeting to be arranged with MWES, DM&CD to help add content into the system.	MWES team met with CD and ADM, MWES have offered assistance on entering job plans onto the system and will also join job plan meetings at the end to assist the CD with entering everything agreed in the job plan to aid timely sign off.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required changed to 02/04/2025.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 12/03/2025. Awaiting confirmation of this date from directorate.	MWES team have worked with directorate to enter activites for one clinician. Action with MWES team to amend this job plan. Action with directorate to complete job planning for the rest of the Dr's	MWES team have worked with directorate to enter activites for one clinician. Directorate are to set up a follow up meeting to discuss the final version before sign off.	No change from previous month	No change from previous month	Action is currently with directorate to schedule job plan meetings in diaries and complete job plans. Further assistance may be required from MWES team.
Gastro	Continue completing job plans in accordance with the monthly trajectory to ensure full compliance by the end of September.	Medicine Deep Dive held 22/07/2025 - Action - Continue completing job plans in accordance with the monthly trajectory to ensure full compliance by the end of September. Progress MDT opportunity and management walk around to sign off Job plans	Meeting being held 04/07/2025 to make final adjustment to job plans	Follow up meeting to be held on 11/06/2025 with directorate to finalise job plans ready for meetings to be held.	On-call has now been confirmed, MWES team working with directorate to add this into job plans, meeting arranged for 09/05/2025 to finalise	No change from previous month.	CD needs to confirm on-call arrangements before job plan meetings can be held. Workforce colleagues are assiting the direcorate with on-call issues.	CD needs to confirm on-call arrangements before job plan meetings can be held. Meeting is being held by the directorate to discuss this on 11/02/2025.	Action with directorate to comple	No update from previous month.	Meeting had with Assistant DM's and all job plans were added to the system with help from MWES team. CD needs to confirm on-call arrangements before job plan meetings can be held.	Meeting due to be held on 9th Oct 24 with CD & DM to receive an update on job planning progress.	Directorate competent on L2P system. Action with CD to review and agree job plan template for the directorate. Once agreed MWES team will support directorate to input job plans on L2P.
Neurology	Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline. Progress one job plan escalation due to non engagement.	Medicine Deep Dive held 22/07/2025 - Action - Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline. Progress one job plan escalation due to non engagement.	3 Job plans complete, action with directorate to complete remaining job plans.	2 Job plans awaiting signatures.	1 further job plan complete due to it being needed for NCIA application.	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	1 Job plan has been signed and completed. Action with directorate to complete job planning.	1 Job plan has been signed and completed.	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	No change from previous month	DM competent on L2P system. On Call template shared with Consultants for agreement. Job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
Nephrology	Same as previous month	Same as previous month	Same as previous month	Same as previous month	No progress with the job plan this month. Job plan now 3 years out of compliance	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	Action with directorate to complete job planning.	No change from previous month	No change from previous month	DM confirmed the job plan is with service manager for approval w/c 7th October	DM competent on L2P system. Action with Directorate to schedule job plan meeting and complete job plan.
Respiratory	Meeting being held 05/09/2025 with MWES team and Directorate management to ensure job plans are recorded accuratley on L2P. 90% compliance by end of Sept will not be achieved.	Medicine Deep Dive held 22/07/2025 - Action - Keri Russell to arrange a meeting with the new Clinical Director and the MWES team to agree on a method for integrating job plans into the L2P system. Directorate to develop a plan overcome the obstacles and confirm a date for completion of job plans with Stephen Edwards by August 14th	Meeting being arranged with management to discuss entering job plan onto L2P.	Same as previous month	Escalated concerns with DD with regards to job plans potentially being recorded incorrectly.	Same as previous month	Same as previous month.	Meeting required with MWES team, DD, CD and DM to discuss how job plans should be entered onto e-system.	1 job plan complete. Action with directorate to complete job planning.	No change from previous month	No change from previous month	No change from previous month	DD confirmed L2P system can record directorates way of working correctly as the CD expressed concerns. Action with CD to contact MWES team to discuss correct input of data into the L2P system.
Stroke	Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline.	Medicine Deep Dive held 22/07/2025 - Action - Phillip Campbell to support resolution of job plans exceeding 14 sessions to facilitate agreement and sign-off. Stephen Edwards and Phillip Campbell to discuss a plan to address the issues associated with number of vacancies and staffing issues	2 Job plans complete, action with directorate to complete remaining job plans.	Same as previous month	No progress made with job plans this month.	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	2 Job plans have been signed and completed. Action with directorate to complete job planning.	2 Job plans have been signed and	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	No change from previous month	DM competent on L2P system. Action with directorate to schedule job plan meetings in diaries and to complete job plans.
Primary Care and Community													

Community COTE	No consultants in this area, only 2 remaining job plans to complete.	No consultants in this area, only 2 remaining job plans to complete.	Only 3 job plans remaining to be completed.	Same as previous month	Same as previous month	Job plan meetings have been and are being held over the next few months. Improvements should be seen in April.	1 further job plan was completed. There are 3 job plans expiring next month that need to be scheduled.	Action with directorate to complete remaining 5 job plans. 4 Job plan meetings due to be held in February.	Action with directorate to complete remaining 6 job plans.	No update from previous month.	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	DM competent on L2P system. Action with directorate to complete remaining job plans.
Dental	100% Compliant for consultants	100% Compliance has been achieved	1 job plan awaiting signatures	Same as previous month	1 Job plan remaining to complete.	Same as previous month.	Same as previous month.	Action with directorate to complete 2 remaining job plans.	Action with directorate to complete 3 job plans.	No update from previous month.	Training session held with CD, DM and consultants. Directorate will commence job planning	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	CD & DM need to complete L2P training.
Frailty	100% Compliance for consultants has been achieved	Action with directorate to cmplete remaining job plans	3 job plans to be completed, meetings have been arranged for July.	2 out of the 3 job plans were completed from previous month.	3 Job Plan meeting due to take place in May	4 Job plans completed. Some due to come out of compliance shortly.	4 job plans awaiting signatures. MWES team have chased these.	Action with directorate to complete 6 remaining job plans.	Action with directorate to complete 8 remaining job plans.	5 Job plans remaining to complete.	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	DM competent on L2P system. Action with directorate and to complete remaining job plans.
Palliative Care	100% Compliance for consultants has been achieved	Action with directorate to complete remaining job plans	2 job plans awaiting signatures and 2 job plans awaiting agreement following meetings in June.	Same as previous month	Action with directorate to complete remaining job plans	MWES team have met with CD to resolve some queries with job plans. 2 job plans signed by CD and are awaiting others sign off.	Job plan's are ready for sign off. Directorate are aware and chasing.	Action with directorate to complete 2 remaining job plans.	Action with directorate to complete 4 remaining job plans.	5 Job plans remaining to complete.	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	All clinicians 100% complete on L2P training. Directorate competent on L2P system. Action with directorate to complete remaining job plans.
Clinical Support Services													
PACCT - Anesthetics	6 Job plans awaiting signature that are able to be completed. 90% consultant compliance will not be achieved due to ongoing issues in directorate.	3 job plans have been entered by MWES team and are awaiting sign off	3 job plans have been entered by MWES team and are awaiting sign off	Same as previous month	Same as previous month	Some job plans are being progressed, however due to ongoing disputes, most job plans will be delayed.	A further 7 job plans were sent to MWES to input into the system and are ready for sign off.	12 paper job plans sent to MWES team from the directorate for the data to be input onto the L2P system. CD has signed these within the e-system and some are awaiting clinician signature. More meetings are being held in February.	A range of job planning queries were submitted to the MWES team. Stephen Edwards responded to these queries and directorate advised they would be commencing job planning in the new year (2025).	Email addressing queries sent by Stephen Edwards. Job planning is to be commenced in the new year.	No change from previous month	No change from previous month	Group training being progressed with MWES team, 46% of clinicians have completed L2P training. A number of queries were raised from the directorate and the MWES team e.g. Agreed local sessional rates for activities, concerns with L2P not recording job plans accurately, recording when SPA is taking place, cost implications of applying the job plan procedure. Workforce colleagues are working through these queries and hope to discuss a resolution by mid Oct. 75 job plans that need to be completed are on hold during this time.
PACCT - Critical Care	Action for directorate to complete remaining job plans.	1 Consultant vacancy being held until consultant job plans are completed. Action for directorate to complete remaining job plans.	Job plans are being undertaken.	Job plans are being undertaken.	Job plans are being undertaken.	MWES team met with the new CD to offer training and assistance, they are comptent on the system and will start job planning those outstanding.	Same as previous month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Action with directorate to complete remaining 8 job plans.	No change from previous month	No change from previous month	No change from previous month	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
PACCT - Pain	1 Job Plan remaining to be completed to achieve compliance.	Same as previous month	Same as previous month	Same as previous month	ADD will pick up the outstanding job plan whilst CD is on leave.	CD is on A/L. MWES team will pick up on their return.	CD is on A/L. MWES team will pick up on their return.	CD is on A/L. MWES team will pick up on their return.	Action with directorate to complete 2 job plans.	No change from previous month	No change from previous month	No change from previous month	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Pathology	2 consultant job plans remaining to be completed to achieve complaine by end of Sept.	Action with directorate to complete remaining job plans	Same as previous month	Same as previous month	Progress continued to be made in this directorate and they are engaged with the process. Some disputes still ongoing.	MWES team met with CD and AGM who are attempting to resolve a dispute with a job plan, MWES also assisted with changing deal on job plans were responsibilites have changes. Progress continued to be made in this directorate and they are engaged with the process.	CD and DM have been in touch with MWES team and job plans are ready to be signed.	Cell path speciality are 100% compliant. Job plan meetings are being held during February for the remaining specilities.	Cell path speciality are 100% compliant. Action with directorate to complete Micro and Chemical speciality.	1 job plan has been signed and completed in Micro.	Pathology - Cellpath is 100% completed - the CD and DM are working on Micro next.	CD has been in touch with MWES for assistance with queries. CD advised all job plans are to be completed in October 24	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.

Radiology	3 Job plans awaiting signatures. Action with directorate to complete remaining consultant job plans to achieve compliance by end of Sept.	Action with directorate to complete remaining job plans	6 job plans are awaiting sign off.	Same as previous month	3 Job plans are awaiting signature	1 out of the 7 job plans has been completed.	Action with directorate to complete remaining 7 job plans.	Action with directorate to complete remaining 6 job plans.	Action with directorate to complete remaining 11 job plans.	MWES team worked with directorate to tidy up multiple job plans within the system. 4 job plans awaiting final signature from the DM.	No change from previous month	No change from previous month	Directorate competent on L2P system. Action with directorate to complete the remaining job plans.
Surgey													
Dermatology	92.3% compliant for consultant job plans	92.3% compliant for consultant job plans	92.3% Compliance has been achieved for consultants. 1 remaining job plan to be completed.	Only 2 remaining job plans to be complete	4 Job plans to be progressed in May.	Same as previous month.	Action with directorate to complete remaining 5 job plans. 1 job plan due to expire on 1st April and needs to be scheduled.	Action with directorate to complete the remaining 7 job plans. MWES team had a meeting with DM who is working their way through the job plans and contacts us regularly if help is required.	Action with directorate to complete the remaining 12 job plans.	No change from previous month	No change from previous month	No change from previous month	Directorate competent on L2P system. Action with directorate to complete the remaining job plans.
ENT	2 remaining consultant job plans to complete to achieve compliance by end of Sept.	Action with directorate to complete remaining job plans.	Action with directorate to complete remaining job plans.	4 Job plans awaiting signature	Good progress being made. 3 job plans complete and 5 job plans awaiting signatures	Same as previous month.	6 job plan meetings have been held this year, but none have been signed/completed. MWES are in contact with directorate to chase completion.	5 job plan meetings being held in February.	Action with directorate to commence job planning.	MWES team have been assisting directorate amend job plan content. Action with directorate to commence job planning.	No change from previous month	No change from previous month	Directorate competent on L2P system. On Call template shared with Consultants for agreement. Once agreed job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
General Surgery	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	MWES team attended 2 drop in sessions where 4 job plans were completed.	6 job plans awaiting signature, MWES drop in session arranged with this directorate	7 Job plans awaiting CD or DM signature	All templates have been allocated in job plans. MWES team attending directorate meeting to do further training on L2P system with clinicians.	MWES team worked on allocating all on-call templates in job plans and have been answering regular queries from the directorate. Progress should be seen in April.	MWES team met with CD 27/02/2025 and has offered help with allocating on-call into the job from the rota. This should hopefully speed up the process of completion of job plans.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 07/02/2025.	Action with directorate to complete the remaining job plans.	Action with directorate to complete the remaining job plans.	Action with directorate to complete the remaining job plans.	MWES team attending directorate meeting on 9th Oct 24 to deliver a group training session	Action is with new CD to attend training with MWES team and to complete remaining job plans.
Haematology	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	90.9% Compliance achieved with consultants	Only 3 job plans remaining to be completed	Same as previous month	Some job plans are currently trying to be resolved in the directorate and has been escalated to the DD for assistance in resolving.	Action with directorate to complete 4 remaining job plans.	5 Job plans left to complete.	Action with directorate to complete the remaining job plans.	No change from previous month	No change from previous month	No change from previous month	DM & CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Ophthalmology	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	4 Job plans awaiting signatures, action with directorate to complete remaining job plans.	Action with directorate to complete job plans	Action with directorate to complete remaining 6 job plans	Action with directorate to complete remaining 6 job plans as one job plan had to be referred back for amendments.	Action with directorate to complete 5 remaining job plans	5 job plans are complete. 4 job plans awaiting signatures.	3 Job plans have been signed and completed. Action with directorate to complete remaining job plans.	2 Job plans have been signed and completed.	No change from previous month	4th Oct 24 Meeting with DM arranged who advised they are undertaking a job plan meeting per week until compliance is reached.	Job planning principles team session undertaken 10/09/24. Directorate will progress job plans after session and further assistance may be required from MWES team.
Oral Surgery	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	Action with directorate to complete remaining job plans.	7 Job plans still awaiting signature from previous month	4 Job plans have been completed and 7 job plans awaiting signatures.	3 job plans awaiting signatures, 5 job plan meetings held in March.	No change from previous month	2 Job plans are awaiting signatures, 4 job plan meeting are to be held in February.	Action with directorate to commence job planning.	Action with L2P to change Core and OHH's as per directorates request.	No change from previous month	No change from previous month	Job plan template added to L2P for Directorate. Action with directorate to schedule job plan meetings in diaries and complete job plans
Rheumatology	100% Compliant job plans	100% Compliance has been achieved	Only 2 job plans remaining to be completed	Only 3 job plans remaining to be completed	Same as previous month	Action with directorate to book meetings for job plans due to expire over the next month.	2 job plans remaining to be completed. 2 job plan expiring in April that need to be scheduled.	3 Job plans remaining to be completed. Directorate advised they are having difficulty with agreeing these job plan with the clinicians, they will escalate if needed.	Action with directorate to complete the remaining 3 job plans.	3 Job plans left to complete.	No change from previous month	No change from previous month	DM & CD is competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
T&O	Meeting to be held to discuss job plan content.	2 x consultant vacancies being held. Some job plans awaiting Stephen Edwards signature, Stephen has requested call with CD to discuss before approving.	Issues were escalated that may take time to resolve, however some job plans are being completed.	1 Job plan completed this month. Issues have been escalated and meeting to be held with DD 11/06/2025.	4 job plans are awaiting signatures	DM has signed 4 Job plans and they are awaiting others signatures.	AGM advised 21 job plans are ready for signing and all SAS Dr's have a date in the diary for March for completion.	MWES team have inputted all job plan data into the system. Action with directorate to finalise job plans.	MWES team are assisting directorate to input the data of the job plans and rota into the system. Action is with directorate to book job plan meetings and check the details of the e-job plans to ensure they reflect what is being delivered.	Mutiple meetings with DM had this month. MWES team are entering the content of the job plan and on-call rota patterns in the system. This needs to be completed and agreed before job plans can with completed.	Meeting to be set up with DM to assist with inputting job plans to L2P. - Awaiting suitable times from directorate	No change from previous month	Action is with directorate to schedule meeting with MWES team to discuss on call allocation of job plan template.

Urology	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	Action with directorate to complete remaining 2 job plans.	2 Job plans left to complete.	Job plan meeting are being held by the directorate and 2 job plans completed so far.	DM raised concerns that clinicians in the area have concerns with the job plan process. DM requested we meet with the clinicians with the DD to answer any concerns they have. Action with directorate to book a meeting for MWES and the CD/DM to meet to plan a appropriate session.	CD & DM competent on L2P system. On Call template shared with Consultants for agreement. Once agreed job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
Urgent Care													
Emergency Medicine	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate have made significant improvement in compliance and are continuing to complete job plans.	Action with directorate to complete remaining job plans.	4 Job plans awaiting CD sign off. 3 Job plans signed and completed.	08/10/2024 meeting held with MWES team, CD & DM and an agreed way to record job plans was agreed and 9 job plans were added to the system. DM has chased clinicians to sign these job plans.	3rd Oct 24 MWES team received 8 paper job plans from DM. MWES team have added 2 of those job plans onto the system in an annualised format. Action with diretorate to arrange meeting with MWES team to review these job plans to ensure correct format before continuing with the others.	Action with directorate to arrange follow up meeting with MWES team. Directorate asked for additional support to input job plan template on L2P. Protected time in diary is required by directorate once date confirmed.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial governance, reporting & control.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Finance Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

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



- Budgetary Control (Appendix 1)
- Losses and Special Payments (Appendix 2)
- Stores and Stocks (Appendix 3)

Cefndir / Background

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

The FCPs presented were considered and approved by the Executive Committee at their meeting on the 4th September and are now being presented to the Audit, Risk and Assurance Committee for approval.

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

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

The FCPs to be reviewed at this Committee are:

- Budgetary Control (Appendix 1)
- Losses and Special Payments (Appendix 2)
- Stores and Stocks (Appendix 3)

Together with a summary of all FCP review dates.

1.1 Budgetary Control

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

The Health Board has two statutory duties:

- First Duty - to ensure that its expenditure does not exceed the funding allocated to it over a 3 year period.
- Second Duty - prepare an Integrated Medium Term Plan (IMTP) to secure compliance with the first duty.

The first year of the IMTP will form the annual budget.

The procedure sets out a control framework and responsibilities of the Board, Chief Executive, Director of Finance, Procurement and Value and Budget Holders in relation to approving, managing and reporting budgets across the organisation.



The document has been circulated for comment as follows:

- Governance and Controls Officer
- Finance Manager – Business Systems
- Corporate Finance Accountant
- Head of Management Accounting & Costing
- Head of Financial Services & Accounting
- Interim Assistant Finance Director – Financial Strategy and Planning
- NWSSP - Audit and Assurance Services

A summary of the main changes to the FCP is set out below. The full revised FCP is included in Appendix 1.

Section	Name	Main Changes
1	Introduction	Updated to include statutory requirements as per the National Health Service (Wales) Act 2006 and the National Health Service Finance (Wales) Act 2014.
2	Policy Statement	2.1 Integrated Medium-Term Plan (IMTP) - Expanded to include the requirement for the Board to approve the IMTP before the financial year begins and submit to Welsh Government for approval.
6	Roles and Responsibilities	6.1 The Board – Clarification of the Boards responsibility to approve the IMTP. 6.2 Chief Executive – Included responsibility for ensuring budgetary control when contractors are empowered to commit expenditure. 6.3 Director of Finance, Procurement and Value – Expanded to include all responsibilities included in the SFIs related to budgetary control. 6.4 Director of Workforce and Organisational Development – Amended to add responsibility for issuing employee contracts, linked to job descriptions and PADR guidance. 6.5 Budget Holders - Expanded to include all responsibilities included in the SFIs related to budgetary control.
7	Annual Budgets	7.1 Budget Setting – Expanded to include all reference to budget setting included in the SFIs. 7.2 Budget Delegation • Expanded reference to delegation letter criteria: individual responsibilities ie balanced budget; arrangements during periods of absence; authority to exercise virements; availability of regular reports, as per SFIs. • Included principle that where budgets have been delegated, the overall responsibility remains with the higher level budget holder. 7.3 Changes to the Budget – Clarification added to state that all central reserves, prior to issue, are approved by the Chief Executive 7.4 Monitoring and Reporting – Included details on the submission of monitoring returns to Welsh Government and the requirement for financial reports to be submitted to the Board and Executive Team. 7.5 Performance Management



		• Included that performance review against budget should apply on a monthly basis (not just in annual PADRs). • Outlined the process for holding budget holders accountable for budgetary performance and the actions to be taken in case of budget variances. 7.7 Cost Recharges – Section included to define a cost recharge and that budget holders of both divisions must agree
8	Training	Included availability of Budget e-Learning course and assessment.
9	Related Procedures	Reference and links included for Standing Orders; SFIs; SoD; Workforce; Vacancy approval process; Recruitment; Procurement and Contract Management procedures.
Appendix 3	Budget Virement Form	Form updated to current version

1.2 Losses and Special Payments

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

Losses and special payments are items that Welsh Government would not have contemplated when it agreed funds for the Health Board or passed legislation. By their very nature they are items that ideally should not arise. They are, therefore, subject to a special Financial Control Procedure compared with the generality of payments and noted in the Annual Accounts.
The procedure documents the processes that should be adopted by Charitable Fund Holders in order to ensure adequate controls over funds and compliance with Charity Commission regulations.

This procedure sets Health Board responsibilities and delegation limits for losses and special payments detailing how payments are approved, accounted for and reported within the organisation.

The document has been reviewed by the following:

- Corporate Finance Accountant
- Head of Financial Services & Accounting
- Head of Legal Services
- Assistant Head of Legal Services
- NWSSP - Audit and Assurance Services

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

Section	Name	Main Changes
5	Scope	Outlined the responsibility of all Health Board employees in relation to losses and special payments, including operational, payment, reporting, and accounting processes.



6	Roles and Responsibilities	6.1 Director of Finance, Procurement & Value – Expanded responsibilities to include all SFI requirements 6.3 Audit, Risk & Assurance Committee – Added to include responsibility for approving write-off of losses 6.4 Divisional Directors and General Managers – Added to include responsibility for patients' property and reporting losses
7	Delegated Limits	7.1 Updated to reflect the revised Scheme of Delegation
9.5	Fruitless Payments	Reference to the criteria of 'blame by a member of staff' and 'disciplinary action' excluded
11	Special Payments	11.3 Category 7 Ex Gratia Payments – Added the process of a full investigation when patient items are reported as lost.
12	Processing of Payments	Section added to reflect the payment process and approval
15	Related Procedures	Reference and links included for Standing Orders; SFIs; SoD; Counter Fraud, Bribery & Corruption; Stores & Stocks; Accounts Payable; Recovery of Overpayments to Employees; Policy for the Management of Clinical Negligence and Personal Injury Litigation.
Appendices 3, 5, 7	Reporting Losses	Forms updated to current addresses and email contacts added

1.3 Stores and Stocks

Owner: Director of Finance, Procurement and Value

Review Date: October 2025

The document has been written to detail the control procedures required for all items in controlled and departmental stores.

The procedure provides detailed guidance for employees with responsibility for requisitioning and issuing of stores and stock items.

It identifies the requirements for recording and accounting for store and stock items with a clear definition of each category.

The document has been circulated for comment as follows:

- CMA Finance Manager
- Corporate Finance Accountant
- Head of Pharmacy
- Estates Managers x3
- NWSSP - Audit and Assurance Services

A summary of the main changes to the FCP is set out below. The full revised FCP is included in Appendix 3.



Section	Name	Main Changes
First Page	Stores and Stocks Management – Do's and Don'ts	A summarised Do's and Don'ts page added
6	Roles and Responsibilities	6.1 Director of Finance, Procurement & Value – Expanded responsibilities to include all SFI requirements 6.2 Directorate Managers, Pharmaceutical Manager, Works and Estates, Ward Managers – Added to identify and clarify responsibilities
7	Definitions	7.3 Consignment Stock – Added definition
8	Principles of Control	8.3 Security – Added requirement to 'clearly define in writing' responsibilities of controlling any keys to ensure areas are locked 8.7 Stocktaking – General principles added for stores and stocks to be kept to a minimum; subjected to an annual stock take; valued at lower of cost and NRV, as per SFIs
12	Related Procedures	Reference and links included for Standing Orders; SFIs; Procurement; Losses and Special Payments
Appendix 1	Annual Stocktake	Letter, guidance and form updated

1.5 Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Budgetary Control Policy & Procedure	25/26	Due for review	Aug-22	02-Aug-25	Presented in Sep '25
Losses and Special Payments	25/26	Y	Oct-22	06-Oct-25	Presented in Sep '25
Stores & Stocks	25/26	Y	Oct-22	06-Oct-25	Presented in 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	



2. Technical Accounting Issues

Technical updates

Since the last committee meeting in June 2025, there have been no technical accounting updates issued by Welsh Government.

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of August 2025 and on a cumulative basis for the 2025/26 Financial Year.

Category	Invoices	In Mth %	YTD %
NHS	Value	99.7	97.6
	Number	95.2	90.2
Non NHS	Value	96.3	96.7
	Number	97.6	97.2

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditor invoices within 30 days of delivery of goods/services in August and cumulatively for the 2025/26 financial year.

The Health Board has achieved the target to pay 95% of the number of NHS creditor invoices within 30 days in August. However, the Health Board is currently below the target on a cumulative basis for the 2025/26 Financial Year.

In reviewing the fall in NHS performance a processing issue was identified regarding invoices relating to the NHS Salary Sacrifice Scheme administered by Northumbria NHS Trust, which meant invoices were not being receipted on time. Due to the volume of invoices, this had an impact on the NHS PSPP figure in May, June and July which has had a subsequent effect on the cumulative figure. This issue has now been resolved, with the Corporate Finance team working with the department to ensure processes are in place to mitigate the ongoing risk.

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

Invoice	Health Board	In Month %	April to July 2025 %	RANK
Non-NHS by Number	Aneurin Bevan UHB	97.0	97.2	1st
	Betsi Cadwaladr UHB	96.4	97.0	2nd
	Cardiff & Vale UHB	95.7	95.8	
	Cwm Taf Morgannwg UHB	95.1	95.8	
	Hywel Dda UHB	96.3	96.6	3rd



	Powys tHB	91.8	91.6	
	Swansea Bay UHB	96.9	96.0	

4. Payments in Excess of £100K

There was one exceptional payment made in the period between April and August 2025.

The payment was made in line with the Health Board’s Approval Process and received the correct level of authorisation internally. Due to the nature of the payment, special authorisation was required by Welsh Government, and as such is highlighted to the committee for noting.

Supplier	Payment Date	Payment Amount	Description
RDP Law LTD	11/04/25	£125,000	Settlement Payment.

5. Standing Financial Instructions

An update on the Standing Financial Instructions (SFIs) self-assessment is covered in a separate report.

Argymhelliad / Recommendation

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

- Budgetary Control (Appendix 1)
- Losses and Special Payments (Appendix 2)
- Stores and Stocks (Appendix 3)

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



Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives





Aneurin Bevan University Health Board

Budgetary Control Financial Control Procedure

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0241

Contents

1.	Introduction	2
2.	Policy Statement	2
3.	Aims	3
4.	Objectives	4
5.	Scope	4
6.	Roles and Responsibilities	4
7.	Annual Budgets	9
8.	Training	19
9.	Related Procedures	19
10.	Review	19
11.	Audit	19
APPENDIX 1 - Example of Budget Delegation Letter		21
APPENDIX 2 - Template for Line Manager/Budget Holder Recovery Meeting		25
1.	Introduction	2
2.	Policy Statement	2
3.	Aims	3
4.	Objectives	3
5.	Scope	3
6.	Roles and Responsibilities	4
7.	Main Procedure	7
8.	Training	14
9.	Review	14
10.	Audit	15
APPENDIX 1 - Example of Budget Delegation Letter		16
APPENDIX 2 - Template for Line Manager/Budget Holder Recovery Meeting		20
APPENDIX 3 - Virement Form		21

1. Introduction

1.

Aneurin Bevan University Health Board has a statutory requirement to meet its financial duty as set out in in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014. The duties are as follows:

- First Duty – A duty to ensure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- Second Duty – A duty to prepare a plan to secure compliance with the first duty while improving the health of the people or whom it is responsible

~~That is the Board has to provide its services within its allocated resources. One of the key mechanisms for ensuring that this requirement is met is a sound system of budgetary control.~~

Welsh Government determine revenue and capital allocations each financial year.

2. Policy Statement

2.

The Health Board must meet its statutory financial duties and this procedure sets out the key mechanisms by which the Board can ensure ~~delivery. this duty.~~

2.1 Integrated Medium Term Plan (IMTP)

The NHS Finance (Wales) Act 2014 requires Health Boards to prepare a plan which sets out its strategy for ensuring it complies with the ~~_~~financial dutiesy.

~~_~~The Integrated Medium Term Plan details how the Board will meets the is statutory dutyrequirement to provide services, within ~~the~~ allocated resources, ~~_~~ measured on a 3 year rolling basis.

~~The Chief Executive has overall executive responsibility for the Health Board's activities and is responsible to the Board for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.~~

~~The Integrated Medium Term Plan (IMTP) provides the foundation for the financial year by expressing the service, workforce and financial plan for year one of the three year plan and forms the basis of the Budget for the year.~~

~~The IMTP must reflect the Welsh Governments' vision for the NHS in Wales and its standards for public service delivery. The governance standards are based on the Welsh Government's Citizen Centred Governance principles.~~

~~The Board will approve the IMTP prior to the beginning of the financial year in accordance with the guidance issued annually by Welsh Government.~~

~~The Board approved IMTP will then be submitted to Welsh Government for approval~~

~~The first year of the IMTP will form the annual budget.~~

~~2.2 Revenue Resource Limit~~

~~The Revenue Resource Limit (RRL) is the allocation of financial resources from Welsh Government (WG) for the financial year. Aneurin Bevan University Health Board has a statutory responsibility to deliver services within its allocated Revenue Resource Limit and three year breakeven duty. Whilst the agreed IMTP may have planned financial deficits and surpluses in any one year, subject to WG approval, as part of the three year rolling breakeven duty, any planned surplus or deficits will be reflected by Welsh Government in the RRL.~~

~~This Financial Control Procedure sets out how budgetary control processes enable the organisation to meet the statutory duty of meeting its RRL and 3 year breakeven duty.~~

3. Aims

The aim of this document is to set out the responsibilities of the Board, Chief Executive, Director of Finance, Procurement and Value and budget holders, across the organisation, in relation to maintaining effective budgetary control. ~~in order that the organisation can exercise sound financial management and meet its statutory financial duty to break even.~~

~~The overall aim of~~ The Budgetary Control procedure details how the Health Board is to enable financial control whilst supporting the achievement of service objectives.

4. Objectives

The Budgetary Control ~~Financial Control~~ Procedure ~~aims to~~ provides a framework for financial control to enable the organisation to meet its statutory financial ~~duties.targets~~. The objectives are specifically to:

- ~~Describe how the organisation's Budget is approved~~
- ~~Describe how budgets are formally delegated through the organisation following approval by the Board.~~
- ~~To set out budget holders responsibilities and accountability to deliver services within their allocated budget.~~
- To set out a defined process that is to be followed by budget holders if budget overspends arise.

5. Scope

The Board delegates responsibility for budgets to the Chief Executive who in turn delegates these through management structures. Whilst the document primarily applies to all managers and clinicians that are given financial responsibilities as part of their roles and job descriptions, all staff of the Health Board have a part to play in effective budgetary control.

6. Roles and Responsibilities

6.1 The Board

~~The Board exercises financial supervision and control by approving the Medium Term Financial Plan (IMTP) and therefore, the annual budget.~~

~~The Board is responsible for ensuring that it meets its financial duty as set out in section 175 of the National Health Service (Wales) Act 2006 as amended by the National Health Service Finance (Wales) Act 2014.~~

~~The Board is responsible for exercising financial supervision and control through approving the Integrated Medium Term Financial Plan and Budget for the organisation.~~

6.2 Chief Executive

The Chief Executive has overall executive responsibility for the Health Board's activities, ~~and~~ is responsible to the Board for ensuring that financial provisions, obligations and targets are met. ~~it meets its statutory financial duty.~~

The Chief Executive has responsibility for initiating a formal process of budget delegation following approval of the annual bu ~~Budget.~~ ~~by the Board.~~

It is the responsibility of the Chief Executive to ensure that contractors, who are empowered to commit expenditure, on behalf of the Health Board are aware of this procedure.

6.3 Director of Finance, Procurement and Value

Prior to the start of the financial year the Director of Finance, Procurement and Value will, on behalf of the Chief Executive, prepare and submit the Medium Term Integrated Plan (IMTP), including the annual ~~budgets~~ for approval by the Board.

The Director of Finance, Procurement and Value is responsible for: ~~will:~~

- Maintaining an effective system of internal controls
- Ensuring that sufficient records are maintained with reasonable accuracy
- Monitoring financial performance against budget and plans
- ~~Devise and maintain systems of budgetary control.~~
- ~~Ensure sufficient records are maintained and accurate.~~
- Regular reporting of ~~Report the~~ financial position to the Board.
- Ensure that appropriate ~~training~~ and communication is in place ~~is available for budget holders~~
- Issue of financial advice
- An accountability and escalation framework established to address material budget variances
- Arrangements in place for the authorisation of budget transfers and virements

6.4 Director of Workforce and Organisational Development (OD)

The Director of Workforce and Organisational Development (OD) is responsible for ensuring all employees are issued with a contract of employment, linked to an appropriate job description.

Performance Appraisal Development Review (PADR) guidance will be available for all staff and recording of meetings will be maintained. Effective financial management is a key personal objective for budget holders, therefore the Director of Workforce and OD will set up appropriate systems to ensure competencies are met and recorded within job descriptions across the organisation.

6.5 Director of Digital

The Director of Digital will ensure that processes are in place to develop the draft IMTP for Board approval within prescribed Welsh Government deadlines.

6.56 Budget Holders

Budget holders are members of staff who are responsible for the day-to-day management of a delegated budget. A budget holder is defined as a person to whom a budget is delegated.

Budget holders are responsible for able to approve income, pay and non-pay expenditure.

The Chief Executive and Director of Finance, Procurement and Value delegate their responsibilities in the form of a divisional budget.

Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.

Budget holder Specific responsibilities include: of budget holders are:

- MBudget holders are responsible for anaging services within their delegated providing services within their respective budget
- MBudget holders are responsible for monitoring monthly budgets, actuals and variance utilising the QlikSense Budget Holder Dashboard (BHD) Finance Business Intelligence Tool (FBI) and liaising with the Business Partner Finance Teams as necessary.
- Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive

- No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board
- Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement and Value
- All budget holders must provide information as required by the Director of Finance, Procurement and Value to enable budgets to be compiled and managed appropriately.
- Any likely overspending, or reduction of income, that cannot be met by virement, is not incurred without the prior consent of the Chief Executive
- Develop plans to address adverse budget variances
- Budget holders should keep a record of any recovery plan meetings with line managers and/or Division as appropriate.
- Comply fully with the Scheme of Delegation
- Contracts above specified thresholds are advertised and awarded through NWSSP Procurement Services
- That all significant financial issues are reported through the management hierarchy, to enable the Director responsible to report the possible financial impact to the Executive Team and Board.
-
- ~~Budget holders are responsible for monitoring monthly budgets, actuals and variance utilising the Finance Business Intelligence Tool (FBI) and liaising with the Business Partner Finance Teams as necessary.~~
- ~~Budget holders must not exceed the budgetary total or virement limits set by the Board~~
- ~~Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive~~
- ~~Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement and Value~~
- ~~All budget holders must provide information as required by the Director of Finance, Procurement and Value to enable budgets to be compiled and managed appropriately.~~
- ~~To not incur any overspend or reduction of income without the prior consent of the Chief Executive subject to the Board's scheme of delegation~~

- ~~• No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board~~
- ~~• Develop recovery plans to address adverse budget variances~~
- ~~• Budget holders should keep a record of any recovery plan meetings with line managers and/or Division as appropriate.~~

7. ~~Annual Budgets~~Main Procedure

7.1 ~~Budgets~~ Setting

The organisation's budget plan for the forthcoming year will be developed from the first year of the Board's Integrated Medium Term Plan (IMTP).

A budget is a plan expressed in financial terms, over a defined period of time. In the context of the Health Board, the plan is for the delivery of specific services and should represent the financial expression of service and workforce plans for the financial year within available resources. The Board approve the Budget for the year.

Prior to the start of the financial year the Director of Finance, Procurement and Value will prepare and submit budgets for approval and delegation by the Board.

The budget will:

- Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan (IMTP)
- Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance and Workforce plans
- Take account of approved business cases and associated revenue costs
- Discussed with appropriate Directors and budget holders
- Be prepared within the limits of available funds
- Take account of ring-fenced, specified and non-recurring funding
- Include both financial budgets and Workforce establishment whole time equivalents
- Be within scope of activities and authority defined by the National Health Service (Wales) Act 2006
- Identify available reserves
- Take account of the principles of Well-being of Future Generations (Wales) Act 2015
- Identify potential risks and opportunities

Budgetary control is delegated to managers and represents a key management objective. Therefore, it represents a significant element of a manager's responsibility and budgetary performance must form a key part of each manager's Performance Appraisal Development Review (PADR).

7.2 ~~Approval of the IMTP Prior to the New Financial Year~~

~~It is a statutory requirement to produce an IMTP that must be approved by the Board prior to the start of the financial year. The IMTP plan will express service and workforce plans for the organisation over a period of three years and include a Medium Term Financial Plan that is derived from those plans.~~

~~The Board will:~~

- ~~• Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation. Following Board approval the IMTP will be submitted to Welsh Government prior to the beginning of the financial year of implementation.~~
- ~~• Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all probity and value for money requirements; and~~
- ~~• Where the Health Board plan is not in place or in balance, prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance.~~

7.3 Budget for the Year

The organisation's budget plan for the forthcoming year will be developed from the first year of the Board's Integrated Medium Term Plan (IMTP). The corporate processes that develop the IMTP will ensure that service and workforce plans are developed, within the financial Revenue Resource Limit, and agreed by the organisation before the beginning of the financial year and are at a sufficient level of detail that enable budgets to be developed for the year.

The Executive Director with the lead for Planning will ensure that processes are in place to produce:

- A draft IMTP (within Welsh Government timescales), which will have sufficient detail within year 1 of the plan to enable the development of budgets for the forthcoming financial year.
- A final IMTP is produced (within Welsh Government timescales) prior to the forthcoming financial year.

Prior to the start of the financial year the Director of Finance, Procurement and Value will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

- Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and Medium Term Financial Plan, and focussed on delivery of safe quality patient centred quality services
- Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce plans;
- Be produced following discussion with appropriate budget holders;
- Be prepared within the limits of available funds;
- Take account of ring-fenced or specified funding allocations;
- Take account of the principles of sustainable development; and
- Identify potential risks.

The plan will make explicit assumptions about budget reserves and contingencies for the year.

7.24 Budget Delegation

The Health Board has a statutory duty to manage its services within the Revenue Resource Limit allocated from Welsh Government (WG). The Board delegates responsibility for delivering a balanced budget to the Chief Executive, within the framework of its Standing Orders and Standing Financial Instructions.

The Chief Executive may delegate the management of a budget ~~or part of a budget~~ to permit the performance of a defined range of activities. The delegation must be in writing, in the form of a letter of accountability and include a clear definition of: ~~This delegation is made through management structures and defined in job descriptions and annual objectives. The delegation will cover:-~~

- ~~t~~The amount of the budget;
- The purpose(s) of the budget
- Individual responsibilities ie achieve a balanced budget
- Arrangements during periods of absence
- Authority to exercise virements
- ~~the requirement to achieve a balanced budget~~
- Achievement of planned levels of service
- The provision of regular reports

The budget holder must sign the accountability letter.

An example of a delegated letter is attached in Appendix 1.

~~Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, Procurement and Value, budgets shall be used only for the purpose for which they were provided.~~

- ~~Budgets are delegated with assumptions about the levels of service to be provided within the available resources described by the budget. Budget holders do not have authority to commit resources beyond the resources delegated in the budget. Expenditure for which no provision has been made in an approved budget, or is not subject to funding under the delegated powers of virements, shall only be incurred after authorisation of the Chief Executive.~~

~~Non-recurring funding must not be used to finance recurring expenditure without the authority in writing of the Chief Executive or nominated deputy for the purposes of financial control.~~

~~Budget holders~~**Managers** must deliver a balanced budget within each and every financial year.

~~The key principle of delegation is that accountability for budgetary control is exercised through the line management hierarchy.~~

~~Review of performance against budget should therefore take place as part of the annual Performance and Development Review (PADR).~~

Budgets are delegated to nominated budget holders and are set for each cost centre. Budget holders are authorised to commit expenditure against the cost centres for which they are responsible. There ~~should~~**can** only be one nominated budget holder for a cost centre and they are held accountable for managing within the budget set.

Where budgets have been delegated, the overall responsibility remains with the higher level budget holder.

Budget holders must adhere to approval limits set out in the Health Boards [Scheme of Delegation](#)

If budget holders are unable to approve expenditure for their respective budgets due to absence then the principle of upward delegation will apply.

7.36 Changes to the Budget

There may be times during the financial year when it is necessary to make adjustments to the budget, for example if additional funding is made available from Welsh Government.

As the budget has already been delegated through the Board and Chief Executive, there should be no requirement to refer changes to the Board. However, where there are significant changes to the proposed usage, which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board be notified and potentially approval sought.

Prior to issue, all central reserves are approved by the Chief Executive.

As part of the monthly control and reporting process, budgets will be reviewed and significant budget changes identified.

7.45 Monitoring and Reporting Process of Delegation

Appropriate Monitoring Returns must be submitted to Welsh Government in accordance with published guidance and timescales.

All monitoring returns must be supported by a detailed commentary signed by the Director of Finance, Procurement and Value and Chief Executive.

The commentary should highlight and quantify risks with an assessment of the impact and likelihood of these risks maturing.

Financial reports will also be submitted to the Board and Executive Team showing performance against budget for the period and forecast outturn for the full financial year.

Financial reports will be made available to budget holders on a timely basis covering the areas for which they are responsible.

~~Following agreement of the Board to the IMTP, the Chief Executive will issue a formal budget letter to each Director who in turn will issue similar letters to their line managers. This process will be repeated through each tier of management, setting out the expectations and responsibilities in terms of budgetary control and financial management.~~

~~The letter content may vary from year to year but will cover:~~

- ~~• The budget allocation.~~
- ~~• Activity and target achievement assumptions on which the budget has been based where this is a material issue. An example would be activity levels and achievement of elective targets such as Referral to Treatment Times (RTT).~~
- ~~• That the budget holder is accountable for the delivery of a balanced budget position each financial year and is also accountable for the recovery of any deficits within the same period.~~

~~That budgetary performance must form part of all budget holders' annual objectives and to be reviewed as part of the annual~~

~~Performance and Development Review (PADR).~~

- ~~• The expectation that formal mechanisms are set up to ensure that budget management is effective across their management area and that budget holders are held to account for their budgetary performance through every level of line management.~~
- ~~• That all line managers review their direct reports in relation to their budget performance at least on a monthly basis.~~
- ~~• That appropriate mechanisms are set up to control expenditure particularly where there are high cost and variable use items.~~
- ~~• That budget holders comply with all relevant policies including:~~
 - ~~▪ All Workforce and Organisational Development policies~~
 - ~~▪ Vacancy Approval Process~~
 - ~~▪ Recruitment Procedures~~
 - ~~▪ Financial Control Procedure – Procurement Policy~~
 - ~~▪ Financial Control Procedure – Contract Management~~

~~A formal budget letter must be issued from each line manager as soon as possible following the start of the financial year. An example of a delegation letter is attached in Appendix 1.~~

~~7.6 Changes to the Budget~~

~~There may be times during the financial year when it is necessary to make adjustments to the budget, for example if additional funding is made available from Welsh Government. As the budget has already been delegated through the Board and Chief Executive, there should be no requirement to refer changes to the Board. However, where there are significant changes to the proposed usage, which are outside of agreed priorities and delegation arrangements, there is an expectation that the Board be notified and potentially approval sought. As part of the monthly control and reporting process, budgets will be reviewed and significant budget changes identified.~~

~~7.7 Budgetary Control and Reporting~~

~~The Director of Finance, Procurement and Value will devise and~~

~~maintain systems of budgetary control. These will include:~~

- ~~• Financial reports to the Board showing performance against budget for the period and a forecast of the outturn for the full financial year.~~
- ~~• Issuing financial reports on a timely basis to budget holders covering the areas for which they are responsible.~~
- ~~• Following the end of a month a report will be produced for the Executive Team, detailing the year to date budget performance.~~
- ~~• Providing support from appropriately qualified and experienced finance staff to support managers in their analysis and management of budget performance.~~

~~Budget holders will ensure:~~

- ~~• Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.~~
- ~~• Budget performance is discussed by managers and their immediate reports at least on a monthly basis.~~
- ~~• That all significant financial issues are reported through the management hierarchy, to enable the Director responsible to report the possible financial impact to the Executive Team and Board.~~

7.58 Performance Management

~~Aneurin Bevan Health Board has a statutory duty to deliver its services within its allocated budget. The Board via the Chief Executive and tiers of line management formally delegates this responsibility to individual budget holders across the organisation. Budget holders are held to account for budgetary performance through formal line management arrangements and are expected to manage within delegated resources on both a monthly and annual basis.~~

~~Review of performance against budget should therefore take place on a monthly basis and form part of the annual Performance and Development Review (PADR).~~

- Budget performance is discussed by managers and their immediate reports at least on a monthly basis.

All significant financial issues are reported through the management hierarchy, to enable the Director responsible to report the possible financial impact to the Executive Team and Board.

Where budget variances arise the following actions must be undertaken by the budget holder and line manager in a formal process of escalation:

- If a budget is overspent in any one month the budget holder where practicable will recover the position by the next reported period.
- If a deficit will take longer than one month to correct and recover then the budget holder and line manager will:

Either

- agree recovery actions over a defined period

Or

- agree virements from another area of budgetary responsibility

A record of actions agreed must be made. A suggested format for recording actions is shown in Appendix 2.

- If a deficit cannot be recovered within a period of 3 months, or virements agreed with the budget holder, the line manager will be required to agree remedial actions with the Divisional Director.
- If remedial actions to recover the deficit, or agree virements still cannot be agreed with the Divisional Director, the line management team will agree remedial actions or virements with the responsible Executive Director.
- If remedial actions to recover the deficit, or agree virements, still cannot be agreed with the Executive Director, the Chief Executive will agree remedial actions or virements.
- If there is continued failure to agree a recovery plan or virements, the Executive Director and Chief Executive will

agree remedial actions with the Audit Committee and Board.

- A record of the meeting to discuss and agree recovery actions must be completed. A suggested proforma is attached in Appendix 2 to record agreed actions.

Budgetary control must form a key objective each year for all management staff with budget responsibilities.

Managers will be held to account for not meeting budgetary targets and subject to formal review as part of their annual Performance Appraisal and Development Review (PADR).

7.69 Budget TransfersVirements

The term for when budget funding is transferred between budget holders is a virement.

Virements are required when a permanent change in service ownership occurs between Divisions. These are recurrent and reflect a long-term shift in budget responsibility.

~~Where budget funding is transferred between budget holders, known as a virement,~~ a A virement form must be completed to formally record the agreement and transfer of funds. A form is attached in Appendix 3.

The virement or allocation of central budget reserves should be formally notified to the Board as appropriate through the financial year.

A Budget Journal Register is held on the Central Management Teams intranet page. All budget journals, including virements, must be recorded on the register, in line with Budget Journal Guidance, before uploading into Oracle.

7.7 Cost Recharges

Cost recharges may be required on a short-term or temporary basis, for example, when staff from one division undertake work on behalf of another. These are non-recurrent.

Budget holders from both divisions must agree the cost recharge.

8. Training

The ~~Finance~~ Director of Finance, Procurement and Value will ensure that ~~f~~Financial and ~~b~~Budget training is available, ~~as part of the staff induction process.~~

This will include a Budget e-Learning course and assessment; training provided by one-to-one contact with Business Partner Accountant teams;~~finance department staff,~~ formal financial management training, briefings, and finance content within other management development programmes.

An overview of the QlikSense Budget Holder Dashboard (BHD) is also provided by the Business Systems team. ~~Finance Business Intelligence is also provided and budget holders are encouraged to attend.~~ Non attendance reports are provided to line managers and Business Partner Accountant teams.

9. Related Procedures

Budget holders must comply with all relevant policies including:

- Standing Orders (SO)
- Standing Financial Instructions (SFIs)
- Scheme of Delegation
- All Workforce and Organisational Development policies
- Vacancy Approval Process
- Recruitment Procedures
- Financial Control Procedure – Procurement Policy
- Financial Control Procedure – Contract Management

9.10. Review

This procedure will be reviewed, maintained and amended at a minimum of every 3 years, in line with the Health Board's policy.

10.11. Audit

This document is a key organisational policy and as such will be subject to regular internal audit reviews to ensure the system is working effectively and that the processes set out in the procedure are being complied with across the organisation.

The content may change from year to year, in line with the Health Boards plans and priorities.

XXth March 20XX

Dear xxx,

As you will be aware, the Health Board has a statutory obligation to perform its functions within available financial resources. In line with the Board's Standing Financial Instructions (SFI) and Budgetary Control Policy, I am formally writing to you to confirm the revenue budget delegated to you for the 20XX-XX financial year – this is set out in Table 1. Achieving your budget responsibilities is one of your key performance objectives and will be reviewed as part of your Performance Appraisal and Development Review (PADR).

Budget Area	Annual Revenue Budget £'000
Xxxx	xxxx

- Agenda for Change and Medical pay awards
- Funding to support additional (£xxxk)
- Funding to support NICE demand and service growth (£xxxk)

The additional funding delegated is subject to review and evaluation of schemes. This is in order to provide assurance that the investment is achieving the necessary organisational performance targets.

This letter provides formal authorisation for you to incur expenditure during the financial year, up to the annual budget, to perform the functions necessary to deliver the Health Board's priorities and objectives. It also clarifies your accountability to deliver services within the budget and not to overspend.

You should manage your budgets in line with the Health Board's Budgetary Control Policy which is available on the intranet and sets out, in detail, budget holder's responsibilities and actions that should take place, if budget overspends arise. This letter should be read in conjunction with the Health Board's Standing Orders (SO), Standing Financial Instructions (SFI), financial policies and procedures – specifically, the Financial Control Procedure on Budgetary Control and the scheme of delegation.

Budgetary Management

The formal delegation of the budget should be cascaded through all tiers of line management responsible for budget management, with budgetary performance reviews undertaken and appropriate actions taken. It is important that all budget holders have read and understood the SFIs and financial control procedures and are competent to manage a budget. Therefore, all budget holders are required to confirm this as part of accepting their budget responsibilities.

Additional Allocations

The budget delegated to you is in line with the financial plan agreed by the Board on the XXrd January 20XX. Further allocations will be made in year as required to reflect additional allocations from Welsh Government, allocation of the agreed provisions within the financial plan and any investment priorities or choices made by the Executive Team and Board in 20XX/XX.

In approving a balanced financial plan for 20XX/XX, the Board recognised that further detailed plans need to be finalised. Funding has been held in reserve pending the completion of these plans and may be allocated subject to satisfactory approval of these plans. This will need to include delivery of key performance targets and appropriate savings. These should be completed and forwarded to myself by the **XXth April 20XX**.

IMTP

The Health Board has submitted its outline IMTP to Welsh Government which whilst demonstrating a balanced financial position carries a high level of financial risk. It is therefore important that every budget holder delivers within their delegated budgets. The expectation is that the department will develop plans to deliver a break-even financial position within this funding envelope.

Financial Advice and Information

Your Business Partner Team are available to offer guidance and training for you and your team as required to facilitate understanding and managing your budget and the FBI (Finance Business Intelligence) reporting tool.

As part of supporting budget holders to competently manage their budgets, the Health Board requires all budget holders to successfully complete appropriate budget training. Further training opportunities will also be made available in year as part of the finance departments training programme for non-finance managers.

Please confirm your acceptance of the delegated budget by signing and returning Appendix 1 to me by **XXth April 20XX**.

Yours sincerely,

XXX

Executive Director of Operations, Corporate Services

CC XXX, Assistant Finance Director - Financial Planning & Performance
 XXX, Assistant Finance Director - Hospital Services
 BPA xxx

Acceptance of delegated budget for the 20XX-XX financial year

To: Divisional Director –

I am signing to confirm acceptance of the budget delegated to me, for the purposes outlined, in your letter dated XXth March 20XX. I can also confirm that I have read and understood the Health Board’s Standing Orders (SOs), Standing Financial Instructions (SFIs) and financial control procedures and policies and that I have undertaken the necessary training to competently manage a budget.

NAME:	SIGNATURE:
POST TITLE:	
DATE:	

APPENDIX 2 - Template for Line Manager/Budget Holder Recovery Meeting

ABUHB BUDGETARY CONTROL POLICY

Record of Line Manager/Budget Holder Meeting to Agree Budget Overspend Recovery Actions

1. Attendees

List of Staff Attending Recovery Meeting	Position
Date of Meeting:	

2. Agreed Actions to Recover Budget Overspend

List Actions	Effective Date

3. Agreement

Delegated Budget Holder	Date
Line Manager Signature	Date

APPENDIX 3 – Virement Form

ABUHB BUDGETARY CONTROL POLICY

VIREMENT FORM

1. Reason for the Virement (Budget Transfer)

Description of Service or Rationale for Transfer	WTE	£
Budget Transfer Timescale i.e. Non recurrent, Recurrent or Time limited		

2. Transfer Agreement

Budget Holder Transferring Funds	Budget Holder Receiving Funds
Name:	Name:
Position:	Position:
Budget Cost Centre and Subjective code:	Budget Cost Centre and Subjective code:
Signed:	Signed:
Date:	Date:

3. For Finance Use

Oracle Account Code			£ Dr		£ Cr	
CC	Subj	Analysis				
Actioned By:						
Name:						
Signed:						
Date:				Ledger Mth/Yr		

Appendix 3 Budget Virement Form

ABUHB BUDGETARY CONTROL POLICY **VIREMENT FORM**

Reason for the Virement (Budget Transfer)

<u>Description of Service or Rationale for Transfer</u>	<u>WTE</u>	<u>£</u>
-	-	-
-	-	-
<u>Budget Transfer Timescale i.e. Non recurrent, Recurrent or Time limited</u>	-	-

Transfer Agreement

<u>Budget Holder Transferring Funds</u>	<u>Budget Holder Receiving Funds</u>
<u>Name:</u>	<u>Name:</u>
<u>Position:</u>	<u>Position:</u>
<u>Budget Cost Centre and Subjective Code:</u>	<u>Budget Cost Centre and Subjective Code:</u>
<u>Signed:</u>	<u>Signed:</u>
<u>Date:</u>	<u>Date:</u>

For Finance Use

<u>Oracle Account Code</u>			<u>£ Dr</u>	<u>£ Cr</u>
<u>CC</u>	<u>Subj</u>	<u>Analysis</u>		
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
<u>Actioned By:</u>	-	-	-	-
<u>Signed:</u>	-	-	-	-
<u>Date:</u>	-	<u>Ledger Month/Year</u>	-	-



Aneurin Bevan University Health Board

Losses and Special Payments Financial Control Procedure ~~Losses and Special Payments~~

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

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Owner: ~~Executive~~Director of Finance, ~~&~~
Procurement ~~& Value~~ & Value

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

Policy Number: ABUHB/Finance/0240

Contents:	Page
Introduction	Error! Bookmark not defined.
Policy Statement.....	Error! Bookmark not defined.
Aims	Error! Bookmark not defined.
Objectives.....	Error! Bookmark not defined.
Scope.....	Error! Bookmark not defined.
Roles and Responsibilities	Error! Bookmark not defined.
Delegated Limits	45
Reporting Incidents of Loss and Potential Loss	57 75
Approval of Payments	68
Fraud, Bribery & Corruption	99 10
Special Payments	99 10
Processing of Payments	13
Accounting for Losses and Special Payments	11 14
Reporting of Losses & Special Payments in the Organisation	11 12 14
Related Procedures	14
Further Information	11 12 25
Audit	11 12 25
Review	11 12 25
Appendix 1 Delegated Limits for Write Off.....	12 13 6
Appendix 2 Process Flowchart.....	16 17 20
Appendix 3 Loss Report Category 1	17 18 21
Appendix 4 Losses Form Bank Charges Reimbursement..	20 21 4
Appendix 5 Loss Report Category 4	21 22 6
Appendix 6 Policy for Ex Gratia Payments	23 24 7
Appendix 7 Compensation Form	25 26 9
Appendix 8 Case Checklist.....	31 32 5

1. Introduction

This procedure sets out the delegation limits for losses and special payments detailing how payments are approved, accounted for and reported within the organisation.

2. Policy Statement

Losses and special payments are items that Welsh Government (~~WG~~) would not have contemplated when it agreed funds for the ~~H~~health ~~Board~~service or passed legislation. By their very nature they are items that ideally should not arise. They are, therefore, subject to a special Financial Control Procedure compared with the generality of payments and noted in the Annual Accounts.

3. Aims

To ensure that all ~~Health Board~~ employees are aware of the reporting requirements in relation to ~~Clinical Medical Negligence~~ or and Personal injury ~~incidents~~ and all other minor losses incurred within the Health Board. ~~ABUHB.~~

4. Objectives

This document details sets out the process to be adhered to ~~within the Health Board~~ when reporting a loss ~~to the organisation~~ to ensure:

- Staff have a clear understanding of their responsibilities ~~with regards to the security of ABUHB assets.~~
- Losses and special payments are recorded when identified.
- Payments are approved appropriately that constitute a loss (e.g. clinical injury compensation payments).
- Losses are reported ~~in the Health Board.~~
- Accounting arrangements are in place.

5. Scope

This document details the responsibility of all Health Board employees in relation to losses and special payments. The operational, payment, reporting and accounting processes.

5.1 ~~All ABUHB employees have a general responsibility for the security of Health Board property and for minimising the risk of loss. Divisional directors have additional responsibilities for the security of patient's property and monies where it has been deposited for safe custody in accordance with the Patient's Property Financial Control Procedure.~~

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th
DRAFTSeptember 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th
DRAFTSeptember 2028

~~5.2 All employees have a responsibility to report a loss to their manager. Managers have a responsibility to notify the Health Board in writing of all losses using the documentation outlined in this procedure.~~

~~5.3 Much of this Financial Control Procedure is drawn from guidance issued in the Welsh Government IFRS NHS Wales Manual for Accounts. This procedure covers all losses which are described in this policy over the following categories:~~

- ~~• Medical Negligence (including Redress and General Medical Practitioners Indemnity)~~
- ~~• Personal Injury~~
- ~~• Ombudsman Claims~~
- ~~• Minor losses~~
 - ~~— Category 1 - Loss of Cash~~
 - ~~— Category 2 - Fruitless payments~~
 - ~~— Category 3 - Bad debts and claims abandoned~~
 - ~~— Category 4 - Damage to buildings~~
 - ~~— Stock discrepancies and losses~~
 - ~~— Fraud~~
 - ~~— Special Payments~~

~~5.4 This policy should be read in conjunction with:~~

- ~~• IFRS Wales Manual for Accounts – Chapter 6 – Losses and Special payments~~
- ~~• Standing Orders~~
- ~~• Standing Financial Instructions~~

6. Roles and Responsibilities

~~6.1 The Director of Finance, Procurement and Value is responsible for:~~

- ~~• Ensuring the appropriate processessystems are in place to record and account to record for losses and special payments.~~
- ~~• All cases are managed in accordance with Welsh Government's Manual for Accounts. Ensuring appropriate systems are in place to enable losses and special payments to be accounted for properly and reported to the Board and Welsh Government.~~
- ~~• In cases of suspected theft or arson, inform the police immediately.~~
- ~~• In cases of suspected fraud and corruption, inform the Local Counter Fraud Specialist (LCFS).~~

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

- Where fraud cases are confirmed, notifying the Audit, Risk and Assurance Committee and Welsh Government's Health and Social Services Group Finance Directorate.
- For material losses, of any kind, inform the Audit, Risk and Assurance Committee and an Auditor General's representative.
- All cases are registered and maintained on a centralised Losses and Special Payments Register.
- Consider whether any insurance claim could be made from the Welsh Risk Pool or commercial insurance arrangements.
- Ensuring the ABUHB has a nominated and trained Local Counter Fraud Specialist and that cases of fraud, misappropriation or other financial irregularities are investigated. The Counter Fraud Bribery and Corruption Policy sets out detailed procedures for dealing with fraud.

6.2 The Medical Director ~~Executive~~ Director of Nursing is

6.2 Responsible for the processing of claims for medical negligence, personal injury, loss of patient belongings and other patient related losses.

6.3 Audit, Risk and Assurance Committee

The Committee will approve the writing-off of losses or the making of special payments within delegated limits determined by Welsh Government.

6.4 Divisional Directors and General Managers

- General Managers and Directors must ensure that processes are in place to ensure the security of patient's property where it has been handed in to the Health Board ABUHB staff for safe keeping in line with the Patient's Property Financial Control Procedure.
- Reporting all losses, using the appropriate documentation outlined in this procedure.

6.5 All Health Board staff ABUHB staff are responsible for:

- Proper security of Health Board ABUHB property and ~~for~~ the avoidance of loss.
- ~~Notifying their~~ line manager of all potential and confirmed losses. ~~losses and potential losses.~~
- ~~Notifying the~~ ABUHB Local Counter Fraud Specialist (LCFS) if a fraud ~~bribery~~ or corruption is suspected or confirmed. ~~discovered or suspected.~~

Status: ~~DRAFT~~ Issue ~~8~~

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~ 18th September 2025

Review by date: ~~6th October 2025~~ 18th September 2028

- General Managers and Directors must ensure that processes are in place to ensure the security of patient’s property where it has been handed in to the ABUHB staff for safe keeping in line with the Patient’s Property Financial Control Procedure.
- 6.5 All Managers are responsible for reporting all losses, using the appropriate documentation outlined in this procedure.

7. Delegated Limits

- 7.1 Losses and special payments above the limits delegated to the ABUHB shown in Appendix 1, must be submitted to Welsh Government for approval prior to any special payment or write off being made. The responsibility for submitting details of the loss to the WG is shown in Appendix 1 depending on the category of loss.
- 7.2 7.1 The delegation limits for Losses and Special payments are detailed in the Scheme of Delegation and shown as below: in ABUHB are shown in the following table and in the HB Scheme of delegation.

£'s	Clinical Negligence / Personal Injury / Redress	
	Settlements	Legal Fees
<£10,000	Head of Legal Services/Asst. Head of Legal Services	Legal Services Manager
<£25,000	Head of Legal Services / Asst. Head of Legal Services	
<£50,000	Deputy Director of Nursing	
<£500,000	2 Clinical Executive Directors*	
<£1,000,000	CEO with 2 Clinical Executive Directors*	
>£1,000,000	Welsh Government and Board	

* Medical Director, Director of Nursing, Director of Therapies and Health Science, or their nominated deputy

	Clinical Negligence/Personal Injury		Redress	
	Settlements	Legal Fees	Settlements	Legal Fees
>£1,000,000	Welsh Government and Board	Welsh Government and Board	N/A	N/A

>£100,000<£1,000,000	Board	Board	N/A	N/A
>£25,000<£100,000	CEO	CEO	CEO	N/A
>£10,000<£25,000	Head of Legal Services	Head of Legal Services	Head of Legal Services	Head of Legal Services
<£10,000	Head of Legal Services	Claims Manager	Head of Legal Services	Claims Manager

Settlements over £100k are reviewed by the Litigation Committee (A sub-committee of the Board)

Ombudsman Claims	Per normal Scheme of Delegation approval limits.

- 7.1** Losses and special payments exceeding delegated limits, as per Appendix 1, must be submitted to Welsh Government for approval prior to any special payment or write off being made. The limit is dependent on the category of loss.
- 7.3** A summary of approval routes is shown as below:

Approvals of Losses & Special payments			
Category	<£10	Up to delegated limit (see appendix 1)	Over Delegated limit
Category 1 – Loss of Cash	n/a	~~As per Scheme of Delegation Claims & Litigation sub-group~~	Welsh Government
Category 2 – Fruitless Payments	n/a	~~As per Scheme of Delegation~~	Welsh Government
Category 3 – Bad debts and claims abandoned	AFD	~~As per Scheme of Delegation Audit, Risk and Assurance Committee~~	Welsh Government
Category 4 – Damage to buildings	n/a	~~As per Scheme of Delegation~~	Welsh Government
Category 5 – Compensation payments made under legal obligation	n/a	As per table in section 7.2. ~~A~~ above in line with ~~S~~ scheme of ~~D~~ delegation	Welsh Government
Category 6 – Extra contractual payments to contractors	n/a	~~As per Scheme of Delegation~~	Welsh Government
Category 7 – Ex gratia payments	n/a	Head of Legal Services	Welsh Government
Category 8 – Extra statutory, extra regulatory payments	n/a	n/a*	Welsh Government

* The Health Board has no delegated limit.

All losses irrespective of value are reported to the Audit, Risk and Assurance Committee.

8. Reporting Incidents of Loss and Potential Loss

8.1 Any member of staff identifying a potential loss shall report the incident details to their Head of Department who will immediately take action to recover the loss, if possible. The circumstances in which the loss arose should be investigated and where necessary tighter controls put in place.

8.2 In the case of losses arising from clinical negligence or personal injury the Policy for the Management of Clinical Negligence and Personal Injury Litigation should be referred to.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th
~~DRAFT~~September-2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th
~~DRAFT~~September-2028

8.3 The Head of Department must complete the relevant losses form, as per from the Appendices, to this policy and forward it to the address set out on the form.

The police should ~~must~~ be contacted as appropriate.

~~8.3~~ **8.4** For loss of patient property, these will be subject to a full local investigation will be completed with the and findings reported to the patient (as per section see 11.3 below).

~~8.4~~ **8.5** All details relating to the "write-off" will ~~then~~ be forwarded to the Assistant Director of Finance - Financial Systems and Services (or their representative) who shall enter the details in the ABUHB Losses and Special Payments Register (LaSPaR).

~~8.5~~ **8.6** In the case of fraud or suspected fraud, the Head of Counter Fraud will seek authorisation to prosecute, from the Director of Finance, Procurement and Value, once the enquiry has been completed. The Counter Fraud, Bribery and Corruption Policy should be referred to for all suspected cases of fraud.

~~8.6~~ **8.7** It is the responsibility of individual employees to safeguard public funds and resources and ~~to~~ report fraud or suspicion of fraud directly to the Local Counter Fraud Specialist.

~~8.7~~ **8.8** Cases of overpayment of salaries and wages are subject to the Recovery of Overpayment to Employees procedure.

9. Approval of Payments

Appendix 2 detailsshow the approval processes for all losses. in diagram form for all losses. This section describes the process for each category of loss in detail.

9.1 Clinical Negligence & Personal Injury

The process for approving payments in cases of clinical negligence and personal injury is described in the Policy for Management of Clinical Negligence and Personal Injury Litigation. All payments are subject to the delegated limits set out in section 7. ~~above.~~

Where concerns are pursued investigated and ~~the possibility of~~ a qualifying liability ~~is identified, confirmation of such is through the Redress Panel~~ cases these are reported in line with the Scheme of Ddelegation.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September-2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September-2028

Where ~~these~~ cases are expected to settle for less than £25K, they are subject to the Welsh Government 'Putting Things Right' framework. These cases are ~~considered through the Redress Panel but are still~~ subject to the delegated limits set out in section ~~77 above~~. Where cases are received as a medical negligence or personal injury claim, they are investigated ~~as a claim~~ regardless of ~~the~~ value, in line with the Policy for the Management of Clinical Negligence and Personal Injury Litigation.

The budget and costs for clinical negligence and personal injury ~~costs~~ are held by the ~~Medical Director~~ Executive Director of Nursing. The Health Board ~~is~~are liable for the first £25k with any expenditure over £25k being reimbursed by the Welsh Risk Pool, provided evidence of learning and actions are submitted and fully approved by the Risk Pool as providing suitable assurance of learning.

Redress payments for settlements and medical expert fees are fully reimbursed by the Welsh Risk Pool, ~~as and when incurred by the Health Board, again subject to learning being fully approved~~.

9.2 Ombudsman Cases

Where the Ombudsman makes a recommendation ~~for a to make a~~ compensation payment, the ~~cost~~payment is approved ~~by~~ and charged to the appropriate divisional ~~or locality~~ budget.

9.3 Other Losses

Other losses may include theft, fraud, arson, ~~and~~ sabotage, neglect of duty or gross carelessness.

9.4 Category 1 – Losses of Cash

~~(a)~~ Overpayments of salaries, wages, fees or allowances.

~~(a)~~

~~(b)~~ Other causes including un-vouched or incompletely vouched payments, overpayments other than those ~~in (b) (a)~~ above, physical losses of cash and cash equivalents ~~(such as stamps)~~ caused by fire, accident or similar causes.

Staff identifying any loss should immediately report this to their senior manager.

In all of the above cases a "loss of cash" form, attached in Appendix 3, must be completed by the manager of the department that incurred the loss. The

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September-2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September-2028

form must then be submitted to the relevant department as identified on the bottom of the form for processing.

9.5 Category 2 – Fruitless payments, including abandoned capital schemes and constructive losses.

These are defined as payments that a potential recipient is legally entitled to even though the ABUHB will receive nothing in return. Examples are:

- (a) Forfeiture under contracts as a result of error or negligence by the Health Board ABUHB.
- (b) Payment for travel or hotel accommodation wrongly booked, or for goods or services incorrectly ordered or accepted.
- (c) The cost of rectifying design faults due to lack of diligence or defective professional practices.
- (d) Payment for bank charges incurred by Health Board ABUHB employees as a result of late payment of wages, where it has been proven that the Health Board is at fault (Appendix 4)

~~In all cases there must have been an element of blame by a member of ABUHB staff.~~

Many degrees of error might be involved. The criterion is ~~not whether the error is considered serious enough to warrant disciplinary action but simply~~ whether the Health Board ABUHB was at fault in incurring, or not avoiding, the liability to make the payment.

As fruitless payments will be legally due to the recipient, they are not regarded as special payments. However, as due benefit will not have been received in return, they should be regarded as losses.

In relation to capital schemes, the delegated limit from Welsh Government to the Health Board is £250,000.

A written report must be completed for all incidents and sent to the Director of Finance, Procurement and Value, ~~so that appropriate action can be taken.~~

9.6 Category 3: Bad Debts and claims abandoned

Bad debts and claims abandoned should be entered in the losses register when it has been determined that the loss is irrecoverable.

Bad debts can only be written off when all reasonable action has been taken to recover the debt.

Status: DRAFT Issue 8

Issue date: 6th October 2022 18th

DRAFT September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: 6th October 2025 18th

DRAFT September 2028

Debts must be approved for write off by the Audit, Risk and Assurance Committee.

The Audit, Risk and Assurance Committee has ~~dgiven~~ Delegated ~~a~~Authority for write-offs, depending on the value of the Bad Debt.

Each debt will be fully reviewed by ~~the~~ responsible officers, before being presented for approval for write-off ~~by the delegated authority~~.

The below table sets out the ~~d~~Delegated ~~a~~Authority levels.

DELEGATED AUTHORITY LEVEL	From £	To £
Assistant Head of Financial Services	-	10
Head of Financial Services & Accounting	10	50
Assistant Director of Finance (Financial Systems & Services)	50	2,500
~~Executive~~ Director of Finance, ~~& Performance~~ ~~Procurement~~ ~~& Value~~	2,500	25,000
Audit, Risk & Assurance Committee	25,000	50,000
Welsh Government	50,000	-

Any such loss written off will be charged to the originating budget.

9.7 Category 4 - Damage to buildings, including fittings, furniture, equipment and loss of equipment and property in stores and in use

Examples of this are:

- (a) Culpable causes e.g. theft, fraud, arson or sabotage, neglect of duty or gross carelessness
- (b) Losses by fire (other than arson)
- (c) Losses by weather damage or accident
- (d) Losses due to deterioration in use or deterioration in store due to defects in administration such as over-provisioning or obsolescence.

In all of the above cases a "report of loss" form, attached in Appendix 5, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the Assistant Director of Finance – Financial Systems and Services.

9.8 Stock discrepancies and losses

If stock becomes obsolete the responsible department must notify the Assistant Director of Finance – Financial Systems and Services in writing so that arrangements can be made for it to be written off.

A stock take of all items will be ~~recorded~~ ~~taken~~ at year-end in accordance with the Stocks and Stores procedure. All losses arising and their value

Status: ~~DRAFT~~ ~~Issue-8~~

Issue date: ~~6th October 2022~~ ~~18th~~

~~DRAFT~~ ~~September 2025~~

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~ ~~18th~~

~~DRAFT~~ ~~September 2028~~

should be clearly identified on the stock taking sheets which are completed on an annual basis. Any loss due to obsolete stock incurred during the year should be formally notified to the Assistant Director of Finance – Financial Systems and Services, in writing, ~~so that the appropriate action can be taken.~~ All obsolete stock losses are recorded on the Losses and Special Payments Register

10 Fraud, Bribery and Corruption

All suspected cases of Fraud, Bribery and Corruption within the Health Board must be reported immediately and in accordance with the Counter Fraud, Bribery and Corruption procedure.

11 Special Payments

Claims for compensation fall into one of the following three classifications:

11.1 Category 5 Compensation payments made under legal obligation:

- These are identified as those where a clear liability exists, as a result of a court order or a legally binding arbitration award. Payments into court and out of court settlements are not payments made under legal obligation*.
- Claims must be submitted to the Director of Finance, Procurement and Value for a decision. The advice of the Chief Executive will be sought as appropriate.
- No acceptance of liability must be given when a claim is received, only an acknowledgement that the claim is receiving attention.

* Legal obligation include employment tribunal rulings. Any settlement on legal advice outside of the tribunal must be treated as ex-gratia payments within the relevant delegated limit.

11.2 Category 6 - Extra contractual payments to contractors.

These are payments which, although not due legally under an original contract, appear to be obligations which a court might uphold. Any such payment must be justified on value for money grounds.

11.3 Category 7 Ex Gratia Payments

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th
~~DRAFT~~September 2025

Review by date: ~~6th October 2025~~18th
~~DRAFT~~September 2028

Ex Gratia payments are payments, which the Health Board ABUHB is not obliged to make or for which there is no statutory cover, or legal liability. There are five separate types of Ex Gratia payment:

- i. Maladministration,
- ii. Loss of personal effects,
- iii. Clinical negligence and personal injury,
- iv. Settlements on termination of employment,
- v. Other cases.

Appendix 6 details the policy and procedure for all cases of claims for Ex Gratia Payments.

In all of the above cases an “ex gratia” form, attached in Appendix 7, must be completed by the manager of the department that incurred the loss. The form must then be submitted to the relevant department for processing as identified on the bottom of the form.

Where the likely loss is in excess of £50K the form in Appendix 8 must be completed and submitted to the relevant department to be submitted to Welsh Government for further approval to write off the loss within the Health Board.

Where a patient or family report the loss of patient items, such as jewellery, cash, clothing, or other patient belongings, these will be subject to a full local investigation, to locate the reported lost items, to establish if the Health Board or its staff have contributed in any way to the loss, whether a referral to the police should be made, and whether any lessons can be learned. The findings of the investigation will be set out in a formal response from the Health Board, including whether an offer of payment is to be made.

11.4 Category 8 - Extra statutory payments.

~~These are payments which the Secretary of State is not empowered by statute to make.~~ Any proposal to make such a payment must be agreed jointly by the Executive Director of Finance, & Procurement and Value and Value and Welsh Government.

12. Processing of Payments

In the vast majority of cases, payments, will be processed by the Health Board, using the Accounts Payable Interface File, process within the Oracle Financial Management System, as per as per the Accounts Payable procedure Financial Control Procedure. This process ensures that all

Status: DRAFT Issue-8

Issue date: 6th October 2022 18th

DRAFT September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: 6th October 2025 18th

DRAFT September 2028

payments have received correct authorisation, prior to being sent to the Accounts Payable department for payment.

The Legal Services team will issue a payment request ~~through~~ to the Corporate Finance team to review and process the payment.

The Losses & Litigation Officer, within Corporate Finance, ~~team~~ will ensure ~~that~~ for all payments, that the correct authorisation has been provided, ~~as per the scheme of delegation outlined above~~. All payments will be collated onto the Interface File and sent for review and verification to a Senior Manager in the Financial Services & Accounting Department. Once verified the Interface File will be sent to the Accounts Payable department for processing and payment.

12.13. Accounting for Losses and Special Payments

The guidance for accounting of losses and special payments is included set out in the Welsh Governments IFRS NHS Wales Manual for Accounts. The ~~Executive~~ Director of Finance, ~~& Procurement~~ ~~& Value~~ ~~and Value~~ is responsible for ensuring details of losses and special payments are entered into the Losses and Special Payments Register (LaSPaR). ~~spreadsheets~~. ~~Operational Day to Day~~ responsibility for the accounting for losses and special payments is delegated to the Assistant Director of Finance - Financial Systems and Services.

13-14. Reporting of Losses & Special Payments in The Organisation

All losses are reported to the Audit, Risk and Assurance Committee in accordance with the Annual, Risk & Assurance work plan and terms of reference by the Assistant Director of Finance – Financial Systems and Services. The report will include a section setting out the recorded “loss” for the year to date, alongside where the category of expense is considered and scrutinised within the Health Board. The purpose of the report ~~to the Audit, Risk and Assurance Committee~~ is to provide details of the financial impact of losses and ~~also to~~ provide the Committee with assurance that processes are in place to review and learn from all incidents.

14-15. Related Procedures

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Counter Fraud, Bribery and Corruption
- Stores and Stocks
- Accounts Payable

Status: ~~DRAFT~~ Issue-8

Issue date: ~~6th October 2022~~ 18th

~~DRAFT~~ September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~ 18th

~~DRAFT~~ September 2028

- **Recovery of Overpayments to Employees**
- **Policy for the Management of Clinical Negligence and Personal Injury Litigation**

165. Further Information

Enquiries regarding this procedure should be directed to either the ~~Executive~~ Director of Finance, ~~& Procurement~~ ~~and Value~~ ~~and Value~~ or the Assistant Director of Finance - Financial Systems and Services

15 176. Audit

The procedure will be subject to internal audit review on an ad hoc basis.

16 187. Review

This procedure will be reviewed every three years unless a requirement arises earlier.

Status: ~~DRAFT~~ ~~Issue-8~~

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~ ~~18th~~

~~DRAFT~~ ~~September 2025~~

Review by date: ~~6th October 2025~~ ~~18th~~

~~DRAFT~~ ~~September 2028~~

APPENDIX 1

Delegated Limits for “Write Off”

It is the responsibility of the Director of Finance to seek Welsh Government approval for claims that exceed the thresholds identified below with the exception of all clinical negligence and personal injury claims where the responsibility lies with the Medical Director

CATEGORY OF LOSS/SPECIAL PAYMENT	DELEGATED LIMITS
	£
A Losses (except in respect of primary care provider services)	
1. Loss of cash due to:	
a. theft, fraud, etc.	50,000
b. overpayment of salaries, wages, fees and allowances	50,000
c. other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b); physical losses of cash and cash equivalents e.g., stamps due to fire (other than arson), accident and similar causes	50,000
2. Fruitless payments (including abandoned capital schemes)	250,000
3. Bad debts and claims abandoned:	
a. private patients (Sections 65 and 66 NHS Act 1977)	50,000
b. overseas visitors (Section 121 NHS Act 1977)	50,000
c. cases other than a-b	50,000
4. Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:	
a. culpable causes eg. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000
b. other causes	50,000

DELEGATED LIMITS

£

B Special payments (except in respect of primary care provider services)

5.	Compensation payments made under legal obligation	FULL *
6.	Extra contractual payments to contractors	50,000
7.	Ex-gratia payments	
a.	to patients and staff for loss of personal effects	50,000
b.	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 including Claimant's costs *
c.	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 including Claimant's costs *
d.	other clinical negligence cases and personal injury claims	50,000 *
e.	other, except cases for maladministration where there was <u>no</u> financial loss by claimant	50,000
f.	maladministration where there was <u>no</u> financial loss by claimant	NIL
g.	patient referrals outside the UK and EEA guidelines	NIL

*** For all clinical negligence and personal injury cases (including court cases) the use of periodical payments should be considered for any settlement (exclusive of legal costs) involving costs to the NHS of £250,000 or more, or for lower awards when this represents good value for money. Proposed out of Court periodical payment awards require approval from the WG H&SSG FD.**

Status: ~~DRAFT~~Issue-8Issue date: ~~6th October 2022~~18th~~DRAFT~~September-2025Approved by: Audit, Risk and Assurance
CommitteeReview by date: ~~6th October 2025~~18th~~DRAFT~~September-2028

8.	Extra statutory and extra regulatory payments	NIL

C Losses and special payments in respect of provision of primary care provider services

Losses		Limit
		£
9.	a. Losses due to overpayments to practitioners of fees, allowances or salary	
	i. involving fraud	1,000
	ii. other	1,000
	b. Un-vouched or incompletely vouched payments	1,000
10.	Claims abandoned	1,000

D Special Payments

11.	Ex gratia payments	1,000
12.	Extra statutory and extra regulatory payments	
	a. to pharmacist contractors for drugs supplied in good faith in respect of forged, etc., prescriptions forms	1,000
	b. excusal of statutory charges for replacement dentures in certain circumstances	up to appropriate maximum statutory charge
	c. other	NIL

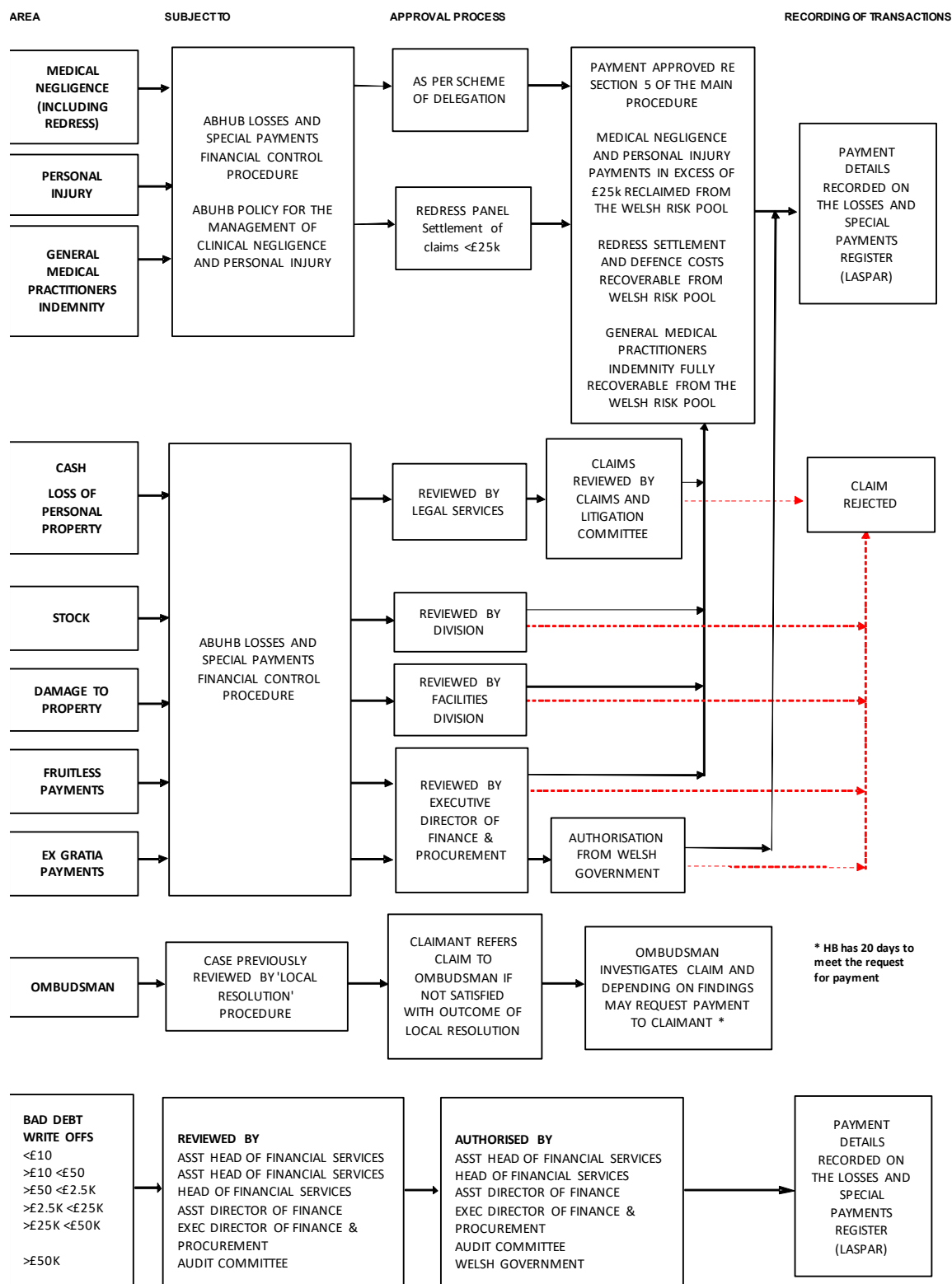
Status: ~~DRAFT~~Issue-8Issue date: ~~6th October 2022~~18th~~DRAFT~~September-2025Approved by: Audit, Risk and Assurance
CommitteeReview by date: ~~6th October 2025~~18th~~DRAFT~~September-2028

E Losses: Fraud cases under investigation

13.	a.	Losses in cases investigated by the health body in respect of prescription fraud.	1,000
	b.	Losses in cases investigated by the health body in respect of dental fraud.	1,000
	c.	Losses in cases investigated by the health body in respect of ophthalmic fraud.	1,000

All ombudsman and bad debt write off payments are charged to the budget of the department where the incident arose.

Appendix 2



For all Medical Negligence & Personal Injury claims please also refer to the IFRS NHS Wales Manual for Accounts – Chapter 6 Losses & Special Payments

For all Redress claims please also refer to the WG 'Putting Things Right' Framework.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

APPENDIX 3



LOSS REPORT – CATEGORY 1 LOSSES OF CASH

Name	
Title of Reporting officer	
Department	
Date	
Type of Case	
Reference	

Checklist/report

Detail the amount involved and the reasons why the loss arose	
If applicable, provide detailed breakdown of salary or other errors. What were the errors made?	
Can the loss be recovered? Provide details of the attempts that have been made to recover the loss (including legal action) or explain why no action has been taken.	
In fraud cases, obtain and complete a fraud report from the ABUHB Local Counter Fraud Specialist. Enter dates of completion of fraud.	
Consider whether the police should be informed of other category 1 losses. If no police involvement is necessary please give reasons. If appropriate please forward the police report (if available) to the WAG HFM Division	

Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or, if no action is to be taken, explain why. Include dates, names of individuals and positions.	
Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.	
What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements.	
What monitoring measures have been introduced to ensure the improvements are working effectively?	
Having completed the above steps, detail the general lessons which can be drawn from this case.	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed:

Printed:

Position:

Date:

Is it necessary to inform the Board/Chief Executive?

Status: ~~DRAFT~~Issue-8Issue date: ~~6th October 2022~~18th~~DRAFT~~September 2025Approved by: Audit, Risk and Assurance
CommitteeReview by date: ~~6th October 2025~~18th~~DRAFT~~September 2028

Yes

☐

No

☐

If no, please give reason:

Do the SFI's require a Board report for this case? If so enclose the report. If not consider whether in the light of this case your SFI's should be amended to require a Board report.

I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that the write off of this loss offers the best value for money in this case.

* *Delete as appropriate*

- * This case is within the delegated authority of this Health body and is not novel, contentious or repercussive. I therefore agree to write off the loss.
- * This case is above the delegated authority of this Health Body and is novel, contentious or repercussive and I therefore request formal approval from the WG Health Department

Signed:

Printed:

Position:

Date:

Countersigned by:

Printed:

Position:

Date:

This section must be completed by two senior officers in accordance with the delegated limits set by the Board.

Once completed this form should be returned to:-

Head of Legal Services

Llanfrechfa Grange Hospital

Llanfrechfa

Cwmbran

NP44 8YN

Email: ABB.LegalServices@wales.nhs.uk

Status: ~~DRAFT~~Issue-8Issue date: ~~6th October 2022~~18th~~DRAFT~~September 2025Approved by: Audit, Risk and Assurance
CommitteeReview by date: ~~6th October 2025~~18th~~DRAFT~~September 2028

Headquarters
St Cadoes Hospital
Caerleon
NP18 3XQ

Appendix 4



LOSSES FORM

BANK CHARGES REIMBURSEMENT (Due to late payment of salary)

Name of Employee

Payroll Number

Amount claimed £.....

Evidence of charges incurred - 3 months bank statements ☐ (✓ if received)
- copy of letter from bank ☐ (✓ if received)

Period Covered

Employee Error * Yes/No

Manager Error Yes/No

Payroll Error Yes/No

* If employee error no reimbursement to be made

Details of incident that led to charges being incurred

Prepared by:

Approved by:

Name

Name

Title

Title

Signature

Signature

Financial Code to be charged 040-xxxx- 37300

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

APPENDIX 5



LOSS REPORT – CATEGORY 4 DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE

Name	
Title of Reporting officer	
Hospital/Clinic	
Department/Ward	
Date/Time	

Checklist/report

Please provide details of the loss/theft/criminal damage/arson:	
Please detail the total value of items. Is the value of loss reduced by insurance? If so, please record the value of the gross loss and the value of the amount recovered by insurance	
Account Code	040-
Have the Police been informed?	Yes ☐ No ☐
If the Police have been informed, please provide details of the notification. Important Note: Details of the outcome of police investigations must be notified to the Finance Director as soon as they become available	
Please detail: Any identified failings in the actions of employees, including	

supervisors and whether there is a need for disciplinary action Any apparent breakdown of procedures	
Please state any future security measures or other corrective action which you feel should be implemented to help prevent a similar incident. If none, please state "None".	

I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above are complete and accurate and that all aspects of the checklist have been properly considered and actioned.

Signed: Printed:

Position: Date:

Once completed this form should be sent to:-

Assistant Director of Finance – Financial Systems and Services

PO BOX 163

Ty Gwent

Lake View

Llantarnam Industrial Park

Cwmbran

NP44 9EJ

Email: robert.j.jones2@wales.nhs.uk

Finance Department

Block C

Mamhilad House

Mamhilad

NP4 0YP

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

APPENDIX 6



POLICY & PROCEDURE FOR EX GRATIA PAYMENTS

1. INTRODUCTION

- 1.1 This appendix details the policy and procedure for ex gratia claims, in respect of cases not pursued as civil law negligence claims. It provides guidance to both managers and claimants to ensure swift and fair adjudication of claims.

2. INVESTIGATION

- 2.1 A standard form (appendix 7) must be used where a claim for compensation is being made for special payment (ex-gratia) to patients, visitors and staff for loss/damage.
- 2.2 The incident of loss or damage must be thoroughly investigated by someone of sufficient seniority to establish all of the relevant facts.
- 2.3 Any claimant who wishes to pursue legal damages should be referred to the Legal Services Department.

3. RESOLUTION BY GENERAL MANAGER OR EXECUTIVE DIRECTOR

- 3.1 The formal recommendation to agree or reject compensation will be made by the General Manager (i.e. ABUHB second-in-line managers) or Director and recorded on the claim form. A recommendation for compensation may not be delegated to another manager.
- 3.2 The General Manager or Director may recommend to reject a claim, or agree full or partial compensation. Compensation must be based upon the second hand value of the item. Full replacement value may be offered where it can be shown that the item was purchased relatively recently.

4. PAYMENT

- 4.1 Completed claim forms (approved and rejected) will be forwarded to Head of Legal Services at Headquarters, St Cadocs
- 4.2 The Head of Legal Services will then make a final decision as to whether to confirm the offer of compensation or rejection of the claim. This is formally recorded on the Claim form, signed and approved within authorisation limits. If the offer is accepted, the claimant must complete and sign a Form of Discharge (Indemnity form) relating to the specific claim. Following receipt of this form signed by the claimant a cheque or BACS payment will be released from the finance department.
- 4.3 If the claimant wishes to appeal against the decision, appeals should be made to the Head of Legal Services. The matter will then be heard at the next Litigation Committee.

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th
~~DRAFT~~September-2025

Review by date: ~~6th October 2025~~18th
~~DRAFT~~September-2028

5. GUIDANCE ON COMPENSATION

5.1 General Loss and Damage

Compensation should be agreed where the investigation reveals on the balance of probability that there has been a failure of the ABUHB duty of care or of ABUHB procedures. Examples include patient property lost or damaged by staff; property lost or damaged after being handed in for safe keeping; and damage to staff property or clothing caused in the legitimate pursuit of their duties, providing that they were not themselves acting negligently e.g. not wearing protective clothing provided, or operating machinery or equipment against advice.

A judgement often has to be made about the state of capability or capacity of the patient. The ABUHB duty of care increases in respect of any patient, who is unconscious, has impaired mental capacity or is otherwise disabled in a way which compromises their ability to be responsible for their own affairs and security.

There may also be rare instances where, although the LHB cannot be described as negligent, justification may exist to support an ex-gratia payment to a claimant.

5.2 Lease Cars

A number of claims have been received in the past from lease car drivers seeking recompense for the excess insurance sum following an accident occurring during normal duties. To be consistent with the above general guidance, claims from any driver (lease car or owner driver) should be approved only where evidence exists that the damage relates to a failure on the part of the ABUHB or its staff. Accident claims against any third party for damage to a vehicle or contents should be pursued routinely via the driver's insurer, and will not therefore need to be considered by General Managers within the Losses procedure.

6. LITIGATION GROUP

The Litigation Group is chaired by the Chair of the Board and comprises of the Chief Executive, Medical Director, Two independent members with attendance by –The Head of Legal Services

6.1 The role of the Litigation Group will be:

- To monitor consistency of claims decisions against Health Board Guidance.
- To review the case of any claimant wishing to appeal against a decision not to offer compensation or the amount offered. No further formal route of appeal will be available.
- To ensure that payments are made.
- To review and monitor the whole of the losses process and to provide advice to General Managers and Executive Directors

APPENDIX 7



Report No.

(for Office Use Only)

This form should be used to make a claim for compensation for:

- Financial loss resulting from an act or failure for Health Board or its staff which does not give rise to legal liability e.g. damage/loss to property belonging to a patient, staff member or visitor
- Hardship caused to persons by official failure or delay e.g. reimbursement of travel expenses following an appointment error

Sections A to J (excluding G) to be completed by staff member receiving the incident report

Section G to be completed, signed and date by Claimant (if present)

Section K to be completed by relevant Senior Manager

Section L to be completed by General Manager/Director

Section M to be completed by The Head of Legal services

Full name: :

Occupation & Band:

Division

Ward/Department

Contact No:

Date/Time reported:

Inpatient

☐

Outpatient

☐

Day patient

☐

Employee

☐

Visitor

☐

Contractor

☐

Full Name:

Male

☐

Female

☐

Age

D.O.B.

Address:

Contact No.

Bleep/Pager No.

If Staff:

Occupation

Band:

Datix Incident Ref (if completed):

Date of incident

Time of incident:

Provide sketch if applicable

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

Hospital or premises address where incident occurred:

Location:

Normal activity carried out where incident occurred:

(Please attach copies of any supporting evidence):

E Details of Property Stolen, Lost or Damaged

(Please attach receipts and quotations if available at time of completion)

Description of items including serial numbers	State whether Organisational or private/personal property	Approximate age of items	Estimated value at time of loss £

F Has claimant expressed a specific wish to be reimbursed?

Yes ☐

No ☐

If yes, amount claimed

Are these items covered by personal insurance?

Yes ☐

No ☐

G Signature of Claimant *(if present)*

I can confirm that the facts on the previous pages are correct:

Signed:

Printed:

Date:

H Investigation and recovery action *(Cross through any question not applicable)*

Was property witnessed by a member of staff?

Yes ☐

No ☐

Ownership verified by (full name):

Position/Band:

Search of ward/department carried out:

Date:

Name:

Position/Band:

Check of patients property book:

Date:

Name:

Position/Band:

Entry found in property book:

Yes ☐

If yes, attach copy

No ☐

Check of central Laundry:

Date:

Checked by:

Position/Band:

Police informed?

Yes ☐

No ☐

Crime No:

Date:

Time:

Notified by:

Position/Band:

Date of Police Visit:

Name of Police Officer

Police Station:

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

I Other investigatory action by ward/department (Please attach copies of any supporting evidence):

J Person completing this report

I can confirm that the facts on the previous pages are correct:

Signed: _____ Printed: _____

Position: _____ Date: _____

NB: All structural damage must be reported to the Works & Estates Department. **Send this completed form immediately to the Directorate Manager responsible for the service/location.** Copies of this form can be located on the intranet.

NOTES:

- (1) Special payments to staff for the loss of, damage to their personal items may only be made where:

(a) the incident occurs during the course of the employment.

(b) the articles lost or damaged are such as might reasonable be carried during the course of their employment

(c) the articles are sufficiently robust for the treatment they might reasonably be expected to bear.

(d) the loss or damage is not due to the staff member(s) own negligence.

(e) the loss or damage is not covered by insurance or by provision for free replacement
- (2) Where the article can be repaired, the payment should cover the actual cost of repair, but where it is lost or damaged beyond repair, the value of the property immediately before the incident should be paid. This will be the cost of a replacement less the estimated amount by which the property has depreciated since purchase.
- (3) The claim should be submitted as soon as possible after loss/damage has occurred. Any unreasonable delay could result in the claim being rejected.

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance Committee

Issue date: ~~6th October 2022~~18th ~~DRAFT~~September-2025

Review by date: ~~6th October 2025~~18th ~~DRAFT~~September-2028

K Senior Managers Report

(Please attach copies of any supporting evidence)

Provide detail of the lessons learnt and action taken:

Directorate Manager sign-off

Signature: _____ Printed: _____

Date: _____

L General Manager/Directors Approval

Yes ☐ No ☐ Cost Centre: 8560-37300

Please give your reasons:

I confirm that the details recorded are to the best of my knowledge accurate and that all aspects of this report have been properly considered and actioned.

General Manager/Director sign-off

Signature: _____ Printed: _____

Date: _____

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th
~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th
~~DRAFT~~September 2028

M Approval by Chair of the Claims & Litigation Group

(a) ☐ The claim was considered and rejected

or

(b) ☐ The claim was considered and approved for £

Signed:

Printed:

Date:

For office use only:

☐ Receipt/Quote

☐ Memo to Finance

☐ To CCL

☐ Approved

☐ Rejected

Completed forms should be forwarded to:

Head of Legal Services

Llanfrechfa Grange Hospital

Llanfrechfa

Cwmbran

NP44 8YN

Email: ABB.LegalServices@wales.nhs.uk

Headquarters

St Cadoc's Hospital

Lodge Road

Caerleon

NP18 3XQ

If the estimated loss value is in excess of £50K – the Health Board will need to seek approval to write off the loss and as such appendix 8 will also need to be completed and submitted to Welsh Government for approval.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September-2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September-2028

APPENDIX 8

FOR HEALTH BODY USE

Checklist to be used when compiling the summary of the case

Category – Type of case - Reference number - Health Body (name and code) -
1. Record the amount involved and the reasons why the loss arose.
2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details.
3. Was fraud involved? If so complete a fraud report and ensure that the LCFS the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report.
4. Was theft or criminal damage involved? If so have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th
~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th
~~DRAFT~~September 2028

5. **For abandoned works**, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?

6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid.

For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?

Status: ~~DRAFT~~Issue-8

Approved by: Audit, Risk and Assurance
Committee

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September-2025

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September-2028

7. **For rental cases only** - did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

For overseas private patients cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors. If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent why was it given before obtaining a sizeable deposit?

9. **Stores (only)** - Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

Status: ~~DRAFT~~ Issue-8

Issue date: ~~6th October 2022~~ 18th

~~DRAFT~~ September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~ 18th

~~DRAFT~~ September 2028

10. **For extra contractual payments to contractors.** Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.

11. **For ex gratia payments.** Have other options been considered? If not, why not? Explain why an ex-gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this. Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance.

For settlements on termination of employment, has relevant central guidance on such payments been followed in all respects? If not, why not?

For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?

12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.

Status: ~~DRAFT~~ Issue-8

Issue date: ~~6th October 2022~~ 18th

~~DRAFT~~ September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~ 18th

~~DRAFT~~ September 2028

13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?
14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.
15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.

16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?

17. Is it necessary to inform the board/chief executive? If not, why not?

18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.

19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.

Status: ~~DRAFT~~Issue-8Issue date: ~~6th October 2022~~18th~~DRAFT~~September-2025Approved by: Audit, Risk and Assurance
CommitteeReview by date: ~~6th October 2025~~18th~~DRAFT~~September-2028

20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government DH&SS FD (if applicable).

Name -

Position -

Date Welsh Government DH&SS FD notified -

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.

Signed by -

22. I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

* Note: Delete as appropriate.

* This case is not novel, contentious or repercussive. I therefore agree to write off of the loss.

* This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government DH&SS FD

Signed by -

Date -

Countersigned by -

Date -

Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.

Status: ~~DRAFT~~Issue-8

Issue date: ~~6th October 2022~~18th

~~DRAFT~~September 2025

Approved by: Audit, Risk and Assurance
Committee

Review by date: ~~6th October 2025~~18th

~~DRAFT~~September 2028

Name -	Position held –
Countersigned by -	Position held -



Aneurin Bevan University Health Board

Stores and Stocks

Financial Control Procedure

~~Stores and Stocks~~

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

Status: ~~DRAFT~~Issue 4
Approved by: Audit Committee
Owner: Director of Finance, Procurement & Value

Issue date: ~~DRAFT~~6th October 2022
Review by date: ~~DRAFT~~6th October 2025
Policy Number: ABHB/Finance/0249

Stores and Stocks Management – Do's and Don'ts

✓ Do's

- ✓ Assign clear roles and document responsibilities
- ✓ Minimise stores and perform annual stocktakes
- ✓ Keep accurate records of stock movements
- ✓ Secure storage areas and control access
- ✓ Use inventory systems like Omnicell/ADC
- ✓ Set and monitor stock level
- ✓ Dispose of obsolete stock properly
- ✓ Train staff on stock procedures
- ✓ Keep storage clean and organised
- ✓ Submit stocktake results on time
- ✓ Include all stock in counts, including decanted items.
- ✓ Store high-use items accessibly
- ✓ Get Finance approval for alternative processes
- ✓ Report overstocking or malpractice

X Don'ts

- X Don't store items unsafely
- X Don't mix consignment and Health Board stock
- X Don't delay delivery checks—verify within 48 hours
- X Don't exceed authorised stock levels
- X Don't use correction fluid on stock sheets
- X Don't ignore expiry dates—rotate stock
- X Don't change stocktake dates without notifying Finance
- X Don't open multiple packages of the same item unnecessarily
- X Don't store bulk stock without lock and key
- X Don't overload storage with stock – this increases the risk of damage
- X Don't store stock in multiple locations unless in use
- X Don't count items individually when issued by box
- X Don't forget signatures on stock sheets
- X Don't operate stores without documented delegation
- X Don't bypass Finance approval for disposals

Contents:

Introduction Error! Bookmark not defined.
Policy Statement.....Error! Bookmark not defined.
Aims Error! Bookmark not defined.
Objectives.....Error! Bookmark not defined.
Scope 2
Roles and Responsibilities Error! Bookmark not defined.
Definitions Error! Bookmark not defined.
Principles of Control Error! Bookmark not defined.
Accounting for Stores and Stocks 7
~~Responsibilities 8~~
Ward Stock Procedures.....Error! Bookmark not defined.
Obsolete Stock.....Error! Bookmark not defined.
Audit 9
Review 9
Glossary 10
**Appendix 1 Procedures for Year End Controlled and Non-Controlled
Stores Stock Take.....11**
**Appendix 2 Audit Protocol for Minimum and Maximum Stock
Levels.....16**

1. Introduction

The ~~document procedure~~ has been written to ~~detail specify~~ the control procedures ~~required needed within ABUHB~~ for all items ~~in controlled and departmental stores. put in to stores and those treated as stock.~~

~~The procedure does not cover the detailed requirements of other control systems such as Oracle. Reference should be made to local operational procedures and user manuals for guidance on these.~~

2. Policy Statement

This ~~financial~~ procedure will provide detailed guidance ~~and direction~~ for ~~those~~ employees with ~~direct~~ responsibility for ~~the~~ requisitioning and issuing of stores and stock items, ~~within ABUHB to mitigate the risk of loss or potential fraud within the Health Board~~
The procedure also includes, including consignment stock, held within the Health Board.

3. Aims

The ~~financial control~~ procedure will ensure that:

- Accurate records of the quantities of all items in stores and stocks are maintained.
- The values of stores ~~s~~ items are properly evaluated and regularly validated.
- Reliable and accurate information ~~available about stores and stocks is generated~~ to support ~~the ABUHB~~ monthly financial reporting and annual accounts.
- Management information is made available to assist in the overall inventory control process.
- There is adequate security in place to prevent loss and assist with the detection of fraud.

4. Objectives

The procedure will clearly identify the requirements for recording and accounting for stores and stock items. ~~With clear and will clarify the distinction between items classified as stores and stock items and consignment stock. and those classified as stock items and will also address the requirements in relation to consignment stock.~~

5. Scope

The document applies to all Health Board employees who have responsibility for the ~~should be read and applied by all ABUHB employees that are charged with the~~ management of Stores and Stock items.

6. Roles and Responsibilities

6.1 Director of Finance, Procurement and Value

- Overall responsibility for the control of stores
- Developing financial control systems
- Developing procedures for the regulation and operation of stores, including accounting arrangements for receipt, issues and returns of goods to stores and losses

6.2 Directorate Managers, Pharmaceutical Manager, Works and Estates, Ward Managers

- Responsible for security arrangement of stock
- Custody of keys for stores
- Management of physical stock checks
- Review slow moving and obsolete items
- Report any significant overstocking
- Follow correct disposal procedures

6.3 All Health Board Staff

All employees charged with the management of Stores and Stocks ~~within the ABUHB~~ must ensure that a proper standard of inventory control is applied, as per section 3.~~identified within the aims section above.~~

7. Definitions

The definitions of stores items, stock items and consignment stock are below~~procedure will address the treatment of those items classified as stores items and those items classified as stock items separately as the distinction between these two terms is an important part of the procedure and specified below.~~

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

4

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

7.1 Stores items are defined as those that are purchased/made where:

- a) Not all the items are used immediately,
- b) It is necessary to have a quantity on hand,
- c) There is a need to “control” the items in a secure place and record their receipt and issue

Items to be controlled in this way will normally be higher value items, where the consequence of loss is greater; those which are susceptible to theft or damage, or those that have to be controlled from a legal viewpoint e.g. drugs.

7.2 Stock items are those items complying with both a) and b) above but not c).

They will typically be lower value items, or those requiring frequent issues e.g. ward held items, where controlling them as stores would be impractical and difficult to achieve.

7.3 Consignment Stock — this is inventory supplied to the Health Board where by the supplier but the supplier retains ownership until the stock item is used and a replacement item requested. The Health Board is then invoiced for the used items.

8. Principles of Control

In order to maintain effective controls, it is important to identify the following: One of the main requirements in effecting control over stores and

Stock is to identify the following:

- a) Classification of items ie stores, stocks consignmentWhich items are to be regarded as stores/stocks
- b) Location of itemsWhere these items are located within the ABUHB
- c) Who is responsible person for stores/stock control
- d) Which type of stocktaking system is to be used

Effectively, the only items treated as Stores are drugs held by Pharmacy, Omnicell used in Theatres and ~~Works and Estate~~-building items held in the estates store.

All other items, such as those held at ward level are to be treated as Stock.

All items, whether treated as Stores or Stock, must be subjected to the principles covering the acquisition, receipt of goods, and their subsequent storage and issue.

Particular controls to be observed are as follows:

8.1 Receipt of goods

Irrespective of the source of external supply, items must be checked ~~immediately straight away~~ upon receipt against the Supplier's documentation and the purchase order to ensure that the quantities are correct and that no items are damaged or missing.

This checking must be performed by someone other than the requisitioning officer to ensure that the principle of segregation of duties is maintained.

Where it is not practical to verify all items immediately on delivery, e.g. where a large number of items are delivered in boxes on pallets, the verification must be carried out within 48 hours of receipt and the supplier's paperwork should be endorsed as not verified.

Care should be taken to ensure that quantities are properly checked before the items are accepted because errors are difficult to rectify at a later time.

Any discrepancies found must be recorded and notified as soon as possible to the Supplier.

Goods delivered must always be stored in a secure place, e.g. where deliveries are made to a central store, they must not be left outside pending checking for quantities etc.

Where items are delivered within the ~~Health Board~~ABUHB, e.g. drugs from the Pharmacy to the Wards, they must be signed for in the same way as if they were delivered from an outside supplier. All supplies of pharmaceutical stock items will be accompanied by a computer generated

Status: ~~DRAFT~~Issue 4

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

6

Issue date: ~~DRAFT~~6th October 2022

Review by date: ~~DRAFT~~6th October 2025

delivery note which must be signed by both the Pharmacy, when the supplies are sent out, and the receiving activity e.g. a Ward when received. The Pharmacy delivery note must be retained on file by receiving department for two years, to comply with legislation.

8.2 Storage of goods

The Health Board ABUHB will maintain a list of items it intends to treat as Stores.

Where stores are maintained within Pharmacy, Theatres and Works and Estates the following principles need to be adhered. In general items in stores must be capable of being reconciled according to the following formulae:

OPENING BALANCE OF ITEMS (quantities)	= O
Add receipts for a period	= R
Deduct issues made during the period	= (I)
Deduct any items scrapped or disposed of	= (S)
CLOSING BALANCE OF ITEMS	= C

Goods held in ~~the~~ Pharmacy, ~~Theatres~~ and Works and Estates Stores should be on shelving or pallets, or within the Omnicell Cabinet in Theatres, to avoid damage in the event of a flood. The seals on the goods should be examined to ensure that the contents have not been tampered with or removed.

8.3 Security

Items must be secured at all times e.g. kept under lock and key and access to the key must be properly controlled and clearly defined in writing, where there is any possibility of physical loss. This is to ensure that the items in stock can be identified as the responsibility of a named individual(s).

Security of stocks is particularly important for Pharmacy items that are subject to legal as well as financial constraints.

In view of the need to protect items against fire hazards, advice should be obtained from the local Health Board ABUHB Fire officer and that advice must be complied with.

8.4 Receipts and Issues

Status: DRAFT ~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT ~~6th October 2022~~

Review by date: DRAFT ~~6th October 2025~~

Receipts of items into the store, and issues from it, must be fully documented. A system must be maintained and each entry ~~in it must be~~ supported by Supplier's documentation (for receipts) or issues notes (for issues). The signature of a designated officer is needed to support all receipts and issues. Is this now electronic?

The list of responsible officers is regularly reviewed and updated.

A periodic reconciliation is carried out between the values of receipts, issues and stocks held.

Similarly, any items that are to be scrapped or decommissioned e.g. due to obsolescence, or broken/damaged beyond repair, must be fully documented and authorised and recorded as part of the year end stock taking exercise.

8.5 Stocks, and Stores and Consignment Stock Records (including consignment stock)

A record needs to be maintained of items kept in store, showing the physical quantities on hand.

This is to ensure that maximum and minimum stock levels are adhered to and that any discrepancies are revealed at the earliest possible stage. A typical record will contain the data shown in appendix 2 ~~below~~ together with a description of the item and the dates of the transactions. It is also important to monitor any changes in use.

8.6 Reordering and Mmaximum/Mminimum Llevels

Items kept in Pharmacy, Theatres and Works and Estates stores ~~need to~~ have maximum and minimum levels set so that the numbers on hand do not become excessive, or do not fall to such a low level that the Health Board ABUHB runs out of stock.

Maximum and minimum levels are established automatically by the system utilised by the service responsible for the stores and reviewed at an interval not exceeding 6 months. The maximum and minimum levels should be authorised by a responsible officer and should only be changed by the signed authority of that officer.

8.7 Stocktaking

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

8

Stores and stock items should be:

- Kept to a minimum
- Subjected to, at least an annual stock take
- Valued at the lower of cost and net realisable value

A full stocktaking exercise is necessary to ensure proper controls are being maintained over stores and stocks~~must be carried out at least annually.~~

~~To improve control of stock items it is necessary to carry out checks of the more important items held more frequently. This is to ensure that the stock values needed to support the ABUHB balance sheet can be calculated,~~ and to ensure that any irregularities are found at the earliest opportunity stage.

~~The Pharmacy and Works and Estates Stores merit a regular stock checking programme. Where If a perpetual inventory systems are~~is available, such as Automated Data Capture (ADC) and Omnicell, which are already deployed across Health Board ABUHB sites, these should be utilised. The use of a perpetual inventory system does not eliminate the requirement for an annual stock checking process, or more regular checking if appropriate.

Perpetual inventory systems follow processes below: ~~This system involves the following steps:~~

- a) Identifying the stores items that need regular stock checks, because, for example, of their high ABUHB value or the possibility of loss.
- b) A plan is produced to show which of these items are to be counted at regular intervals during the year.
- c) Items are then counted according to this plan and the results compared with the stores records. Discrepancies are need then ~~to be~~ investigated and for written off as necessary.

Two of the major advantages of the perpetual system are that:

- a) It ensures that irregularities are identified as soon as possible ~~shown up earlier than with the annual stocktaking system,~~
- b) If the processes are accurately carried out, the annual stock check can be made easier.

Where it is clear that items have been physically lost or otherwise need to

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

be written out of the accounts, the Assistant Director of Finance (~~Financial Systems and Services~~) should be advised with full details in accordance with the Losses and Special Payments ~~financial control~~ procedure.

All documents e.g. requisitions and issue notes, must be properly "underscored" after completion to ensure fraudulent additions cannot be made.

~~All stores records shall be in such a form and shall comply with such a system of control as the Director of Finance, Procurement and Value may approve.~~

Consignment stock stakes should be undertaken on the same basis as above.

9. Accounting for Stores and Stocks

When stock and non-stock items are purchased, they are charged to the cost centre that requested /acquired them.

At each year end a full stock check must be undertaken of all items of stores and stocks. This must list all items held in store and be priced according to the principles issued by the Finance department.

The date of the annual stock-take will be agreed between the Business Partner Accountant and the Service Manager who then communicate the details to the ~~Service Manager and then notified to the~~ Central Management Accounting ~~team.team.~~

To ensure that the stocktaking processes are properly complied with, the Finance Department issue ~~detailed~~ instructions to all concerned, detailing ~~processes procedures that have~~ to be observed. Appendix 1 provides the full details of the processes, a summary is included below: ~~details of the procedures issues which in summary include:~~

- a) The identification and treatment of obsolete stock₇
- b) The means to avoid counting stock twice₇
- c) The means to ensure that all stock is counted, including that in transit at the time of the stock-take₇
- d) The requirement for all stock to be counted by 2 employees
- e) Proper preparation of the area containing the stock so that the stocktaking is made easier. This will include such activities as the grouping of like items together₇

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

- f) The date and times of the stock-take~~7~~
- g) The basis of pricing of stock including the accounting for VAT~~7~~

The stock sheets must be kept for audit purposes.

At each year end the value of the stores and stocks must be compared with the previous year's value, and the increase or decrease accounted for in the Annual Accounts. ~~ABUHB financial accounts.~~

~~10.~~ Responsibilities

~~The Director of Finance, Procurement and Value is primarily responsible for the accounting for the stores and stocks and for the accurate statement of their value in the accounts.~~

~~The management in charge of the department that controls the stocks, e.g., Directorate Managers, Estates Department, and Ward Managers are responsible for the proper custody of items under their control, and for the accurate recording of receipts and issues and taking stock in line with guidelines.~~

~~101.~~ Ward Stock Procedures

Maximum and minimum stock levels have been set for all wards. It is the responsibility of ~~Directorate~~Divisional Managers to ensure Ward Managers are aware of their responsibilities in this area and they comply with the audit protocol ~~in~~on Appendix 2. A system of spot checks must be carried out and the checks should be evidenced in accordance with the protocol.

~~112.~~ Obsolete Stock

During a review of stores and stocks, ~~the stocktaking procedures~~ items identified as being unused for a period greater than 12 months should be recognised and the responsible officer must determine where stock is slow moving or obsolete.

If items have not moved for a period greater than 24 months or have been identified as obsolete after 12 months, the items then they should be segregated ~~from the remaining stock and stores~~ and not included in the periodic review stocktaking procedures~~process~~.

The responsible officer must approve disposal of obsolete stock. The Procurement Manager must be informed prior to disposal~~7~~, in an effort to

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

ensure that any disposal proceeds are maximised. Any obsolete/written off stock should be recorded along with the value on the year end stock taking sheets.

Checks should be carried out on a regular basis to ensure that there is no 'out of date' stock on the shelves.

Where stock has a shelf life the stock should be rotated when restocking.

12. Related Procedures

- **Standing Orders**
- **Standing Financial Instructions**
- **Procurement**
- **Losses and Special Payments**

13. Audit

Annual audits are completed by NWSSP Audit and Assurance Services ~~carried out in relation to stores and stocks by the internal department~~ with further review, if required, ~~undertaken~~ by Audit Wales as part of the ~~Annual Accounts audit sign-off.~~

14. Review

The review period for the procedure is 3 years.

15. Glossary

Perpetual Inventory System – a program that continuously estimates your inventory based on your electronic records, not a physical inventory.

Consignment Stock – stock owned by one party but held by another.

Appendix 1

Aneurin Bevan Health Board Controlled and Non-Controlled Stores Stock Takes 2024-25

I am writing to request that you arrange for controlled, non-controlled and consignment stock takes to be undertaken in the areas within your delegated budget.

The stock takes should be undertaken in accordance with the attached guidance.

The results of the stock takes will be incorporated in the Health Boards Annual Accounts for the year ended 31 March 2025.

Please be reminded that stock takes should only include items currently in use. Obsolete stock should be identified separately and written off as part of the stocktaking process.

Key requirements that must be adhered to.

- The stock take must be undertaken during the period 01st February to 28th February 2025
- You must provide us with planned dates of the stocktakes by 24th January 2025. Please send an E Mail confirming your stock take dates and contact details to ABB CMATeam
- Once stock take dates have been notified to finance these must be adhered to.
(Late changes to the dates of inventory counts should be avoided. If unavoidable the change of date should be notified to the Financial Services and Accounting Team using the email above immediately and must allow sufficient time for either Internal or External Audit to attend the revised stock taking date)
- Where possible please can you request budget holders to start and complete stock takes during the same day to prevent anomalies in the stock takes arising as a result of stock being issued and deliveries received.

Completed stock take sheets should be returned to ABB CMATeam by 28th February 2025.
This is to ensure that the charge/credit to expenditure and posting the results of the stock take to Oracle is actioned in the General Ledger in Month 11 (Guidance on the stock taking process is attached)

Finally during week commencing 17th March 2025, you will be asked to provide written confirmation that there have been no material differences in stock levels on non-controlled stores between the dates of the stock take and 17th March 2025. These should be received by the CMA Team no later than 5pm on 3rd April 2025

Please contact Simon Oram of the central Management Accounts Team if you have any queries

Simon Oram

9th January 2025

Team Leader – Central Management Accounts

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

13

Issue date: DRAFT~~6th October 2022~~

Review by date: DRAFT~~6th October 2025~~

Guidance Stocktaking Process Controlled and Non-Controlled Stores

1. Stocktaking Process

- 1.1 Items purchased for controlled stores are charged to the store when purchased. Goods are issued from controlled stores on production of a requisition, the goods are valued at average cost and Budget holders are charged with the cost of goods issued.
- 1.2 Items purchased for uncontrolled stores are charged to Budget holders when purchased.
- 1.3 The value of Stocks and Work-in-Progress has to be shown in the Annual Accounts. The Manual for Accounts states that stocks, of consumable stores, raw materials and manufactured items held at the year end, are to be valued at the lower of cost or net realisable value.
- 1.4 A stocktake of all stores must be undertaken at least once per annum to provide a valuation of stock and work-in-progress for the annual accounts.
- 1.5 Stores should be kept tidy at all times and items stored should be clearly labelled, stored in storage containers (e.g. bins, drawers, shelves etc.) to aid the stock taking process.
- 1.6 Internal and External Auditors may attend the actual stocktake to carry out sample checks.

2. Stocktaking Process

- 2.1 The Finance Director or Delegated Finance Officer shall notify Budget holders, in writing, when and how stocktakes are to be undertaken.
- 2.2 All stock held on both controlled and non-controlled stores must be counted. Consignment Stock must be counted separately from ABUHB Stock. **The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count.** The members of staff undertaking the stock take count must ensure the accuracy of the count.
- 2.3 Consignment stock must be counted separately and should be clearly identifies so not to be mixed in with normal stock. The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count. **The members of staff undertaking the stock take count must ensure the accuracy of the count.**
- 2.4 Supervisors are required to undertake a sample check of the counted stock to ensure the accuracy.
- 2.5 All items must be counted and verified by both members of staff. It is not acceptable for 1 member to count the stock and for the 2nd member of staff to undertake a sample check on a number of items counted.
- 2.6 The count is to be recorded on stock sheets of an approved and acceptable design, the attached excel file includes a worksheet as a pro-forma. Budget holders who wish to use a different stock

Status: DRAFT~~Issue 4~~

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT6th October 2022

Review by date: DRAFT6th October 2025

sheet should check with the CMA Team that the design of the stock take sheet they propose to use is acceptable.

2.7 All items of stock should be populated on the stock take sheets prior to the stock take being undertaken to ensure that all items have been recorded and to prevent any unnecessary delays whilst undertaking the stock take. This will facilitate more accurate and time effective counting.

2.8 Stock should be counted based on the issues made e.g. if a box of gloves is issued per box and priced per box then the box should be counted. In a situation where individual gloves have been issued staff should count full boxes and half full boxes only – not the individual gloves remaining in an open box.

2.9 All inventory must be counted regardless of the value

2.10 Staff are reminded to keep an organised storage area where by items with similar packaging are not mixed together.

2.11 Any stock decanted from the main storage area must be included within the stock take count

2.12 The stock sheets are to be:-

- Completed in ink or typed or a computer print out
- Different types of stock should be clearly identified and listed on separate sheets
- The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted
- The unit of stock must be clearly stated
- Unit cost must be shown against each item and whether the costs include VAT or exclude VAT
- Sequentially numbered in the format 1 of 6, 2 of 6, etc.,
- Dated and signed by the Officer taking stock and the Officer verifying the stocktake
- Dated and signed off by a Senior Manager or the Budget holders.

2.13 The consignment stock sheets are to be :-

- Completed in ink or typed or a computer print out
- Different types of stock should be clearly identified and listed on separate sheets
- The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted

- The unit of stock must be clearly stated
- Unit cost must be shown against each item and whether the costs include VAT or exclude VAT
- Sequentially numbered in the format 1 of 6, 2 of 6, etc..
- Dated and signed by the Officer taking stock and the Officer verifying the stocktake
- Dated and signed off by a Senior Manager or the Budget holders.

2.14 The original stocktaking sheets are to be forwarded to the CMA Team for valuation. Photocopies are unacceptable.

2.15 Stock sheets not completed in accordance with these instructions will be returned to Budget holders for correction.

2.16 The CMA Team will

- Ensure that stock sheets are completed in accordance with this procedure
- Calculate the value of the stock
- Calculate the amount to be charged to/credited to expenditure
- Post the change in stock value to the ledger
- Notify the Budget Holder of the effect of the stocktake
- Enter the results of the stocktake on the worksheet in the excel file
- Provide access to all details of controlled stock, non-controlled stock and Consignment stock to the Financial Accounts Team

STOCKTAKE		2024/25							
SITE _____				SHEET NO: _____ OF _____					
DEPARTMENT _____				DATE _____					
STORE TYPE _____									
DESCRIPTION	UNIT OF ISSUE	QUANTITY IN UNITS	UNIT COST VAT £	VALUE VAT £					
TOTAL BROUGHT FORWARD									
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
				0					
TOTAL CARRIED FORWARD					0				
STOCK TAKEN BY:		CERTIFIED BY:		SIGNED OFF BY:					
NAME (BLOCK LETTERS)		NAME (BLOCK LETTERS)		NAME (BLOCK LETTERS)					
SIGNATURE:		SIGNATURE:		SIGNATURE:					
DESIGNATION:		DESIGNATION:		DESIGNATION:					

~~Aneurin Bevan University Health Board~~ ~~Appendix 1~~ ~~Controlled and Non-Controlled Stores Stock Takes~~

~~Example of email sent to managers~~

~~I am writing to request that you arrange for controlled, non-controlled and consignment stock takes to be undertaken in the areas within your delegated budget.~~

~~The stock takes should be undertaken in accordance with the attached guidance.~~

~~The results of the stock takes will be incorporated in the Health Boards Annual Accounts for the year ended 31 March 2022.~~

~~Please be reminded that stock takes should only include items currently in use. Obsolete stock should be identified separately and written off as part of the stocktaking process.~~

~~Key requirements that must be adhered to.~~

- ~~➤ The stock take must be undertaken during the period 01st February to 28 February 2022~~
- ~~➤ You must provide us with planned dates of the stocktakes by 24th January 2022. Please send an E Mail confirming your stock take dates and contact details to ABB_CMA Team~~
- ~~➤ Once stock take dates have been notified to finance these must be adhered to.~~
~~(Late changes to the dates of inventory counts should be avoided. If unavoidable the change of date should be notified to the Financial Services and Accounting Team using the email above immediately and must allow sufficient time for either Internal or External Audit to attend the revised stock taking date)~~
- ~~➤ Where possible please can you request budget holders to start and complete stock takes during the same day to prevent anomalies in the stock takes arising as a result of stock being issued and deliveries received.~~

~~Completed stock take sheets should be returned to ABB_CMA Team by 28th February 2022. This is to ensure that the charge/credit to expenditure and posting the results of the stock take to Oracle is actioned in the General Ledger in Month 11 (Guidance on the stock taking process is attached)~~

~~Finally during week commencing 21st March 2022, you will be asked to provide written confirmation that there have been no material differences in stock levels on non-controlled stores between the dates of the stock take and 21st March 2022. These should be received by the CMA Team no later than 5pm on 1st April 2022~~

~~Please contact the Team Leader – Central Management Accounts if you have any queries~~

~~Team Leader – Central Management Accounts 12th January 2022~~

Status: DRAFT Issue 4

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT 6th October 2022

Review by date: DRAFT 6th October 2025

Guidance Stocktaking Process Controlled and Non-Controlled Stores

1. ~~Stocktaking Process~~

~~1.1 Items purchased for controlled stores are charged to the store when purchased.~~ Goods are issued from controlled stores on production of a requisition, the goods are valued at average cost and Budget holders are charged with the cost of goods issued.

~~1.2 Items purchased for uncontrolled stores are charged to Budget holders when purchased.~~

~~1.3 The value of Stocks and Work-in-Progress has to be shown in the Annual Accounts. The Manual for Accounts states that stocks, of consumable stores, raw materials and manufactured items held at the year end, are to be valued at the lower of cost or net realisable value.~~

~~1.4 A stocktake of all stores must be undertaken at least once per annum to provide a valuation of stock and work-in-progress for the annual accounts.~~

~~1.5 Stores should be kept tidy at all times and items stored should be clearly labelled, stored in storage containers (e.g. bins, drawers, shelves etc.) to aid the stock taking process.~~

~~1.6 Internal and External Auditors may attend the actual stocktake to carry out sample checks.~~

2. ~~Stocktaking Process~~

~~2.1 The Finance Director or Delegated Finance Officer shall notify Budget holders, in writing, when and how stocktakes are to be undertaken.~~

~~2.2 All stock held on both controlled and non-controlled stores must be counted. Consignment Stock must be counted separately from ABUHB Stock. **The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count.** The members of staff undertaking the stock take count must ensure the accuracy of the count.~~

~~2.3 Consignment stock must be counted separately and should be clearly identifies so not to be mixed in with normal stock. The count must be undertaken by two members of staff, one employed in the department and another member of staff (either within the department or external to the department) to verify the count. **The members of staff undertaking the stock take count must ensure the accuracy of the count.**~~

~~2.4 Supervisors are required to undertake a sample check of the counted stock to ensure the accuracy.~~

~~2.5 All items must be counted and verified by both members of staff. It is not acceptable for 1 member to count the stock and for the 2nd member of staff to undertake a sample check on a number of items counted.~~

Status: DRAFTIssue 4

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

Issue date: DRAFT6th October 2022

Review by date: DRAFT6th October 2025

~~2.6 The count is to be recorded on stock sheets of an approved and acceptable design, the attached excel file includes a worksheet as a pro-forma. Budget holders who wish to use a different stock sheet should check with the CMA Team that the design of the stock take sheet they propose to use is acceptable.~~

~~2.7 All items of stock should be populated on the stock take sheets prior to the stock take being undertaken to ensure that all items have been recorded and to prevent any unnecessary delays whilst undertaking the stock take. This will facilitate more accurate and time effective counting.~~

~~2.8 Stock should be counted based on the issues made e.g. if a box of gloves is issued per box and priced per box then the box should be counted. In a situation where individual gloves have been issued staff should count full boxes and half full boxes only—not the individual gloves remaining in an open box.~~

~~2.9 All inventory must be counted regardless of the value~~

~~2.10 Staff are reminded to keep an organised storage area whereby items with similar packaging are not mixed together.~~

~~2.11 Any stock decanted from the main storage area must be included within the stock take count~~

~~2.12 The stock sheets are to be:-~~

- ~~• Completed in ink or typed or a computer print out~~
- ~~• Different types of stock should be clearly identified and listed on separate sheets~~
- ~~• The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted~~
- ~~• The unit of stock must be clearly stated~~
- ~~• Unit cost must be shown against each item and whether the costs include VAT or exclude VAT~~
- ~~• Sequentially numbered in the format 1 of 6, 2 of 6, etc.,~~
- ~~• Dated and signed by the Officer taking stock and the Officer verifying the stocktake~~
- ~~• Dated and signed off by a Senior Manager or the Budget holders.~~

~~2.13 The consignment stock sheets are to be :-~~

- ~~• Completed in ink or typed or a computer print out~~
- ~~• Different types of stock should be clearly identified and listed on separate sheets~~
- ~~• The officer undertaking the stocktake must sign any alterations. The use of correction fluid is not permitted~~

Status: DRAFTIssue 4

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

20

Issue date: DRAFT6th October 2022

Review by date: DRAFT6th October 2025

- ~~• The unit of stock must be clearly stated~~
- ~~• Unit cost must be shown against each item and whether the costs include VAT or exclude VAT~~
- ~~• Sequentially numbered in the format 1 of 6, 2 of 6, etc.,~~
- ~~• Dated and signed by the Officer taking stock and the Officer verifying the stocktake~~
- ~~• Dated and signed off by a Senior Manager or the Budget holders.~~

~~2.14 The original stocktaking sheets are to be forwarded to the CMA Team for valuation. Photocopies are unacceptable.~~

~~2.15 Stock sheets not completed in accordance with these instructions will be returned to Budget holders for correction.~~

~~2.16 The CMA Team will~~

- ~~• Ensure that stock sheets are completed in accordance with this procedure~~
- ~~• Calculate the value of the stock~~
- ~~• Calculate the amount to be charged to/credited to expenditure~~
- ~~• Post the change in stock value to the ledger~~
- ~~• Notify the Budget Holder of the effect of the stocktake~~
- ~~• Enter the results of the stocktake on the worksheet in the excel file~~
- ~~• Provide access to all details of controlled stock, non-controlled stock and Consignment stock to the Financial Accounts Team~~

Status: DRAFT Issue 4
Approved by: Audit Committee
Owner: Director of Finance, Procurement & Value

Issue date: ~~DRAFT~~6th October 2022
Review by date: ~~DRAFT~~6th October 2025

Appendix 2

ANEURIN BEVAN UNIVERSITY HEALTH BOARD AUDIT PROTOCOL FOR MINIMUM AND MAXIMUM STOCK LEVELS

- 1) On receipt of stores/stock from the NWSSP Central Stores, it should be checked and stored away on the same day.
- 2) No stock should be stored at floor level without the support of a pallet unless stored in a racking system.
- 3) All bulk stock should be kept under lock and key.
- 4) No stock should be crammed into storage areas to prevent damage and risk implications.
- 5) Stock should be kept in one area only other than what may be in use at any one time.
- 6) There should not be any stock held over the Maximum agreed level.
- 7) Stock should be kept in original boxes etc., where possible, especially Syringes (Needles) to identify expiry dates and to identify stock levels (Blood Bottle).
- 8) Each Ward and Department should be able to give two names of nominated staff who control the ordering.
- 9) Any member of staff, if approached, should know the procedure on how to obtain a credit from Stores using the appropriate correspondence.
- 10) Staff should be aware of the procedure used for requisitioning and ordering via Oracle.
- 11) Staff should be aware of the Protocol should they have a complaint about any item of stock.
- 12) The storage areas should be in a clean and tidy environment.
- 13) Stock which is used the greatest should be stored the closest to the Store-Room entrance.
- 14) NO STOCK e.g. Universal Containers etc., should be stored in the sluice area.
- 15) Each Ward/Department Manager should encourage Junior Staff to keep the Storeroom in a manageable condition. This will also allow them to have an understanding of stock and what it is used for.
- 16) There should not be more than one box/package of any one item opened.
- 17) Stock should be rotated. Last in at the back. (Possibly numbering or dating boxes etc.)
- 18) Where possible, blood bottles should be ordered x 5 packs. Each pack contains 20 blood bottles. 1 box contains 5 packs. All Blood bottles should be stored in the original boxes. This enables easier identification of expiry dates.

Status: ~~DRAFT~~Issue 4

Approved by: Audit Committee

Owner: Director of Finance, Procurement & Value

23

Issue date: ~~DRAFT~~6th October 2022

Review by date: ~~DRAFT~~6th October 2025

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Standing Financial Instructions (SFIs) Self-Assessment
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Finance Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Risk and Assurance committee with the outcome of the Standing Financial Instructions (SFIs) Self-Assessment exercise.

The Audit, Risk and Assurance committee is asked to note the information provided in the report.

Cefndir / Background

The SFIs are a core part of the governance framework for the Health Board, as defined and mandated by the Welsh Government.

The SFIs translate statutory requirements into operational practice, ensuring probity, accuracy, economy, efficiency, effectiveness and sustainability.

The Health Board has performed a self-assessment exercise to ensure that our local procedures align with the SFIs.

Relevant divisions and key individuals were contacted, in order to ascertain, if the Health Board is compliant to each section of the SFIs.

If compliant, a detailed description or relevant documentation has been provided.

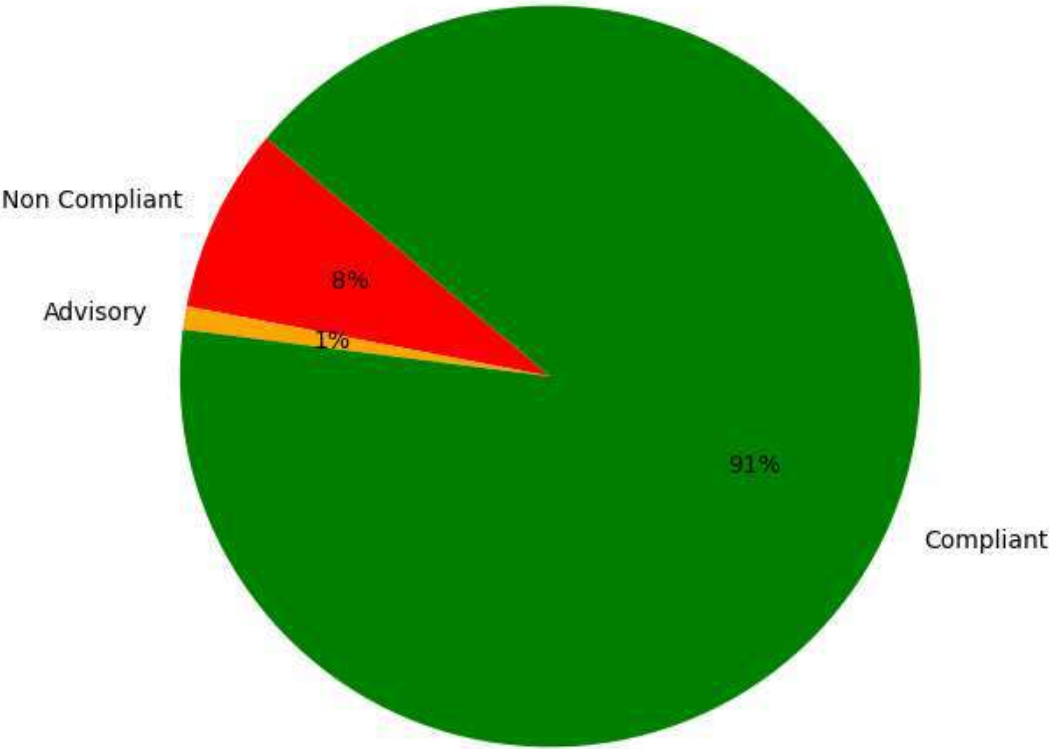
Where the Health Board is not currently compliant, an explanation and plan of action has been included.

The SFI Self-Assessment was presented and discussed by the Executive Committee at their meeting on the 17th July, and is now being presented to the Audit, Risk and Assurance Committee.

Asesiad / Assessment

Summary

The outcome of the SFI Self-Assessment resulted in compliance as below:



The full assessment can be found in Appendix 1 and contains details around the Non-compliant and Advisory matters outlined in the next sections.



Non-Compliance

The non-compliant lines are identified below, with SFI requirement, explanation of non-compliance and remedial action to be followed:

SFI requirement	Finding	Action
4.2 First Financial Duty -The Break Even Duty		
Expenditure does not exceed funding allocated over a rolling 3 year period	The Health Board reported a full year deficit of £7.185m in the 2024-25 Annual Accounts	Adhere to the IMTP 2025-28 which details a deficit of £14m 25-26, £6m 26-27 and break-even in 27-28.
5.1 Budget Setting		
Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will include both: 1. financial budgets, and 2. Workforce establishment budgets (budgeted whole time equivalents)	The IMTP 2025-28 was presented and approved by the Board in March 2025. However, whole time equivalents are not currently included in budgetary reporting.	Each division should have clearly defined workforce budgets with budget variance analyses performed in alignment with that for financial budgets.
10.6 Prepayments - Payments on Account		
Should be exceptional and only considered if value for money case can be demonstrated. A written request should be sent from the Executive Director to the Director of Finance, Procurement and Value for approval. Budget Holders are responsible for ensuring items due are received and managed	The requirement is followed in practice, however, no guidance is documented	A section explaining the prepayment process to be added to the Procurement Financial Control Procedure
13 Grant Funding (13.1 Legal Advice, 13.2 Policies & Procedures, 13.3 Corporate Principles Underpinning Grants Management, 13.4 Grant Procedures)		
Non-procured payments to external bodies or individuals for activities. Payments made to fund or reimburse expenditure on agreed items or functions with legally binding conditions	The Health Board currently has no guidance or policies documented relating to the issuance, monitoring and governance of grants.	A policy for grants funding to be created. To include the following criteria: - Purpose and scope - Definition and distinction - Statutory and legal compliance - Governance and accountability - Application and approval process - Monitoring evaluation and audit - Review and updates

Advisory



During the course of the assessment, even though compliant, the line below has been highlighted as an improvement area:

SFI requirement	Finding	Action
Section 2.2 The Chief Executive and Director of Finance- Responsibilities and Delegation		
The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control	The Scheme of Delegation financial limit up to 50k states job titles as 'Divisional Directors/General Managers/Assistant Directors.' Job titles in ESR and on internal systems can differ which can increase the risk of financial limits being assigned to incorrect individuals	Executive review of all 50k budget holders and ensure alignment between Job Titles outlined in the Delegated Authority Policy and the delegations in place.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the report and support the actions identified.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.



Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	SFI – Standing Financial Instructions ESR – Electronic Staff Record
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • Workforce • Service Activity & Performance • Financial	Is EIA Required and included with this paper? A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



<https://futuregenerations.wales/about-us/future-generations-act/>



Model Standing Financial Instructions for Local Health Boards

SFI Requirement	ABUHB Compliant Y/N	ABUHB Arrangements in Place (Detail)	ABUHB Arrangements in Place (Document)	Gaps (if any identified)	Comments	Actions	Other
1. Overview							
1.2 Overriding Standing Financial Instructions	Y	Procedure for NHS Staff to Raise Concerns Speaking up Safely Framework	 				
1.3 Financial Provisions and Obligations of LHBs	Y	Board meets it's obligation to perform functions as per Standing Order Instructions					
2. Responsibilities and Delegation							
2.1 The Board	Y	Board Public Meeting Minutes Sept 24		Yes			
2.2 The Chief Executive and Director of Finance	Y	Scheme of Delegation			The Scheme of Delegation financial limit up to 50k states job titles as 'Divisional Directors/General Managers/Assistant Directors.' Job titles in ESR and on internal systems can differ which can increase the risk of financial limits being assigned incorrect individuals	Executive review of all 50k budget holders and ensure alignment between Job Titles outlined in the Delegated Authority Policy and the delegations in place.	
2.3 The Director of Finance	Y	Organisational Induction SharePoint page Budget Holder e-Learning Course ESR Mandatory Courses	 		Scheme of Delegation contains various financial, operational and workforce elements		
2.4 Board Members and LHB Officers, and LHB Committees and Advisory Groups	Y	Board & Committees Structure				Training is provided to all delegated budget holders	
2.5 Contractors and Their Employees	Y	The Health Board does not currently have any third parties committing expenditure on it's behalf					
3. Audit, Fraud and Corruption, and Security Management							
3.1 Audit Committee	Y	Audit, Risk & Assurance Committee Annual Programme of Business 2025-26					
3.2 Chief Executive	Y	Internal Audit Progress Report					
3.3 Internal Audit	Y	Internal Audit Plan 2025-26					

3.4 External Audit	Y	Annual Accounts 24-25 Audit Report					
3.5 Fraud and Corruption	Y	Counter Fraud Bribery & Corruption FCP			The Health Board has in place three dedicated Fraud and Corruption roles: Director of Finance, Assistant Director of Finance and Chairperson of the Audit Committee		
	Y	Counter Fraud Work Plan 2025-26					
3.6 Security Management	Y	Welsh Government Circulars communicated to appropriate divisions throughout the Health board					
4. Financial Duties							
4.1 Legislation and Directions	Y	As per below					
4.2 First Financial Duty - The Breakeven Duty	N	Board Finance Report 24-25		Yes	The Health Board reported a full year deficit of £7.185m in the 2024-25 Annual Accounts	Refer to Section 4.3. Adherence to the IMTP 2025-28 which details a deficit of £14m 25-26, £8m 26-27 and break-even in 27-28	
4.3 Second Financial Duty - The Planning Duty	Y	IMTP 2025-28					
5. Financial Management and Budgetary Control							
5.1 Budget Setting	N	Board IMTP Report 25-28		Yes	Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. This years IMTP does not include reference to WTE. There is general awareness, across the Health board, the requirement to ensure budget is available before placing vacancies on TRAC and adherence to headcount in ESR	Each division should have clearly defined workforce budgets with budget variance analyses performed in alignment with that for financial budgets.	
5.2 Budgetary Delegation	Y	Budget Delegation Letter					
5.3 Financial Management, Reporting and Budgetary	Y	Board Finance Report 24-25					
5.4 Capital Financial Management, Reporting and Budgetary Control	Y	Board Finance Report 24-25					
5.5 Reporting to Welsh Government - Monitoring Returns	Y	ABUHB MMR Tables					
		ABUHB MMR Commentary					
6. Annual Accounts and Reports	Y	Annual Report & Accounts 2023-24					
7. Banking Arrangements							

7.1 General	Y	GBS Letter					
		GBS Service Level Agreement					
7.2 Bank Accounts	Y	AB Revenue Bank Account					
7.3 Banking Procedures	Y	Cash & Bank FCP					
7.4 Review	Y	Banking arrangements reported to ARAC periodically. Next update due for Sept 25					
8. Cash, Cheques, Payment Cards and Other Negotiable Instruments							
8.1 General	Y	Purchasing Cards FCP					
8.2 Petty Cash	Y	Petty Cash FCP					
	Y	Petty Cash - Mental Health FCP					
9. Income, Fees and Charges							
9.1 Income Generation	Y	R&D Finance Policy					
9.2 Income Systems	Y	Accounts Receivable FCP					
9.3 Fees and Charges	Y	R&D Finance Policy	As per Section 9.1				
9.4 Income Due to Debt Recovery	Y	Recovery of Overpayments to Employees FCP					
10. Non-Pay Expenditure							
10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability	Y	Board Report - Revised Scheme of Delegation	As per Section 2.1				
10.2 The Director of Finance's Responsibilities	Y	Authorised Signatory List maintained, including specimen signatures, which adheres to the Scheme of Delegation. Procurement policy as per section 11.2					

10.3 Duties of Budget Holders and Managers	Y	Budgetary Control FCP					
10.4 Departures from SFI's	Y	Procedure for NHS Staff to Raise Concerns					
10.5 Accounts Payable	Y	Accounts Payable FCP					
10.6 Prepayments	N			Yes	The requirement is followed in practice, however, no guidance is documented.	A section explaining the prepayment process to be added to the Procurement FCP	
11. Procurement and Contracting for Goods and Services							
11.1 Procurement Services	Y	NWSSP Provide a Procurement Service on behalf of the Health Board through both collaborative national contracts and a local contracts. The Aneurin Bevan Intergrated Partnership (NWSSP Procurement Services) work with Health Boards Stakeholders to understand needs and requirements and aact a link between the Health Board and National Services Procurement FCP					
11.2 Policies and Procedures	Y	Contract Management FCP	 				
		NWSSP 'Which Procurement Route' link	Which Procurement Route			NWSSP has a suite of policies and procedures to ensure that procurements are managed in line with Health Board Governance requirements and in line with Public Sector Procurement Legislation. The NWSSSP Document Management System (DMS) outlines the approach that should be adopted for various levels of spend and the governance requirements for each of these. Compliance is	
11.3 Procurement Principles	Y	The DMS takes into account procurement principles such as Transparency, Non-discrimination, Equal treatment, Proportionality, Legality, Integrity, Effectiveness, Efficiency					
11.4 Procurement Regulations and Legislation Governing Public Procurement	Y	The DMS has recently been updated to comply with latest procurement regulations Procurement Act 2023 & Health Services Procurement Wales Regulations 2025					
11.5 Procurement Procedures	Y	The DMS includes all stages of the procurement process from Development to Tendering through to Contract Award and Management. The procedures cover off all levels of spend from quotation, below threshold tenders and above threshold tenders.					
11.6 Procurement Consent	Y	NWSSP 'Procurement Process - Above Threshold' link	Procurement Process - Above Threshold			The above procedures include governance arrangements both internally within the Health Board and via Welsh Government including consent at planning and award stage for contracts in excess of £1m and Summary reporting requirement for contracts in excess of £500k. For contracts awarded and managed by NWSSP Procurement services the reporting arrangements are managed by NWSSP.	
11.7 Sustainable Procurement	Y	NWSSP 'Above Threshold - Sustainable Procurement' link	Above Threshold - Sustainable Procurement			Sustainable Procurement is embedded within the NWSSP DMS policies and procedures including the requirement for sustainable risk assessments to be undertaken during contract planning and the request for decarbonisations plans as part of the procurement process. All Procurementst consider how the Wellbeing and Future Generation Act goals can be delivered through the contract.	

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)	Y	Procurements are managed in a way to minimise the barriers for SME's, TSO's, SFB's through ensuring appropriate lotting structures and where appropriate reserving contracts for particular business types. All Contract are advertised via Sell2Wales to allow equal opportunity for these businesses to bid.				
11.9 Planning Procurements	Y	NWSSP Procurement Toolkit Template		Procurement%20Toolkit%20Template.xlsx	NWSSP Procurement services support the Health Board with a robust planning process to understand the requirements of the contract and consider what can be delivered through the contract. The planning process will cover off market research, benchmarking, sustainability/social value goals, pricing strategy in order to determine the best approach to the contract. The plan is signed off by business	
11.10 Procurement Process	Y	The above planning process will determine the most appropriate procurement process to be followed, this will be depend on the value, availability of national contracts or frameworks and the specific requirement of the Health Board.				
11.11 Procurement Thresholds	Y	The NWSSP Procurement procedures align with the Health Board SFI threshold requirements for Quotation, below threshold tender and above threshold tender.				
11.12 Designing Competitions	Y	NWSSP Contract Planning - Briefing Paper		Procurement%20Contract%20Planning%20Briefing%20Paper.docx	The designing of competitions is managed through the planning process and the agreed design of the competition is included in the briefing paper which is signed off by stakeholders prior to proceeding to tender stage.	
11.13 Single Quotation Application or Single Tender Application	Y	Both SQA's and STA's require approval following the submission of a written form (SQA/STA Request Form) the request is first submitted to procurement for Head of Procurement approval and then follows internal governance process of Head of Finance and/or Chief Executive approval. All SQA's/STA are then reported to ARAC.				
11.14 Disposals	Y	Capital Procedures & Guidance Notes FCP		As per section 5.4		
11.15 Evaluation, Approval and Award	Y	Evaluation panels are agreed as part of the planning process previously mentioned. All contracts entered into by the Health Board are approved following the scheme of delegation via the Request for Approval Form and contract outcome report and is managed by				
11.16 Contract Management	Y	The Health Board has recently implemented a financial control procedure to improve contract management within the Health Board. This procedure outline the requirements for contract managers to develop a contract management plan and to hold				
11.17 Extending and Varying Contracts	Y	NWSSP - Consideration to Extend an Agreement Template		Procurement%20Consideration%20to%20Extend%20an%20Agreement.docx	Under NWSSP Procurement updated procedures contract will only be extended following the completion of the consideration to extend a contract template being submitted. Contract can only be extended if the original agreement included an option to extend and approval was given at the Request for Approval Stage. Any extension outside of this approach would only be in line with Public Contract Regulations and supported with a further Request for	
11.18 Requisitioning	Y	Requisitioning is managed via the Oracle system and in line with the scheme of delegation. Requisitions for non-catalogue items are forwarded to procurement within the system where the procurement team check compliance before generating purchase order which follows the scheme of delegation for approval before it is released.				
11.19 No Purchase Order, No Pay	Y	ABUHB No PO No Pay Letter to Staff Dec 24		No%20Purchase%20Order%20No%20Pay%20Letter%20to%20Staff.docx	The Health Board has adopted the All Wales No PO No Pay policy that means save for a minimal number of exceptions that invoices received without an official purchase order will not be paid.	
		NWSSP - No PO No Pay policy		NHS-Wales-No-PO-No-Pay-No-Purchase.pdf		
11.20 Official Orders	Y	Official Orders are only generated in the system once the procurement team have converted the requisition into purchase order and the purchase order has been approved in line with the scheme of delegation.				
12. Health Care Agreements and Contracts for Health Care Services						

12.1 Health Care Agreements	Y	Approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services FCP	 ABUH8_Commiss..._0891 Policy and		Long Terms Agreements in place with all NHS Providers. Signed off annually. Out of Area policy in place for referrals outside of normal pathways		
		Out of Area Referral FCP	 ABUH8_Commiss..._0642 Out of Area				
12.2 Statutory Provisions	Y	Swansea Bay LTA 24-25	 Swansea Bay LTA 24-25.pdf		Reflected in the signed annual agreements		
12.3 Reports to Board on Health Care Agreements (HCAs)	Y	Board Report External Contracts M11 24-25	 Board%20Report%20Externa%20Contra		Reported monthly as part of the finance report		
13. Grant Funding							
13.1 Legal Advice	N			Yes	The Health Board does not currently rely on providing grant funding to third parties to achieve strategic aims. Where arrangements are undertaken a process is in place where a Health Board Regional Integrated Grant Letter is completed. However, the process and requirements to undertake such activities could be more explicitly documented	A policy for grants funding to be created	
13.2 Policies and Procedures	N			Yes	The Health Board does not currently rely on providing grant funding to third parties to achieve strategic aims. Where arrangements are undertaken a process is in place where a Health Board Regional Integrated Grant Letter is completed. However, the process and requirements to undertake such activities could be more explicitly documented	A policy for grants funding to be created	
13.3 Corporate Principles Underpinning Grants Management	N			Yes	The Health Board does not currently rely on providing grant funding to third parties to achieve strategic aims. Where arrangements are undertaken a process is in place where a Health Board Regional Integrated Grant Letter is completed. However, the process and requirements to undertake such activities could be more explicitly documented	A policy for grants funding to be created	
13.4 Grant Procedures	N			Yes	The Health Board does not currently rely on providing grant funding to third parties to achieve strategic aims. Where arrangements are undertaken a process is in place where a Health Board Regional Integrated Grant Letter is completed. However, the process and requirements to undertake such activities could be more explicitly documented	A policy for grants funding to be created	
14. Pay Expenditure							
14.1 Remuneration and Terms of Service Committee	Y	Board & Committees Meeting Structure	As per Section 2.4				
14.2 Funded Establishment	Y	IMTP 2025-28	As per Section 4.3				
14.3 Staff Appointments	Y	Vacancy Approvals Standard Operating Procedure	 Vacancy%20Approvals%20Standard%20Op				

14.4 Pay Rates and Terms and Conditions	Y	Board Report Ethnicity and Gender Pay Gaps					
14.5 Payroll	Y	Payroll SLA 24-25					
		Salary Sacrifice FCP					
14.6 Contracts of Employment	Y	Recruitment activity is managed via our recruitment system, Trac. Contracts are issued via Trac when the start date is entered into Trac. Contracts will be sent on or before the first day of employment in accordance with employment legislation when the recruiting manager agrees and inputs the start date in Trac.					
15. Capital Plan, Capital Investment, Fixed Asset Registers and Security of Assets							
15.1 Capital Plan	Y	2025-26 Capital Board Report					
		Capital Opening Programme 25-26					
		AWC Project Prioritisation					
15.2 Capital Investment Decisions	Y	Capital Business Case			Business cases follow the Better Business Cases process as prescribed by the NHS Wales Infrastructure Investment Guidance. Lower value DCP scheme approved via a Project Proposal Document as per FCP.		
		Capital Bid Proforma			Better business Cases applies to major AWCP funded schemes. Associated investments in revenue over £50k are taken through the internal Pre Investment Panel (PIP) prior to Exec / Board approval.		
15.3 Capital Projects	Y	Capital & Estates Board Agenda			Schemes are either approved in the opening programme, at monthly Capital & Estates Board meetings or escalated for urgent approval outside of these meetings. Schemes are approved in line with the SOD and then assigned to a budget holder. Individual orders within shemes are approved in line with SOD. Monthly reporting to Capital & Estates Board , ABUHB Board and WG.		
15.4 Capital Procedures and Responsibilities	Y	Capital Procedures & Guidance Notes FCP			Project Bank Accounts are in place for NHH SRU and Newport East schemes. WG agreement obtained to not run a PBA for GUH ED extension and RGH Endoscopy schemes.		
		Capital Assets & Charges FCP					
15.5 Capital Financing with the Private Sector	Y	ABUHB has two remaining PFI schemes. Monnow Vale Community Hospital (Mar-04 to Mar-36) and the NHH Energy scheme (which is now classed as a ROU asset) which terminates in December 26 .			Schemes approved by WG. A PFI expiry review has been completed by the IPA in relation to NHH Energy scheme.		

15.6 Asset Registers	Y	ABUHB asset register is held on the Asset 4000 system for purchased assets and Prolease for Right of Use Assets. ABUHB is implementing an RFID tracking system for equipment assets to electronically scan assets annually which interfaces with the fixed asset register. Remaining untagged assets are verified by the owning divisions via a manual verification return annually.			Asset values are reviewed for impairments annually as part of the annual accounts exercise.		
15.7 Security of Assets	Y	New Asset form to be completed by Divisions and sent to Capital Finance Team.					
		Disposal form to be completed by Divisions and sent to Capital Finance Team.					
		Divisional Capital Meeting Agenda			Assets either RFID tagged or verified by division annually.		
16. Stores and Receipt of Goods							
16.1 General Position	Y	As per below					
16.2 Control of Stores, Stocktaking, Condemnations and Disposal	Y	Stores & Stocks FCP					
16.3 Goods Supplied by an NHS Supplies Agency	Y	Oracle Placing Requisitions and Receipting Training					
17. Disposals and Condemnations, Losses and Special Payments							
17.1 Disposals and Condemnations	Y	Capital Procedures & Responsibilities FCP		As per Section 15.4			
17.2 Losses and Special Payments	Y	Losses and Special Payments FCP					
18. Digital, Data and Technology							
18.1 Digital Data and Technology Strategy	Y	Digital Strategy 2019			The strategy will be refreshed in 2025 as a Digital Transformation Strategy in line with the Health Board's 10 year strategy and to reflect NHS Wales direction of travel/digital strategy.		
18.2 Responsibilities and Duties of the Responsible Director	Y	Digital Procurement FCP					

18.3 Responsibilities and Duties of the Director of Finance	Y	General Ledger FCP					
18.4 Contracts for Data and Digital Services with Other Health Bodies or Outside Agencies	Y	DHCW SLA Charges 2025-26					
18.5 Risk Assurance	Y	The Cyber Security team provides monthly security risk assurance. Risks are escalated within the formal enterprise wide risk management framework or through the Information Security Governance Framework to the SIRO.					
19. Patients' Property							
19.1 LHB Responsibility	Y	Charitable Funds Bank Accounts					
19.2 Responsibilities of the Chief Executive	Y	Private Patients Property Receipt Book					
19.3 Responsibilities of the Director of Finance	Y	Patients Property FCP					
20. Funds Held on Trust (Charitable Funds)							
20.1 Corporate Trustee	Y	Charitable Funds Committee Agenda					
20.2 Accountability to Charity Commission and the Welsh Ministers	Y	Charitable Funds FCP					
		Charitable Funds Annual Report & Accounts 2023-24					
20.3 Applicability of Standing Financial Instructions to Funds Held on Trust	Y	As per above					
21. Retention of Records							
21.1 Responsibilities of the Chief Executive	Y	Information Governance Staff Handbook					

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker Q1 Position
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Audit Risk and Assurance Committee (the Committee) with a comprehensive overview of the current status of all identified internal and external audit recommendations as at the end of Q1 2025/26 (30 June 2025).

The report also updates the Committee on the progress made since the last reporting period, highlighting recommendations with revised deadlines, those that remain outstanding and those that have been completed.

Cefndir / Background

This report was last presented to the Committee in May 2025; the report covered the position up to the end of Quarter 4 2024/25 (31 March 2025). At that meeting the Committee approved the following position:

- **35** recommendations were completed;
- **24** recommendations had their timeframes revised; and,
- **8** recommendations remained overdue.

This resulted in a total of **69 live recommendations** on the Audit Tracker at year end.



Internal and External Audit Recommendation Tracking

Since the previous report to the Committee, which recorded 69 live recommendations on the Tracker, an additional 128 recommendations from 15 reports issued between February and June have been added. As of the end of Quarter 1 (01 April 2025 – 30 June 2025), the Tracker contained a total of **197** live recommendations. Updates were requested for **96** recommendations that were overdue as of 30 June 2025.

Table 1 below presents a breakdown of the **96** recommendations requiring updates, grouped by Lead Director responsibility.

Table 1

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance & Procurement	Director of Nursing	Medical Director	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Allied Health Professions	Total
Number of updates requested	13	2	13	4	32	10	16	5	1	96

The position reported in Table 2 reflects updates provided by Lead Directors in relation to their assigned live recommendations. Based on this information, the Committee is asked to

- **Approve** the completion of **57** recommendations;
- **Approve 38** revised implementation deadlines;
- **Note** the **14** Overdue against their agreed implementation dates.

Table 2

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Medical Director	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Allied Health Professions	Total
Completed	11	2	3	2	9	9	16	4	1	57
Revised Deadline	2	-	10	2	22	1	-	1	-	38
Overdue	-	-	-	-	1	-	-	-	-	3
Total	13	2	13	4	32	10	16	5	1	96

The summary data presented in Table 2 is further broken down in Tables 3 to 5, as outlined below:

- **Table 3:** Provides a summary of the **57** recommendations confirmed as completed. (Refer to Appendix A for full details.)
- **Table 4:** Sets out the **38** recommendations with revised deadlines. (Refer to Appendix B for full details.)

- **Table 5:** Sets out the 1 recommendation that remain overdue. (Refer to Appendix C for full details.

Table 3

Completed Recommendations					
Audit Title	Assurance Rating	Number by Priority Rating			
2020/21 IM&T Control & Risk Assessment	N/A	1			
2022/23 Dementia Services	Reasonable	1			
2022/23 Audit Wales Structured Assessment	Not Rated	1			
2023/24 Clinical Coding	Reasonable	1			
2023/24 Medical Equipment & Devices - Ultrasound	Reasonable	1			
2024/25 Facilities	Limited	2			
2024/25 Discharge Planning Progress Update	Not Rated	6			
2024/25 Divisional Governance Arrangements	Reasonable	4			
2024/25 Embedding of Policies - Speaking Up Safely	Limited	2			
2024/25 Grange University Hospital Emergency Department Extension	Reasonable	11			
2024/25 Intelligence Led Organisation	Reasonable	1			
2024/25 Job Planning	Limited	2	7		
2024/25 Maternity Services Improvement Plan	Reasonable	1			
2024/25 Mental Health and Learning Disabilities	Reasonable	1			
2024/25 Performance and Accountability Framework	Reasonable	1			
2024/25 Quality Governance Follow Up	Not Rated	1			
2024/25 Reinforced Autoclaved Aerated Concrete Nevill Hall Hospital	Reasonable	1			
2024/25 Review of Cost Savings Arrangements	Not Rated	2			
2024/25 Staff Survey	Reasonable	1			
2024 Audit Wales Structured Assessment	Not Rated	6			
2024/25 Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	3			
TOTAL		10	25	2	20
		57			



Table 4

Recommendations with Revised Deadlines					
Audit Year and Title	Assurance Rating	Number by Priority Rating			
2018/19 Audit Wales Structured Assessment	Not Rated	1			
2020/21 IM&T Control & Risk Assessment	Not Rated	1			
2022/23 Records Management	Limited	1			
2022/23 IT Strategy	Reasonable	2			
2022/23 Discharge Planning	Limited	1	2		
2022/23 Dementia Services	Reasonable	1			
2023/24 IT Infrastructure	Reasonable	2			
2023/24 Providing Care to Asylum Seekers and Refugees	Reasonable	1			
2024/25 Audit Wales Structured Assessment	Not Rated	2			
2024/25 Embedding of Policies - Speaking Up Safely	Limited	1			
2024/25 Discharge Planning Progress Update	Not Rated	11			
2024/25 Records Management	Limited	2			
2024/25 Job Planning	Limited	1			
2024/25 Intelligence Led Organisation	Reasonable	1			
2024/25 End of Life Care	Reasonable	1			
2024/25 Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	7			
TOTAL		5	11	1	21
		38			

Table 5

Overdue Recommendations				
Audit Year and Title	Assurance Rating	Number by Priority Rating		
2024/25 Audit Wales Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	1		
TOTAL		-	-	-
		1		



Following the agreed removal of the **57** completed actions and the approval of **38** extension requests, **140** recommendations will remain live on the tracker, including the **1** overdue recommendation.

Of the **140** recommendations, **125** remain within the accepted extension threshold of two deadline revisions. The remaining **15** exceed this threshold, warranting closer scrutiny and, where appropriate, escalation. It is important to note that in some cases, implementation is contingent on external factors or the completion of related recommendations. Additional information on these recommendations can be found in Tables 6 and 7 below.

Table 6

Implementation Status	Total number of Recommendations
Within Original Deadline	85
1 st Extension	22
2 nd Extension	18
Total Number within the Threshold	125
3 rd Extension	6
4 th Extension	5
5 th Extension	3
6 th Extension	-
7 th Extension	1
Total Number Outside the Threshold	15
Overall Total	140

The **15** recommendations that fall outside the extension threshold are taken from the following reports, Refer to Appendix D for full details.

Table 7

Recommendations Outside of Agreed Deadline Extension Threshold			
Audit Year and Title	Assurance Rating	Number by Priority Rating	Number of Extensions Requested
2020/21 IM&T Control & Risk Assessment	Not Rated	4	1 x 5 th Extension 3 x 4 th Extension
2021/22 Pathology	Reasonable	1	3 rd Extension
2021/22 IT System Controls (WRIS)	Reasonable	4	All on 3 rd Extension
2021/22 Facilities - Care After Death	Reasonable	1	3 rd Extension
2022/23 Records Management	Limited	1	7 th Extension
2022/23 IT Strategy	Reasonable	2	Both on 5 th Extension



2022/23 Tredegar Health & Wellbeing Centre	Limited	1	4 th Extension
2023/24 IT Infrastructure	Reasonable	1	4 th Extension
Total		15	

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the completion of **57** recommendations;
- **APPROVE 38** revised implementation deadlines;
- **NOTE** the **1** recommendation that remains overdue against its agreed implementation date and for which no further extension has been requested.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Explained within the report.



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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well, Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies





Appendix A Completed Recommendations

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Planning, Strategy and Partnerships	N/A	1.1	Ensure the organisation's new long-term strategy clearly defines the required sustainable service solutions and decisions for the medium to longer term. This should include a strong focus on population health and prevention.	Population Health and Prevention will be at the heart of the organisation's new long-term strategy and have been core themes from the engagement period. The long-term strategy will set out a clear strategic direction for the organisation. It will provide clarity of long-term direction, long-term outcomes and provide a framework for decision making to support the sustainability of the organisation. The long-term strategy will not set out specific service provisions however it will be supported by a number of plans. This will include the development of a refreshed clinical services plan for the organisation which will describe sustainable service solutions. Key to this will be the Strategic Outline Case for Nevill Hall Hospital which will be presented to the Board in May 2025.	Director of Strategy, Planning and Partnerships	30/06/2025			Completed		0			Management response remains extant- strategy not the place to set out service changes	30/06/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Planning, Strategy and Partnerships	N/A	1.3	Publish well-being objectives either alongside or within its new long-term strategy and ensure Well-being of Future Generations (2015) Act requirements are an integral part of the strategy.	Refreshed well-being objectives will be the organisational objectives and will be set within the new long-term Strategy.	Director of Strategy, Planning and Partnerships	30/06/2025			Completed		0			Complete- Wellbeing Objectives in new strategy	30/06/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	4.1	The Health Board should strengthen its oversight of Standing Financial Instruction and Single Tender Actions by: introducing a self-assessment on Standing Financial Instruction compliance;	A self-assessment of Standing Financial Instructions will be established as part of the annual review at year end to the Audit, Risk and Assurance Committee.	Director of Finance and Procurement	31/03/2025			Completed		0			Report has been shared with the executive team and will be presented to the Audit Committee in September 2025	30/06/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Corporate Governance	N/A	6.1	The Health Board should ensure there is effective separation of responsibilities between the role of the Health Board Chair and the Chair of the Partnerships, Population Health and Planning Committee. The Health Board should seek to appoint a separate committee chair from the wider cohort of independent members.	In 2025/26 the Partnerships, Population Health and Planning Committee will be chaired by the Vice Chair.	Director of Corporate Governance	30/04/2025			Completed		0			Health Board's Vice Chair now chairs this committee.	30/06/2025

4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Corporate Governance	N/A	8.1	The Health Board should ensure there is a clear approach that links the strategic risks in its risk register to the strategic objectives in its annual plan.	The Strategic Risk Register will be reviewed and updated to ensure alignment of risks with the objectives of the IMTP and Annual Plan 2025/26.	Director of Corporate Governance	30/04/2025			Completed		0			The corporate risk assessment template has now been updated to link each risk to a relevant section of the IMTP or Annual Plan. From the September reporting cycle, the dashboard will also include this alignment as a high-level reference guide.	30/06/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Planning, Strategy and Partnerships	N/A	9.1	The Health Board should ensure there is a stronger focus on primary and community care performance within its integrated performance reports.	The Health Board acknowledges the recommendation and has included in the 2025/26 Planning Process is a stronger focus on Building Community Capacity and Population Health and Prevention aligned with the Ministerial Delivery Expectations. As part of the 2025/26 Plan and update of the Integrated Quarterly report, measures will be included for: • Vaccinations, • Diabetes recommended care process delivery • Delayed Pathways of Care, • Access standards • Dental access, • Community nursing and palliative care resource levels • Enhanced Community Care These are alongside the Primary Care Minimum Data set measures which also include Optometry and GMS and the Health Board Priorities for: Transforming Community Services, • NCN and Place Based Care, • Premature Preventable Mortality	Director of Strategy, Planning and Partnerships	30/06/2025			Completed		0			included in PMF	30/06/2025
4648A2024	External Audit	Review of Cost Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	2.2	The Health board should put clear arrangements in place to canvass savings and efficiency ideas from service users and other stakeholders.	Arrangements to identify opportunities for improvement from patients and stakeholders are based on a range of approaches, including patient involvement in consultations, specific project work (e.g. Value based healthcare projects) and receiving feedback from Liaisons. Opportunities to learn from patient compliments and complaints are also taken as part of learning across all services. Patient stories are also used as a mechanism to identify good practice. We are also promoting the Bevan Commission campaign of “Silly Rules” within the organisation, encouraging service users, stakeholders and staff to identify opportunities, through the review of “silly rules” to improve, streamline or where appropriate remove steps, requirements or processes. We will review the outcome of this work to see if there are local opportunities.	V&SB Theme Lead Executive Directors	31/03/2025			Completed		0			The staff survey responses have been collated and a report presented to the Executive V&SB in June 2025, additionally the Finance & Performance Committee will receive an update in July 2025. The 'silly rules' report remains outstanding and will be removed from the action due to its delay.	30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.3	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	'Complex List' to be developed into CWS2 with daily data feedbacks, local authority and health staff to have access to the digital system.	Executive Director of Nursing	31/03/2024			Completed		0			CWS2 rolled out across all sites and wards	30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.8	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	A patient discharge leaflet will be developed to reinforce the 'what matters' conversation and discharge planning at point of admission.	Executive Director of Nursing	30/04/2025			Completed		0			Discharge leaflet produced in the Six Goals brand, reinforcing 'what matters' conversation	30/06/2025

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.9	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	The Health Board and its partners have secured additional funding to pilot the Balancing Rights and Responsibilities Training – the first cohort took place in November 2024 and following evaluation will be embedded within the discharge programme.	Executive Director of Nursing	30/06/2025			Completed		0			Balancing Rights and Responsibilities Training undertaken across health and social care and evaluation workshop held to discuss next steps	30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.1	Ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended;	Roll out renewed guidance to service users.	Chief Operating Officer	31/01/2025			Completed		0	• Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and complete by end of March 2026		Ambulance transport arrangements intranet site containing all information updated; guidance sent to Flow Centre & Ops Teams as points of contact for wards.	30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.2	Putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	Utilise current WAST reports available to provide monthly updates on waiting times and themes. Arrange for standing agenda item at Tier 3 Transport Group meeting	Chief Operating Officer	31/01/2025			Completed		1	• Assistant Medical Director of Planning, leading T&F Group to develop standardised approach • Discussion with Informatics re prioritisation of of digital project to be considered by the Executive Committee • Pilot 'perfect' week following IT solutions		Discussed on monthly basis with WAST at local & national forums. Health Board has also written to WAST to raise concerns about unsustainable position with respect to poor performance. Verbal response received on 30 July; awaiting formal response and action plan from WAST Assistant Director of Operations (Ambulance Care).	30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.2	Putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	Discharge Lounges to be operational across all sites, to ensure timely patient transport.	Chief Operating Officer	31/03/2025			Completed		0	• Assistant Medical Director of Planning, leading T&F Group to develop standardised approach • Discussion with Informatics re prioritisation of of digital project to be considered by the Executive Committee • Pilot 'perfect' week following IT solutions		"Discharge lounges operational at GUH, RGH & NHH. All transport concerns & themes are generally raised by the relevant sites & reported into the GUH System Lead for onward escalation. Monthly reporting from WAST shows performance; discussed at local & national forums. "	30/06/2025
ABUHB-2425-18	Internal Audit	Staff Survey	Reasonable	Director of Workforce and OD	Medium	1.1	Action Plan and monitoring As above. The absence of a formalised, centralised action plan and inconsistent directorate-level implementation pose significant risks to effectively addressing issues identified in the staff survey. While some initiatives, such as the Workforce and Wellbeing Steering Group, show promise, broader adoption and monitoring mechanisms are required to ensure sustained improvement.	Agreed Action: Following the recent audit and recognising that the resources needed to meaningfully respond to the findings are not available (i.e. to ensure high engagement, responsiveness and accountability from Divisions), we have decided to step the survey down from an organisational wide level and will focus only on the annual All Wales staff survey launched every October. Access to the employee experience survey will be on a bespoke self-service model so ensuring high engagement where teams feel this is relevant or appropriate.	Assistant Director of Workforce and OD	01/04/2025			Completed		0			"Survey stepped down from an organisational wide level. Focus will only be on the annual All Wales Staff Survey launched every October. Access to the employee experience survey will be on a bespoke self-service model so ensuring high engagement where teams feel this is relevant or appropriate. "	30/06/2025

ABUHB-2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce and OD	High	3.1	Speaking up safely framework compliance Pre-December 2024 all concerns raised were managed through multiple HR spreadsheets under various mechanisms such as Respect and Resolution, Raising Concerns, Capability, and Disciplinary. The lack of clear categorisation meant that all concerns were treated as speaking up safely concerns, without a structured approach to differentiate and manage them per the framework. Key gaps included, but not limited to: • No documented proof of compliance with required timeframes (acknowledgment within 7 days, follow-up within 14 days, and resolution communication within 28 days). • No evidence of lessons learned being identified from concerns raised.	Agreed Action: Management will ensure the new process for speaking up safely concerns fills all gaps from the old process. This may include but not limited to: Centralised reporting – Create a dedicated speaking up safely repository separate from HR cases, replacing spreadsheets with a case management system. Consider collaboration with HR – ensure regular meetings with HR to identify data triangulation and a possibility of a joint case management system. Ensure timely responses – monitor the timeframe for responses to concerns raised using the new system. Expected Evidence of Implementation: Evidence of compliance to the speaking up safely framework demonstrated through new 9 speaking up safely internal audit due in 2025/26.	Assistant Director of Workforce and OD	31/05/2025			Completed		0			Centralised Reporting: A dedicated SUS repository has been established since the launch of the new framework in December 2024. This is password protected and secured on Sharepoint accessible only by the co-lead Guardians. In addition a separate Lessons Learned log is maintained and discussed following the closure of each case. Lessons are discussed weekly between the SUS co-Guardians. This is again password protected and stored securely on sharepoint. Collaboration with HR: Monthly SUS-HR data triangulation meetings take place. The meeting has an approved Terms of reference. Meetings have been conducted on the first Thursday of each month since March 2025. The attendees include co-lead Guardians, Head of HR, Deput Head of HR and HR Business Partners. Ensure Timely responses: The timeframe of responses is monitored through our internal database. In addition these are discussed at the monthly SUS steering group meetings.	30/06/2025
4693A2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Workforce and OD	N/A	4.1	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: 4.1 taking steps to increase uptake rates for Duty of Quality and Duty of Candour e-learning, to ensure staff have a good understanding of their responsibilities under the requirements.	The NHS Wales – Duty of Candour has been through the Core Learning Advisory Committee and formally adopted as a mandatory e-learning module for all relevant staff in the Health Board. The NHS Wales – Duty of Quality training is scheduled to be taken through the Core Learning Advisory Committee and formally adopted as a mandatory e-learning module for all relevant staff in the Health Board.	Director of Workforce & Organisational Development	30/06/2025			Completed		0			The NHS Wales – Duty of Candour has been through the Core Learning Advisory Committee and formally adopted as a mandatory e-learning module for all relevant staff in the Health Board.	30/06/2025
ABUHB-2425-08	Internal Audit	Divisional Governance Arrangements	Reasonable	Chief Operating Officer	Medium	1.1	Guidance on Key Risks There was no specific guidance provided on the nature of key risks and matters that should be considered for escalation, and the judgement required, including how this links into the risk management escalation process, set out within the Risk Management and Assurance Framework. Staff would benefit from specific guidance/ clarity on the threshold for issues to be escalated.	Agreed Action: We accept this recommendation and recognise that the absence of clear guidance on what constitutes a "key risk" and when escalation is appropriate may result in inconsistent or delayed escalation of important issues. To strengthen our risk management culture and improve consistency, the following actions will be taken: • Add a Risk management page introduced on Divisional Intranet. • Adhere to the Risk Management and Assurance Framework reference escalation routes, risk grading, and ownership responsibilities. • Communication and Awareness of the Risk Management Framework. • Risk management training. Expected Evidence of Implementation: Monitoring Uptake and Impact Use of the guidance and consistency of escalations will be reviewed through quarterly governance audits and feedback loops at SLT and divisional Programme meetings, as delegated by SLT.	Assistant Head of Business & Performance	30/06/2025			Completed		0			We have reviewed Divisional Risk management and escalation processes, and in line with the Corporate Risk Management framework we have developed a Divisional Risk Management framework, combining Corporate information alongside a Divisional interpretation and localisation of processes. We have also developed a process map to demonstrate the process from Local to Divisional level, a quick reference guide for simple, easy access for operational staff, and an action plan to operationalise the framework. This was presented to the Divisional SLT on 22.07.25 and supported. The next steps now will be to share wider with the Divisional Management Team through the Divisional DMT meeting, be clear on roles, responsibilities and expectations, and promote and encourage Risk Management training across the Division. A risk management page has been added to the Division's intranet pages, with links to the Corporate RMF and guidance. Now the Divisional process and framework are supported, these will also be added and the page updated to reflect local	30/06/2025
ABUHB-2425-08	Internal Audit	Divisional Governance Arrangements	Reasonable	Chief Operating Officer	Medium	2.1	Key Risks May not be Escalated Meeting notes from the SLT held on the 8th of October 2024,detailed specific operational issues with corresponding actions in progress. Notably, in the case of 'Posts for Future Care Planning,' it was indicated that PCC could not address the risks internally, but there was no reference to any escalation. We were able to further clarify that the issue was addressed outside of the meeting and addressed outside of the PCC. It is important that all risks identified for escalation are documented and given an appropriate route for escalation.	Agreed Action: We acknowledge the recommendation and agree that all risks requiring escalation must be clearly documented and followed through appropriate escalation pathways. The following actions will be implemented: Documenting of risk escalation: An Action/ Decision log will be introduced for SLT meeting to capture risks identified for escalation, including details of: - o Nature of the risk. - o Why internal resolution is not feasible. - o Agreed escalation route. - o Responsible person for escalation. - o Timeline for escalation and follow-up. Strengthen the Divisional Risk escalation process through the QPS forum. Strengthen Governance Links: We will ensure a clear governance pathway exists between Divisional Programmes, Operational Directorates,SLT and Corporate. Once a quarter, SLT will review the Divisional and Programme Risk Registers, and ensure appropriate escalation processes are in place. Expected Evidence of Implementation:	Assistant Head of Business & Performance	27/06/2025			Completed		0			An action log has been introduced for the Divisional SLT meeting. As above, we have reviewed the Division's risk management and escalation processes, and there is now an agreed process and frequency for SLT to review the Divisional Risk Register.	30/06/2025
ABUHB-2425-08	Internal Audit	Divisional Governance Arrangements	Reasonable	Chief Operating Officer	Medium	3.1	Recording & Tracking of Risks Although risks were identified at the Divisional Assurance meetings and addressed at SLT meetings, we were unable to establish if key risks were identified in a manner which means they were considered for escalation beyond SLT or formally tracked to ensure they were reported to a relevant forum / body. Arrangements would be strengthened from improved monitoring/ tracking of key risks.	Agreed Action: We accept this recommendation and recognise the importance of ensuring that key risks are not only addressed at SLT level but are also monitored, tracked, and escalated to the appropriate forums where necessary. The following action will be implemented: Introduction of an action log for the Divisional Senior Leadership team meetings, to ensure actions, items for escalation or discussion outside of the meeting are captured, including defined lead/timeframes and to provide a feedback mechanism for each action. Expected Evidence of Implementation: Meeting Notes and Agendas • SLT and Divisional Assurance meeting action/decision log: - o Clearly recording key risks discussed. - o Documenting decisions to escalate (or not) with rationale. • Agendas showing follow-up of previously escalated risks. • Access to the Corporate Risk Register showing risks escalated from SLT/divisions. Updated Risk Registers Divisional risk registers updated to reflect escalated risks.	Business Manager	30/05/2025			Completed		0			An action log has been introduced for the Divisional SLT meeting. As above, we have reviewed the Division's risk management and escalation processes, and there is now an agreed process and frequency for SLT to review the Divisional Risk Register.	30/06/2025

ABUHB-2425-08	Internal Audit	Divisional Governance Arrangements	Reasonable	Chief Operating Officer	Medium	4.1	Feedback A formal process was not in place for the escalation, recording and tracking of key risks, to ensure that Divisional Management can be confident that key risks were escalated to them for consideration and their feedback had been fully implemented/ addressed. This should be considered alongside the development of a divisional process and the recording / tracking of risks referenced above.	Agreed Action: We acknowledge the absence of a formal process for the escalation, recording, and tracking of key risks at divisional level, and we agree this has the potential to impact assurance and oversight by divisional management. To address this, the following actions will be taken: Creation of a SLT meeting Action/Decision Log to record: o All risks escalated from services or teams. o Divisional-level decisions and actions. o Whether the risk was escalated further (e.g., to SLT or corporate level). o Date of review, feedback loop, Agreed Action: We acknowledge the absence of a formal process for the escalation, recording, and tracking of key risks at divisional level, and we agree this has the potential to impact assurance and oversight by divisional management. To address this, the following actions will be taken: Creation of a SLT meeting Action/Decision Log to record: o All risks escalated from services or teams. o Divisional-level decisions and actions.	Assistant Head of Business & Performance	27/06/2025			Completed		0			As above. Divisional Risk management and processes have been reviewed, and following communication and implementation, will be reviewed and amended if required.	30/06/2025
ABUHB-2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	1.1	Governance arrangements The Division is in the process of undertaking a review of its governance structure to ensure it is fit for purpose, recognising that the existing structure is slightly complicated with many different meetings taking place. During our review, we identified discussion taking place, across multiple forums, however, there was no clearly defined pathway for the monitoring and reporting on the actions outlined in the 90-day plan.	Agreed Action: • Continuous reporting through daily, fortnightly, and monthly meetings, and the reinstated MH&LD Committee. • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. • Improvement plan aligns with Health Board's Quality Strategy and new accountability framework. Expected Evidence of Implementation: • Monitor against the Performance Management and Accountability Framework (PMF) at Divisional Assurance (DA) meetings, quarterly and mid-year reviews with the wider execs.4 • Agreed workplan for the MH&LD Committee and plan for the year – starts April 2025. • Triangulate inspection and audit data, linking it with the wider QPS team identifying any trends or areas of concerns. • Continue monthly IQPD reporting. • Continue reporting to JET twice yearly. • Bespoke Board Development sessions as required.	Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates	30/06/2025			Completed		0	• * Continuous reporting through daily, fortnightly, and monthly meetings, and the reinstated MH&LD Committee: A range of meetings take place, daily safety flow, weekly patient flow and monthly meetings eg DMT, Exec Assurance, Finance, QPSE, wider DMT to include all SLTs within the Division • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. Regular attendance at QPSE with the committee	Proposed to CLOSED arrangements in place and operating within the Performance and Accountability framework .	30/06/2025	
ABUHB-2425-10	Internal Audit	Maternity Services Improvement Plan	Reasonable	Director of Nursing	Medium	1.1	Reporting It would aid the reader if the Maternity Neonatal Phase working spreadsheet could include the following: • Individually assigned responsibility for actions, such as the Head of Midwifery, to enhance accountability and provide a clear point of contact for updates. • Defining specific timelines for key milestones would offer the Board tangible assurance of progress (rather than the current method of targeting short, medium and long term). • Clearly identify those aspects that cannot be achieved e.g. those requiring external support or relating to broader All-Wales issues. The status of all actions will be reviewed for accuracy, particularly those included at the spreadsheet without a formal status (i.e. red, green, amber). • Minor discrepancies at the spreadsheet were identified and shared with management for addressing. Establishing well-defined accountability routes will improve reporting, ensuring stakeholders understand their roles and responsibilities. This structured approach will strengthen oversight, enhance transparency, and support better outcomes for maternity service.	Agreed Action: Head of Midwifery and Service Improvement Manager have completed the following actions to include :- • Review of the Maternity and Neonatal assurance tracker regarding priority areas for action same updated to include additional information regarding specific accountability. ie Lead Nurse for neonates/ HoM • Maternity and Neonatal assurance tracker updated by to reflect timelines against Health Board priorities • Maternity and Neonatal assurance tracker updated, rag rated red, amber and green, to all all areas, and those not applicable made evident. Minor discrepancies rectified ie Overview tab and amended where responsibility outside of the Health Board. Oversight will be via Multi professional Monthly Divisional QPS, quarterly Directorate and Maternity and Neonatal Assurance Group. With any areas for escalation highlighted. Expected Evidence of Implementation: The Maternity Action Plan Tracker serves as evidence of progress against established actions. It is readily accessible and can be	Director of Nursing	31/03/2025			Completed		0		Immediate actions implemented : tracker updated priority actions, rag rated, assigned to a lead and minor discrepancies reviewed and ammended	30/06/2025	
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.4	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.	Agreed Action: No positive pay impacting changes will be made unless accompanied by an in-date job plan. 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.	Director of Finance and Procurement and Director of Workforce and OD	30/06/2025			Completed		0		This requirement has been included in the communication to all consultants and management teams. The Director of Workforce has informed payroll of this requirement and asked if they are able to help by identifying any controls they can put in place in the event that such changes are requested.	30/06/2025	
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.5	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.	Agreed Action: 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. 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.	Director of Finance and Procurement and Director of Workforce and OD	30/06/2025			Completed		0		This requirement has been included in the communication to all consultants and management teams. The Director of Workforce has informed payroll of this requirement and asked if they are able to help by identifying any controls they can put in place in the event that such changes are requested.	30/06/2025	

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.7	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.	Agreed Action: A further communication will be sent from the Medical Director and Chief Operating Officer to each consultant 5 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.	Chief Operating Officer/Medical Director	31/05/2025			Completed		0				The Medical Director has sent a letter to all consultants. In addition the Medical Director, Director of Workforce and Chief Operating Officer have sent a communication jointly to all General Managers and Divisional Director to share with their management team. Both communications explain the approach and the actions that need to be taken to improve compliance.	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	2.3	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.	Agreed Action: 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.	Medical Director/Chief Operating Officer	30/06/2025			Completed		0				"The requirement is included in the job planning training which all consultants have been asked to undertake previously. It has also been included in the communication to all consultants, and management teams referenced in 1.7. The Medical Director, Director of Workforce and Chief Operating Officer have issued a joint communication to all General Managers and Divisional Director to share with their management team explaining the approach and the actions that need to be taken to improve compliance."	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	3.3	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.	Action Action: 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.	Chief Operating Officer/Medical Director	30/06/2025			Completed		0				The Medical Director has sent a letter to all consultants. In addition the Medical Director, Director of Workforce and Chief Operating Officer have sent a communication jointly to all General Managers and Divisional Director to share with their management team. Both communications explain the approach and the actions that need to be taken to improve compliance.	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	5.1	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.	Agreed Action: In discussion with the Director of Corporate Governance identify the appropriate risk register for job planning compliance to be identified in. Expected Evidence of Implementation: Clearly identified risks on the appropriate risk register, regularly reviewed and monitored	Medical Director/Chief Operating Officer	30/06/2025			Completed		0				This has been amalgamated into a shared risk between the Dir Workforce & OD and the Medical Director on the Executive Comm Risk Register (confirmation email from Head Corp Risk & Ass 29/5/25 and considered at Exec Comm 5/6/25). Risk reads: There is a risk that the Health Board will not achieve full implementation of Medical E-Systems, including meeting the 90% job planning completion target by 30th September 2025. Due to limited engagement from clinical teams, competing clinical priorities, insufficient capacity within Divisional teams, and the complexity of medical workforce arrangements across multiple sites.	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	5.2	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.	Agreed Action: 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.	Chief Operating Officer	30/06/2025			Completed		0				The compliance rate and progress and plans towards full compliance is discussed at monthly Division Assurance meetings. Meetings are recorded and evidence available.	30/06/2025

ABUHB-2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce and OD	High	4.1	Evidence documentation We tested seven concerns raised over the past 12 months and the Health Board was unable to provide adequate evidence of their compliance to the speaking up safely framework. Although a new process is in place this remains untested, and action should be taken to ensure any gaps in process are rectified.	Agreed Action: Management will: Improve documentation – Record-keeping and conduct regular audits for compliance. Transfer old concerns – management will review any open speaking up safely cases being managed under the old process and transfer them to the new process where appropriate. Communication to Board – Continue to present Concerns raised at the People and Culture Committee, also present at the Trade Union Partnership Forum, LNC and within the annual Workforce Director Annual Board report. Expected Evidence of Implementation: Evidence of review of feasibility of implementing a case management system. Regular agenda item at key committees	Assistant Director of Workforce and OD	30/06/2025			Completed		0			As stated in the final Audit report, limited assurance on this objective reflects the time period prior to the implementation of the new system. Improve Documentation: Our SUS database is our method of record keeping and is updated weekly (since December 2024) in a weekly meeting between the co-lead guardians. The process is due for re-audit later this year, following this, we will schedule a regular cadence of audit with our SUS steering group. We are currently developing the All Wales SUS Maturity Matrix n behalf of the Welsh Government worker safety Board which will inform the method used to audit the service. Transfer of old concerns: There are no open concerns from the 'old' process which requiring transferring to the new system. Communication to the Board: The Welsh Government SUS framework states we must as an organisation embed Speaking	30/06/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Low	5.1	Management should ensure that the source data is retained that was used to generate the entries in the Health Board’s MDS submission regardless of the model employed to generate the forecasts.	For all MDS measures derived from the Health Board corporate data warehouse, the source data is retained and is replicable. For MDS measures derived from sources outside of the Health Board corporate data warehouse, the Planning team will implement a process to ensure that this source data is retained.	Director of Digital	30/04/2025			Completed		0	August 2025 - For all MDS measures, the source data will be retained by the provider service and/or planning team, to ensure that this source data is retained and replicable. This will be advised as part of the development process.	Source data is retained for all MDS measures with Information Services and the planning team.	30/06/2025	
ABUHB-2425-26	Internal Audit	Reinforced Autoclaved Aerated Concrete – Nevill Hall Hospital	Reasonable	Chief Operating Officer	Medium	1.2	The RAAC working groups should be more formalised with terms of reference established that identifies membership, roles and responsibilities etc.	AGREED - These will be reviewed in line with the above Management Plan to consider additional members and any clarity necessary for roles and responsibilities	Director Estates and Facilities Division	31/01/2025			Completed		0		Terms of Reference been developed and ratified by the RAAC Governance Group in April 205 with a 6 month review in place	30/06/2025	
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	1.1	Lack of effective / timely reporting to the Project Board potentially impacting oversight and scrutiny The key role of a Project Board is to provide appropriate oversight, scrutiny, and approval of key decisions. It was evident that the timing of the Project Board’s establishment (post FBC approval), impacted initial scrutiny. Thereafter, evidence to support the receipt, scrutiny and approval of key project issues was limited (ref other key findings below). It is acknowledged that key technical issues may be considered outside of the Project Board (by the UHB’s Advisers etc), but associated advice and decisions should be communicated to the Project Board as appropriate. There would therefore be benefit in reviewing the functioning of the Project Board and associated project support / advice.	The role of Project Board will be considered in future projects which are taken forward through the SCAPE Framework. Review of Project Board role for future projects including how the role is articulated within the Project Execution Plan.	Assistant Director of Strategic Capital	30/04/2025			Completed		0		This will be implemtented future projects as per recommendations and included as part of the lessons learnt review.	30/06/2025	
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	1.2	Declarations of Interest The Health Board requires officers to provide Declarations of Interest including any connection to a private body. This would be relevant for Health Board officers with such involvements with the project. As contracted parties and those involved in the project change over time, it is important therefore that these are current e.g. as per declarations which are refreshed at Health Board meetings. However, project specific Declarations of Interest were not made and maintained for Health Board officers on an on-going basis.	Declarations of interest will be added as an agenda item at project meetings. Expected Evidence of Implementation: Project agendas including declarations of interest.	Project Director	31/03/2025			Completed		0		Included as a Standing Item on Agendas	30/06/2025	

ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	3.1	Collateral Warranties The contract requires the completion of Collateral Warranties. These provide direct legal recourse to sub-contractors in the event of main contractor insolvency. Collateral warranties should therefore be in place for key subcontractors prior to the delivery of any associated works. To enforce timely provision, the contract states that ""if the contractor has not ... submitted ... Collateral Warranties required...one quarter of the Price for Work Done to Date which relates to the work....is retained by the Client in assessments of the amount due to the contractor. At the time of audit, the foundations had been completed, and works on the main structure had commenced.	Actioned since audit fieldwork: Relevant Collateral Warranties are being obtained as relevant to those commenced within the programme. Warranties can only be issued to sub-contractors once the sub contracts were signed by the sub-contractors. Queries have been raised by a number of sub-contractors over minor wording changes, which the CA has responded to.	Project Director	31/03/2025			Completed		0			Actioned and detail provided to audit	30/06/2025
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	4.1	Parent Company Guarantee In the event of contactor insolvency, a Parent Company Guarantee, can be an important financial safeguard. This enables recourse to the Parent Company for any outstanding liabilities, including completion of the works. The build contract provides the option of an "ultimate holding company guarantee. While the chosen contractor benefitted from a parent company, this option was not selected. The associated risks and benefits were not considered within the procurement strategy or otherwise reported and approved.	Parent Company Guarantee requirements (and alternatives) will be considered, with decisions approved (by the Project Board) and documented at all future projects. Expected Evidence of Implementation: The consideration of Parent Company Guarantee requirements (and alternatives) will be documented Project Board minutes (at all future projects).	Project Director	31/03/2025			Completed		0			This will be reviewed at future projects as per recommendation	30/06/2025
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	5.1	The need for a current project programme. A project programme reflective of site activities is a key project control. It informs both forecasting and understanding of project progress, performance, and cash flow requirements. The absence of a current programme also impedes the assessment of Compensation Events (which relate to time and cost impacts of project changes).Six months into construction, the project had yet to be provided with a current project programme. While this issue was narrated within Project Management reports, it was not profiled as a key issue. A Project Manager Instruction was issued in June 2024, subsequently securing its delivery. However, on-going programme slippage makes timely update an imperative.	Actioned since audit fieldwork – a current programme has now been obtained. Expected Evidence of Implementation: Provision of a programme current to the works by the contractor (as being progressed on site).	Project Director	31/03/2025			Completed		0			Actioned and detail provided to audit	30/06/2025
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	6.1	Lessons learnt The stated intention of the procurement strategy was to ensure delivery ahead of winter 2024/25, with a fixed lump sum price. At the time of audit, the contract price had increased by £547,227 with delivery over a month in delay (largely attributable to a one month delay in planning approval). At the time of concluding audit fieldwork additional delays relating to design issues had been notified, the contractual agreement of which was on-going.Risks and controls can be impacted by a variety of factors such as the nature of contractual arrangements e.g. separately contracted design and build, where a builder may challenge some technical buildability. Noting the variance between objectives and out-turn, a formal lessons learnt review would benefit future projects.	A formal lessons learnt review will be undertaken, this will include for example, time and cost delivery, performance of the parties, and application of chosen framework. Expected Evidence of Implementation: Publication of lessons learnt review to relevant forums.	Project Director	31/03/2025			Completed		0			This will take place at the end of the project. No further action until project has completed	30/06/2025
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	7.1	Change control: There was a need to align the operation of change control with procedures detailed within the Project Execution Plan (see above).The Project Board Terms of Reference included a remit to "monitor and manage the agreed change control process." While changes were reported to the Project Board, their role in approval was not described within the Project Execution Plan and their approval was not minuted. Noting this, there is also the opportunity to clarify processes."	We will ensure the function of Project Board is clarified in relation to Change Control within the Project Execution Plan. Expected Evidence of Implementation: Review of Project Execution Plan for projects taken forward through this Capital route.	Project Director	31/03/2025			Completed		0			This will be reviewed at future projects as per recommendation	30/06/2025

ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	8.1	Design development / change Design change / development is managed through the Early Warning / CE processes defined within the NEC contract. At the time of the audit, the project was reported to be delayed by over a month (with the contractor referencing the potential of further delays to the provision / clarification of design information / drawings).There was a need to review the design development processes being applied at the contract by all parties to determine the reasons for delay and ensure early resolution and the avoidance of additional costs / further delays. The Project Execution Plan should also define these processes, including client sign-off.(The associated need for effective performance monitoring and controls is considered at the Project Management section)."	Actioned – a review was conducted into the causality of delay. This determined that it arose from contractor performance issues rather than procedural issues. Expected Evidence of Implementation: Project lessons learnt to include Contractor delay review."	Project Director	30/04/2025			Completed		0			This will take place at the end of the project. No further action until project has completed	30/06/2025
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	9.1	"Project Performance reporting The project required performance monitoring returns to the SCAPE contractor framework. The Project Board should also be informed of project performance via such reporting. Issues arising at the project included: • five months into delivery the project had yet to benefit from a programme reflecting on-site progress; • project delays associated with late planning approvals; • cash flow arrears, potentially impacting project funding (see financial controls); and • the need to supply Collateral Warranties. However, the Health Board rated contractor performance as 9/10 – narrated as "content". Performance monitoring had not therefore highlighted key control matters to the Project Board for scrutiny/action."	a) Key Performance Indicator (KPI) are being completed for the project within internal review and discussions. As the project is not run through the Designed for Life Framework there is no requirement to return to NWSSP: Specialist Estates Services. b) Based on this best practice KPI collation, we are ensuring robust performance monitoring feedback to the contractor. c) We are additionally ensuring that performance issues are summarised and reported to the Project Board. Expected Evidence of Implementation: • Performance monitoring feedback to the contractor and professional team; and • Performance summaries to the Project Board (as contained within reporting / minutes).	Project Director	30/04/2025			Completed		0		Escalation meetings held to address performance KPI reviews ongoing Will continue to manage and address performance of SCP and other professional advisors who are involved in the project.	30/06/2025	
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	10.1	Funding: The Welsh Government funding approval letter stipulated: "Funding ..must be claimed in full by 31 March 2025" This placed any potential delay beyond March 2025 at funding risk. It was confirmed at the time of the audit fieldwork that, the Head of Capital Finance intended to write to Welsh Government to clarify the requirement. Confirmation of appropriate future funding provisions was required.	Actioned - Confirmation has been obtained from Welsh Government that having accepted funding in full, expenditure can be continued into 2025/26.Expected Evidence of Implementation: Letter of funding and expenditure clarification from Welsh Government.	Project Director	30/04/2025			Completed		0		Detail provided to Audit	30/06/2025	
ABUHB-2425-30	Internal Audit	Grange University Hospital Emergency Department Extension	Reasonable	Director of Planning, Strategy and Partnerships	Medium	11.1	Project Bank Account Welsh Government require that their funded: "construction and infrastructure contracts of £2m ..are required to apply a Project Bank Account unless there are compelling reasons not to do so." This enables timely payments to the contractor and safeguards funds in the event of main contractor insolvency). An approved Decision Report submitted to Welsh Government is required for any exceptions. A Project Bank Account was de-selected as a contract option. However, while Welsh Government were informed, a Decision Report was not completed, and the intended operation of alternative controls was not documented at the Project Execution Plan. A formal approval was not therefore obtained."	Operation of a Project Bank account had already been discussed with Welsh Government, and the appropriate form has also now been submitted to Welsh Government for approval. Expected Evidence Approval of a Project Bank Account Decision Report by Welsh Government.	Project Director	30/04/2025			Completed		0		Detail provided to Audit	30/06/2025	
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations are scheduled to be presented to Exec TeamQ1 , and Board in Q2;	Director of Digital	30/06/2021			Completed		0	August 2025 Terms of reference approved for Digital, Data and Technology Committee and first meeting will be held in October."	Governance structure is now complete within the Digital, Data and Technology directorate with formal reporting into the Executive Committee and assurance provided to the Finance & Performance Committee.	30/06/2025	

	Internal	Dementia Services	Reasonable	Director of Nursing	Low	R4	There should be easily available information / training for staff to ensure patients can communicate with Welsh speaking staff.	The Workstream 4 (Hospital Charter) to link with the Welsh Language Lead and Workforce and Organisational Development leads to identify the number of Welsh Speaking Staff, identify how we can better identify Welsh Speakers and ensure access to Welsh Speakers as part of our Person Centred Care Dementia Care work programme.	Lead Nurse Dementia	01/09/2023			Completed		2			The ABUHB bedside magnetic patient boards create the opportunity for patients choice of language for communication preference and need. In collaboration with the welsh languae team a magnetic PSAG symbol has been created and can be added to the boards to display this communication language preference. tis along side symbols displayed on staff uniforms which help identify welsh speakers aid the welsh language offer. information and resources available in welsh are on the pulse intranet pages as well as external web pages. the Equality and Diversity team are accessible for additional and bespoke advice, guidance and support.	30/06/2025
	Internal	Clinical Coding; Final Internal Audit Report	Reasonable	Director of Digital	High	R4.2	We recommend that the Health Board devise a plan to address the longstanding underperformance in claeiring the backlog of uncoded episodes. The performance of the plan should be reported regularly to the Board or an appropriate forum.	Backlog of episodes will be systematically coded when the new Clincial Coding Structure in implemented. The new structure provides the workforce with he capability to deliver on the monthly coded episodes target and address backlog.	Chief Information Officer	30/06/2024			Completed		2	August 2025 - The performance of clinical coding and the clearance of any backlog is reported to and discussed at the Information Governance Group and assurance provided to the Finance & Performance Committee		Coding structure completed and the team are focused on improving Clinical Coding compliance which will be assured through the Finance & Performance Committee. The Health Board continue to be engaged in the National Clinical Coding Improvement Initiative.	30/06/2025
	Internal	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.3	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	The division will be rolling out the AllocateMe function as part of the Health Roster payroll drop down project. (The Health Roster payroll drop down project is forecasted to take twelve months)	Buisness Support Manager	31/01/2025			Completed		2			"In line with the recommendation and previous updates Management has investigated this and the AllocateMe function will be used as part of the health roster roll out Consultation with staff has concluded which would create the resource and platform to deploy this across the Division. This will take a natural order of time due to the need to phase it and link with the wider rostering team. It is expected this will take the rest of the financial year but as the work has now formally commenced on this work it is proposed this action is not tracked at audit level	30/06/2025
	Internal	Facilities - Jan 2024	Limited	Chief Operating Officer	Medium	R7.4	Management should investigate the following system improvements and implement if appropriate: Bank: • the possibility of using the AllocateMe function within the Bank Staff system to create a better approach to allocating bank shifts to a wider pool of staff; • utilisation of Safe Care or Allocate to monitor when staff start and end their shift; and • the completion of the programme of work to prevent staff from completing all associated steps of approving and paying a bank shift.	Explore the use of safe care or alternative system to monitor staffs start and finish time this is part of the pre-enabling plan for the roll out Health Roster payroll drop down.	Buisness Support Manager	29/02/2024			Completed		2			This has been explored and is not feasible. Will be considered with wider HB and nationally to see if becomes viable in the future as part of wider Roster roll out March 2024: This has been explored. Unfortunately this is not possible at this stage. Other options are being explored.	30/06/2025
	External	Structured Assessment 2022	Not Rated	Director of Nursing	N/A	R3	R3 There is limited use of patient and staff stories at Board. The Health Board should consider how it can increase and maximise the benefit of patient and staff stories in Board and committees to help centre and focus meetings on the things that matter most, and to help triangulate this intelligence with formal agenda items.	A Digital Story Protocol for staff and patient stories is currently under development and once approved an electronic digital repository of stories will be created. Digital Story Telling training has been commissioned. The CIVICA Citizen Feedback System now allows people to leave narrated stories. A selection of these will be played at the start of every Board meeting. The Executive Team will agree a programme of staff and patient stories that help triangulate intelligence with formal agenda items.	N/A	31/03/2023			Completed		1			Draft agenda for Board re Stories set up until May 2026. Agreed at Executive meeting on 14/08/2025 for an organisational collaborative approach for patient stories - tiered approach, with a story repository and tracker set up. All stories to be stored in repository with consent. Story tracker - includes themes/divisions/where shared/ learning. In additon documents including story toolkit, patient story pathway, frequently asked questions,Methods of Capturing Patient, Carer, Staff and Community Stories and Patient Story-Schedule for Board 2025-26	30/06/2025

	Internal	Medical Equipment & Devices - Ultrasound	Reasonable	Director of Allied Health Professionals	Medium	R2	We recommend that services using ultrasound equipment ensure all items are covered by appropriate service or maintenance contracts and are tracked centrally.	Monitoring of service and maintenance contracts is managed through individual departments as well as the EBME service. The physical verification audit will be utilised to ensure equipment has a current maintenance contract as well as evidence that maintenance has taken place within the prescribed period. EBME will investigate potential for MEDUSA to hold contract information centrally on MEDUSA. The system can be set up to provide Alerts. The alert can be used as an early warning indicator for both EBME and the owner that equipment is approaching a maintenance period. If, after investigation, the potential is not viable or investment required not available, then this particular set up on the system will not be implemented; this is not critical to the Health Board meeting the recommendation. The Ultrasound Governance Committee will represent the strategic	EBME Manager	01/11/2024			Completed		1			The intention was to include contracting information on the original audit form however, the practicalities of this caused concern when discussed within the Ultrasound Governance Group. The agreement was to generate a separate maintenance contract form to capture device specific information. This information is then reconciled against the equipment record in Medusa. The audits are overseen by the Ultrasound governance group to ensure continued assurance with respect to maintenance contracts	30/06/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	6.1	Deep Dives: 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.	Agreed Action: The use of Deep Dives to support performance improvement and assurance has not been consistent. The 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	Assistant Director Planning & Performance	30/06/2025			Completed		0			Deep Dives would occur during Q2 if recommended following review and assurance. They are recommended to remain as an escalation action as part of the PMF	30/06/2025
4648A2024	External Audit	Review of Cost Savings Arrangements	Not Rated	Director of Planning, Strategy and Partnerships	N/A	7.1	The Health Board should ensure its performance and accountability framework is working as intended and acting as an appropriate lever to manage divisional and directorate underperformance against savings targets.	The Board has established a performance and accountability framework that operates an assessment of performance that may invoke management escalation arrangements where performance is not as expected. This framework was approved by the Board in September 2023. This specifically includes financial performance measured by budget holder budget variance. Where adverse performance is identified, and triggers are met the budget holder may be subject to escalation measures. This is discussed by the executive team. Savings delivery performance is an element of this process however this is given greater focus as part of divisional assurance reporting and Value and Sustainability Board reporting. The Performance and Accountability arrangements are to be reviewed as part of the 12-month review of the Performance Management Framework.	Executive Director of Strategy, Planning & Partnerships	31/05/2025			Completed		0			The framework remains subject to annual review	30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	9.2	The Health Board should improve record keeping by: establishing a programme of case-note audits focused on the quality of record keeping.	Medical records Audit Programme: The Health Board carries out regular case-note audits. Compliance checks include audit criteria of: black ink, dates, legible, signed and times. The current compliance for outpatients for this audit is 68% and in-patients' documents is 95%. By focusing on these areas, the Health Board can ensure that staff understand the importance of comprehensive documentation and establish a robust audit programme to maintain high-quality record keeping. The results from the audit findings are scheduled to be fed back at the Clinical Standards and Effective Group. Audit results will be used to develop targeted action plans and	Director of Nursing	30/04/2025			Completed		0			An ongoing audit programme has been fully implemented by the Medical Records teams, under the leadership of the Digital, Data and Technology (DDaT) Team. This aligns with the NHS Wales Records Management Code of Practice for Health and Social Care, which clearly outlines the responsibility of all health and care staff to manage records appropriately. Health records are ensuring compliance with key legislations. To strengthen clinical assurance, the Corporate Audit Team is conducting annual audits focused on the clinical content of patient notes. These audits ensure that health and care professionals meet the standards set by their respective registrant bodies. Both the DDaT and Corporate Audit teams are now collaborating on a joint improvement plan. This plan will address identified gaps and drive improvements in record-keeping standards. It will be submitted to the Executive Team for formal approval in due course, ensuring strategic oversight and accountability.	30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	10.1	The Health Board should ensure it has mechanisms in place to understand the experiences of patients and carers in the discharge process in line with their existing policy and apply learning.	Patient experience feedback is captured within the Health Board on the CIVICA Experience Platform. This system is across all inpatient wards and a number of other areas e.g., ED, MIU, SDEC, AMU, etc. All feedback captured is viewed by the ward and wider Directorate and Division, so any comments around discharge could be viewed (from open questions in surveys), however, there is no specific question regarding 'Discharge'. In addition, all comments collected are analysed by the system and put into themes to understand trends. One theme is dedicated to 'Patient Pathway' with a sub theme around 'Discharge', this allows for specific analysis of experience on this subject and understanding of	Director of Nursing	30/04/2025			Completed		0			"Patient experience feedback is captured within the Health Board on the CIVICA Experience Platform. This system is across all inpatient wards and a number of other areas e.g., ED, MIU, SDEC, AMU, etc. All feedback captured is viewed by the ward and wider Directorate and Division, so any comments around discharge could be viewed (from open questions in surveys), however, there is no specific question regarding 'Discharge'. In addition, all comments collected are analysed by the system and put into themes to understand trends. One theme is dedicated to 'Patient Pathway' with a sub theme around 'Discharge', this allows for specific analysis of experience on this subject and understanding of	30/06/2025

4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	11.1	The local authorities should ensure relevant social services teams routinely capture service users' and carers' experiences and apply learning	Local Authorities regularly seek feedback from service users both This can be more challenging in relation to hospital discharge but is an area for improvement. There is the annual census questionnaire and a range of internal feedback mechanisms/ questionnaires including complaints and compliments. Annual report re complaints and compliments	Director of Nursing	30/04/2025			Completed		0			Local Authority assessment teams have robust quality assurance systems alongside our engagement workstreams and regulatory responsibilities as outlined in the Social Services and Wellbeing Act 2014.	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	2.1	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.	Agreed Action: 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. 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	Director of Workforce and OD	30/06/2025			Completed		0			Update August 2025 This requirement was not part of our original contract with L2P however they have agreed in principle to include this in the systems development. The timescales for this are unclear at present due to other priorities. The Medical E systems team will provide updates following their regular meetings with L2P. In the meantime the Medical E-Systems team continue to remind CDs an local managers of the requirements to complete the outcome sections during all interaction with them as means of mitigating any risks.	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	3.1	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.	Agreed Action: 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. 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.	Director of Workforce & OD	30/06/2025			Completed		0			Update August 2025 There is already an alert icon in the L2P system that identifies a sessional change in the job plan. L2P however have agreed in principle to add to the alert within the system to identify that a change form is required. The timescales for this are unclear at present due to other priorities. However, the requirement may vary when SMA is rolled out for Medical staff. The responsibility for ensuring changes are reflected in ESR sits with the local management teams. The necessity to complete a change form and submit to pay roll for any changes to the number of sessions within the job plan to ensure correct payment and accurate reporting has been reinforced with Divisional Directors and General managers in the letter sent on behalf of the Medical Director/Chief Operating Officer and Director of Workforce on 19th June 2025.	30/06/2025

Appendix B Revised Timescale Requests

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	3.1	To become financially sustainable in the longer-term, the Health Board should: develop a detailed longer-term financial plan that is linked to the new long-term strategy currently in development and ensure progress against delivery is reported appropriately.	The long-term financial plan will be developed alongside the long-term strategy and will triangulate service, workforce and financial aspects of the strategy once measures and metrics of change are clarified. This will be iterative to ensure clarity of affordability and outcome benefits expected.	Director of Finance and Procurement	30/06/2025	31/12/2025		Overdue		1	August 2025: This will be developed as part of the detailed plans aligned with the long term strategy		included in PMF	30/06/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	3.2	Develop a detailed route-map to support the delivery of the long-term strategy.	As per recommendation 3.1, the financial plan will be developed alongside the service plan.	Director of Finance and Procurement	30/06/2025	31/12/2025		Overdue		1	August 2025: Refer to above, Also the route map to recovery will need to be refreshed during 2025/26 to ensure financial savings are identified for the major thematic areas within the V&SB categories by the lead executives and delegated budget holders			30/06/2025
ABUHB-2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce and OD	High	1.1	Resourcing The current resourcing for the speaking up safely framework is insufficient, with no dedicated staff or budget allocation, except for the external reporting platform Vivup, which is funded for 12 months through charitable and income generation sources. Depending upon the volume of cases that are raised this may change in the future. Currently, the Assistant Director of Workforce & OD and the Consultant Clinical Psychologist serve as speaking up safely guardians but manage this role in addition to their existing responsibilities.	Agreed Management Action: A review of demand for Speaking up Safely will be undertaken and the outcome of this review will inform an organisational discussion on resourcing implications. Expected Evidence of Implementation: Evidence of a demand and capacity review of the first 6 months with recommendations on the most suitable route forward. Outcome of review will be available September 2025	Assistant Director of Workforce and OD	30/06/2025	30/09/2025		Overdue		1	The review of current resourcing levels has begun with a planned reporting date of September 2025 as per the final Audit report.			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.1	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Policy: • The Health Board will review its Discharge Policy in light of the new National Policy published in September 2024. • The Policy will include standard operating procedures (SOP) for Discharge to ensure that there is clarity for staff. • A communication plan for staff, partners and managers will be completed and posters for ward areas will be developed which set out simply the SOPs.	Executive Director of Nursing	31/03/2024	30/09/2025		Overdue		0	• The Health Board discharge policy is currently being reviewed by the Head of Discharge. • The policy will be a practical guide, user friendly that is accessible to staff and aligns with the WG Optimal Hospital Flow Framework. • The policy will include signposting information for community and voluntary services to support timely patient discharge • There will be a launch for the new policy, with information available on the intranet and associated promotional material such as ward posters			30/06/2025

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.2	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Pathways: • Clinical Workstation 2 (CWS2), which is currently being rolled out across the healthboard has the functionality to assign the correct pathway to each patient: this will integrate with Qlik to ensure daily live capture of patient pathways.	Executive Director of Nursing	30/11/2024	31/12/2025		Overdue		0	• CWS2 a digital application that records discharge pathways has been rolled out across all sites and wards • Ward based dashboards are currently being developed to display discharge pathways, clinically optimised status and reason for delay • Digital team have confirmed delivery of dashboards - Q3			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.4	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Agreement has been reached to develop an app called 'Ask Annie: this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	Executive Director of Nursing	30/04/2025	07/08/2025		Overdue		0	• Feasibility study undertaken for the Community Directory of Services/Ask Annie app by private company TPX Impact • RIF application submitted to RPB for funding to progress to phase 2			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.5	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	A series of workshops are planned to develop a single integrated pathway for Discharge – this will aim to reduce complexity and duplication by creating single access points for discharge services and advice and guidance. This follows a successful piece of work on integrating front door pathways.	Executive Director of Nursing	31/01/2025	31/12/2025		Overdue		0	• Collaborative Meeting held in August - a discharge pathway review has been commissioned jointly across health and social care which will be complete by October			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.6	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	An optimal ward project 'Perfect Ward' is planned which will right size the processes, capacity and capability within ward environments to optimise patient flow and discharge.	Executive Director of Nursing	31/03/2025	31/03/2026		Overdue		0	• Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and complete by end of March 2026			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.7	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Audit and evaluation of the Discharge improvements, plans and pathways will be undertaken post implementation.	Executive Director of Nursing	30/06/2025	31/03/2026		Overdue		0	Evaluation of Optimal Ward Pilot undertaken			30/06/2025

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.1	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Further review of the training for new registrants and additional update training will be scoped in the context of the abovetraining and the development of the app.	Executive Director of Nursing	30/04/2025	31/03/2026		Overdue		0	Awaiting review and evluation of the discharge pathway			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.11	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Embedding of the Optimal Hospital Flow Framework across all sites – Red to Green, SAFER, D2RA, Deconditioning	Executive Director of Nursing	30/04/2025	31/03/2026		Overdue		0	"• Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and complete by end of March 2026"			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.1	Ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended;	Discuss potential for live reporting system with the National NEPTS Delivery Action Group and Joint Commissioning Committee	Chief Operating Officer	31/03/2025	31/12/2025		Overdue		0	• Feasibility study undertaken for the Community Directory of Services/Ask Annie app by private company TPX Impact • RIF application submitted to RPB for funding to progress to phase 2	WAST live reporting not completed; remains an action on JCC NEPTS Delivery Action Group. Will raise again at next meeting, although this has not been scheduled due to the reconfiguration of the JCC meeting structures.		30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.1	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	Further work to improve the flow of information will be addressed through the 'Perfect Ward' project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge.	Executive Director of Nursing	31/03/2025	31/03/2026		Overdue		0	"• Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and complete by end of March 2026"			30/06/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.2	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	Agreement has been reached to develop an app called 'Ask Annie': this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	Executive Director of Nursing/Director of Digital	30/04/2025	07/08/2025		Overdue		0	"• Feasibility study undertaken for the Community Directory of Services/Ask Annie app by private company TPX Impact • RIF application submitted to RPB for funding to progress to phase 2"			30/06/2025

ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	1.1	Lesson learnt The escalation process through the Health Board is inconsistent, with issues prioritised differently across the organisation. We observed examples of record management issues raised at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH), but no formal actions have been initiated resulting in sustained improvement. Furthermore, robotic functionality has been fully implemented to identify data issues with the output generated as an automatic email detailing the problem. While this approach appears sound, in practice, it results in multiple emails being sent to the same individual regarding issues across multiple patients. We note that the volume of the system-generated emails is significant and due to the high number, there is a risk that they may not be fully acknowledged or addressed by responsible individuals.	Agreed Action: Datix is the incident reporting system for the Health board. We will highlight the inconsistent use of this system to the system lead and health and safety manager, and recommend more training offers, to training on documenting the formal actions that have been taken, as part of the management review. We recognise that the output from the robotic functionality requires analysis, and a more targeted follow up is necessary for improvement. Expected Evidence of Implementation: The Health and Safety team and Datix system lead would be required to provide evidence of training. Datix training sessions are scheduled regularly and staff are directed to the training video on the intranet for reporting incidents. We will review the current process with RPA and implement follow up meetings with individual directorates to support action. Documented evidence of this will be available for audit purposes	Health and Safety Manager and Datix System Lead.	30/06/2025	31/10/2025		Overdue		1	"August 2025: The audit findings were highlighted to The Health & Safety Manager and Datix System Lead who responded ""We regularly run sessions for managers on the management review / investigation process and staff are directed to the training video on the intranet for reporting incidents. We also have a suite of guidance documents on all aspects of reporting incidents on the intranet, and also the incident reporting policy"". Evidence of Training logs would be investigated. Emailed 24/07/2025 for an update			30/06/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	31/10/2025		Overdue		1	August 2025: Welsh PAS lesson plans and guides are currently awaiting final sign off. User guides which include instructions on updating the key note are going through version control ahead of publication. There is functionality within WPAS that prompts users to check key notes and this feature is being explored with services by the system manager. Standard Operating procedures including the patient policy are being reviewed to align with the Planned Care Academy. Meetings with services has begun, to review booking			30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	3.2	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.	Agreed Action: 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. 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.	Chief Operating Officer/Director of Finance	30/06/2025	30/09/2025		Overdue		1	Awaiting 90% compliance with job planning in the system. Review September 2025			30/06/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance.	Chief Information Officer	31/05/2025	30/11/2025		Overdue		0	August 2025 - implementation and compliance. This policy is currently in development and will be completed when the Digital, Data and Technology organisational change process is finalised.			30/06/2025
	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	Director of Digital	31/12/2021	31/03/2026		Overdue		4	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.			30/06/2025

	Internal	Records Managment	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	DPO & Head of IG Interim ADI – Governance & Assurance	31/12/2023	31/10/2025		Overdue		7	August 2025 - No further progress on Business Case development, awaiting review of priority business cases by the Executive Committee			30/06/2025
	Internal	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	CCIO / CNIO	01/06/2023	30/09/2025		Overdue		5	August 2025 - Further work was required on the clinical leads paper following feedback from the Director of Nursing and Director and Director of Allied Health Professions (AHPs) & Health Science. This will now be taken to the Executive Committee in September following further refinement.			30/06/2025
	Internal	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	CCIO / CNIO	01/06/2023	30/09/2025		Overdue		5	August 2025 - Further work was required on the clinical leads paper following feedback from the Director of Nursing and Director and Director of Allied Health Professions (AHPs) & Health Science. This will now be taken to the Executive Committee in September following further refinement.			30/06/2025
	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.1	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	01/04/2024	31/12/2025		Overdue		2	"• Assistant Medical Director of Planning, leading T&F Group to develop standardised approach • Discussion with Informatics re prioritisation of of digital project to be considered by the Executive Committee • Pilot 'perfect' week following IT solutions"			30/06/2025
	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	Assistant Medical Director for Planning	01/04/2024	31/12/2025		Overdue		2	"• Assistant Medical Director of Planning, leading T&F Group to develop standardised approach • Discussion with Informatics re prioritisation of of digital project to be considered by the Executive Committee • Pilot 'perfect' week following IT solutions"			30/06/2025

	Internal	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	Planning Director / Head of Performance	01/10/2023	31/12/2025		Overdue		2	The analysis of readmission data remains problematic at this time however national developments focusing on measurement of deconditioning and length of stay. Readmission data could only be provided at a patient level at this time. Prevention of admission in High Risk Adult cohorts are the subject to a separate programme of work under the 6 goals programme. I would suggest closure of this action is considered given the alternatives to address and review readmission reasons and groups			30/06/2025
	Internal	Dementia Services	Reasonable	Director of Nursing	Low	R4	Where operationally and clinically possible, a patient's locality should be considered as part of the admission / transfer process.	Patient Flow Team to consider this specific aspect, linked to the developed KPI's above	Programme Manager linking in with Patient Flow Leads	01/09/2023	31/03/2026		Overdue		2				30/06/2025
	External	Structured Assessment 2018	Not Rated	Director of Digital	High	R3	R3 The Health Board should improve its information governance arrangements by: improving compliance with the information governance training programme to reach the national rate of 95%.	Information Governance training reviewed to include the legislation changes as a result of GDPR. An additional module was developed and launched for Cyber Security which is mandatory for all staff to complete. The Information Governance Unit has set up Information Governance Delivery Groups (IGDG) for each of the Divisions in the organisation. The meetings are held bimonthly and training is included on the agenda for every meeting. Discussions are held specifically around compliance and Managers are tasked with improving their compliance rates. Reports are assessed at Transformation to Digital (T2D) Delivery Board.	Head of Information Governance	01/03/2020	31/03/2026		Overdue		2	"August 2025 - Review of national mandatory training module still underway, Director of Digital has written to all Divisional Directors where mandatory training compliance is below target to request support in improving and signposting to the Information Governance team if further support is required. Revising date to 31/03/2026 given delays to the national delivery of suitable training packages."			30/06/2025
	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	Head of Informatics Service Management	30/11/2024	31/03/2026		Overdue		4	August 2025 - Work continues but lack of resources within directorate is hindering progress, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.			30/06/2025
	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	Chief Technology Officer	31/07/2024	31/03/2026		Overdue		2	August 2025 - Work continues but lack of resources within directorate is hindering progress, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.			30/06/2025

	Internal	Providing Care to Asylum Seekers and Refugees	Reasonable	Chief Operating Officer	Medium	1.1	The Health Board should undertake a service review based on the requirements of vulnerable groups within the Health Inclusion Service to determine if the workforce / resource position required remains appropriate. As part of the review, future demand and the level of patient support required should be considered alongside the requirement to build a resilient workforce and deliver the service in accordance with the Policy.	The Health Board will undertake a review to scope the demand and capacity requirements of Asylum Seekers and Refugees from initial arrival to settlement in Gwent to establish the workforce / resource requirements to sustain the service. The review will scope demand and capacity since service was developed in 2019 to current position, taking into account population needs assessment and changing legislation i.e. S98, supporting those fleeing conflict.	Directorate Manager Additional Clinical Services	30/04/2025	31/12/2025		Overdue		2	A service review has been completed across the Health Inclusion service [delayed due to bereavement leave]. This review has scoped demand and capacity since the service was implemented to current position, taking into account all eligible service users i.e Asylum seekers, refugees, sex workers, homeless and Gypsy and Romani travellers. The review has proposed a Tier 3 service model to support our most vulnerable populations to access health services and this is scheduled for presentation to PCCS SLT on 2 September 2025.			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	1.1	The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.	Current hospital discharge models are being reviewed and once finalised will be communicated clearly to all hospital and community staff. The current system is over complex and must be simplified for the benefit of people. Significant investment across the region on Balancing Rights and Responsibilities (BRR) training, focussing on front door pathways to support staff to take proportionate rights and risk-based decisions that put the person at the heart of decision making and whether an admission is necessary and appropriate. This is multi professional and multi-agency training across the five Local Authorities and Health Board. All staff operating in the hospital discharge space will have access to the range of policies and procedures as part of their induction and ongoing CPD/	Director of Nursing	31/03/2025	31/03/2026		Overdue		1	September 2025: Head of Discharge currently reviewing Health Board discharge policy working with the five local authorities. Revised policy to be ratified by the Clinical Standards and Policy Group ahead of implementation. Roll out of the WG Out of Hospital Flow Framework supports embedding the principles of D2RA, Red to Green, SAFER and deconditioning. OHFF provides training on discharge planning, rolled out across all Health Board wards and sites. Oversight and communication of			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	2.1	The Health Board should update its discharge policy to ensure that it reflects the national guidance issued by the Welsh Government in December 2023.	Update discharge policies including – complex and reluctant discharges and choice policy to reflect the national guidance	Director of Nursing	28/02/2025	30/09/2025		Overdue		1	September: Head of Discharge currently reviewing Health Board discharge policy working with the five local authorities. Revised policy to be ratified by the Clinical Standards and Policy Group ahead of implementation.			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	3.1	The Health Board and local authorities should review capacity to embed and deliver 7-day discharge. Despite discharges needing to happen daily, current ways of working do not support this, and a lack of weekend discharge means patients have a prolonged stay in hospital which increases risk of deconditioning and acquiring infection.	The Local Authorities and Health Board have discharge support in place to via Home First and Hospital to Home 7 days per week. Care packages can be reinstated and restarted on weekends, continue to embed a 7-day approach to discharge across the system. Temporary care can also be commissioned. Continue to embed 7-day discharge planning via the Home First and Hospital to Home, there is often reluctance to support discharges at weekends (risk averse) even where the Local Authorities’/Health Boards’ assessments indicate the person can be safely discharged home. Trusted Assessor model via Home First, workforce is a challenge	Director of Nursing	31/03/2025	30/09/2025		Overdue		1	September: Review of criteria led discharge to support weekend discharges, engagement with the interim Medical Director and Executive Director of Nursing. Local Authorities and Health Board have discharge support in place via Home First 7 days a week across GUH and RGH. Hospital 2 Home and Emergency Care at Home provision in place to support weekend discharges. Revised Home First model to be implemented in September 2025, Trusted Assessor model across all sites with 7 day working.			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	4.1	The Health Board should clarify roles and responsibilities regarding care package prescribing to ensure patients are not given unrealistic and unnecessary expectations in relation to care provision. This is particularly the case with older patients who may be seen as frail. This can disempower patients from being independent and may lead to future readmissions.	Review of roles and responsibilities regarding care package prescribing through the optimal ward model at RGH across three wards to include education/training and review of board rounds. Develop roll out plan for the optimal ward framework across all Hospital sites.	Director of Nursing	31/03/2025	31/03/2026		Overdue		1	September 2025: Review of roles and responsibilities regarding over prescribing of care packages via the roll out of the Optimal Hospital Flow Framework and discharge resource review. Joint discharge review commissioned by the RPB to ensure optimal use of resource across the patient pathway including a review of roles and responsibilities.			30/06/2025

4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	5.1	The Health Board should review its cultural appetite and approach to risk in relation to patient discharge. This should ensure risk is assessed across the whole patient pathway, so beds are not unnecessarily occupied	Updated discharge policies will be shared and form part of the education and communication framework to help prioritise the discharge agenda across the MDT, supported by the Strategic lead for discharge and the senior nurse. The risk in relation to non compliance with the discharge framework is evaluated and discussed at divisional and corporate level via local meetings and integrated boards and will feed into the discharge work streams	Director of Nursing	31/03/2025	31/03/2026		Overdue		1	September 2025: Update discharge policy, review of risk in relation to patient discharge aligned to round out of OHFF.			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	6.1	The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to assess patients when required.	The Local Authorities and Health Board have undertaken a review of opportunities to embed a Trusted Assessor model against national best practice and local datasets for Pathway of Care Delays linked to assessment codes. Three areas of recommendation have been presented to Integrated Discharge Board to progress. Integrated front door • Embedding of quality conversations that promote positive risk management through the Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces. Review undertaken of assessment	Director of Nursing	31/03/2025	30/09/2025		Overdue		1	September 2025: "The Local Authorities and Health Board have undertaken a review of opportunities to embed a Trusted Assessor model against national best practice and local datasets for Pathway of Care Delays linked to assessment codes. Three areas of recommendation have been presented to Integrated Discharge Board to progress. Integrated front door			30/06/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	9.1	The Health Board should improve record keeping by: 9.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.	Monthly Audits: Ward staff conduct monthly audits of nursing documentation to assess the standard and detail of information recorded in patient records. This includes Admission documents, Risk Assessments, Care Records, and Discharge documents. Ward Accreditation Programme: The completion and detail of information recorded on these documents are included in the Ward Accreditation programme, which ensures that staff are aware of the importance of comprehensive documentation. Electronic WNCR Programme: Discharge Planning documentation is available on the electronic WNCR programme, which facilitates better access and	Director of Nursing	30/04/2025	30/09/2025		Overdue		1	September 2025: "BRR training focus on embedding training particularly at front door at GUH and COTE wards. Ongoing audits will include evidence that this appropriate is adopted, focus on patient outcomes. Ongoing ward audits aligned to the roll out of the Optimal Hospital Flow framework."			30/06/2025
ABUHB-2425-11	Internal Audit	End of Life Care	Reasonable	Director of Nursing	Medium	1.1	Framework for the capture and management of patient Future Care Planning documentation Whilst we appreciate that it is the responsibility of the individual to share FCP documents with the necessary health care providers (Health Board, GP, OOH GP, Ambulance Service, District Nursing service etc.) there is an absence of a policy within the Health Board and / or a supporting procedure to cover the: capture; coordination; and management of these key documents.	Agreed Action: The Health Board are working towards implementing a robust framework for capturing and managing patient Future Care Planning (FCP)documentation. This will include the following elements: Identification and Targeting: Implement a structured approach to identify patients who would benefit from FCP, such as those with chronic illnesses, frailty, or nearing end-of-life. Tools like the Elderly Risk Assessment score can be useful. Standardised Documentation: Use standardised forms and templates to ensure consistency in FCP documentation. This can include advance directives, anticipatory clinical management plans, and patient preferences for care. Multidisciplinary Collaboration: Encourage daily multidisciplinary huddles to discuss and document FCP for identified patients. This ensures that all relevant healthcare professionals are involved in the planning process. Electronic Health Records (EHR) Integration: Transition to digital ACP plans for better accessibility and efficiency. Integrate FCP documentation into the EHR system to ensure accessibility and continuity	Director of Nursing	30/04/2025	30/12/2025		Overdue		0		This action has been delayed due to the lack of a national policy on Future Care Planning, in the absence of that policy ABUHB will develop an internal management policy which will be shared with partners by the end of December		30/06/2025

Appendix C - Remaining Overdue Recommendations

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion	Proposed Revised	Date Revised Deadline	Original completion	Revised Deadline	Number of Revised	Progress of work underway	Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	7.1	The Health Board should monitor compliance with its discharge policy to assess the effectiveness and consistency of the application, and whether the intended outcomes are being achieved. This includes adhering to its own policy that an annual programme of learning will be reported to the Patient Quality, Safety and Outcomes Committee.	Data collected via POCD, CWS2 length of stay and discharge work streams will form the cornerstone of improving guidance, shaping the educational programme and focusing resources to improve and evaluate outcomes. Further development of CWS2 to replace the Complex List. Formal dashboard in development and reported to the Integrated Discharge Board. Learning and feedback to be presented at local forums and integrated boards and the patient Quality outcomes committee	Director of Nursing and Director of Digital	31/03/2025			Overdue			September 2025: POCD and length of stay delays monitored weekly, positive impact in reduction in both areas. Adherence to current discharge policy but noted it review which is currently under way to complete end of October. Including guidance around optimal discharge framework and guidance.			30/06/2025

Appendix D - Recommendations Exceeding Extension Threshold

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommendation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Revised Deadline was approved by ARAC Committee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is available	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted and an options paper will be developed for consideration by the Board.	31/12/2022		31/12/2025			Overdue	Not Yet Due	4		May 2025: No update awaiting Internal Audit work. "January 2025 Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan. The organisational change process for Service Management structures is underway and due to complete April 2025." June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments.			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co-produced to manage all priority investments.	30/09/2021		30/09/2025			Overdue	Not Yet Due	5		"April 2025 - Data & Analytical Strategy approved by the Executive Committee and work on component strategies underway for Health & Care Record, Information Governance / Cyber Security and Technical Infrastructure. The Digital Strategy will be reissued following the publication of the Health Board's 10 year strategy." January 2025 Digital champions across all in-patient areas for WNCR Digital Clinical Council reformed and meeting 5th Dec '24, Reporting to Clinical Advisory Forum At the request of Planning, the development of a new Digital Transformation Strategy for ABUHB will commence once the ABUHB 10 year strategy has been agreed. An OCP has been agreed and will be consulted on in Q4 2024/25 that includes a refreshed strategy, planning and engagement function that will further develop stakeholder engagement at local, regional and national level. "" August 2024: Digital Champions in place through the M365 Team. Business partnering to be reviewed by DDaT Senior Leadership Team" January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been made on the request process, business partnering and			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics. The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	31/12/2021		31/07/2025			Overdue	Not Yet Due	4		April 2024 - Implementation of the new security platform has commenced at the Grange University Hospital and configuration of the platform is underway. August 2024: A review of the cyber security plan and Information Asset Register has identified significant work remains to understand critical assets across the estate alongside the new security platform mentioned in the April 2024 which has now been funded by Welsh Government. This platform will be in place by March 2025 so this work will now not be completed until July 2025, in the meantime all assets will continue to be protected by our cyber security controls. January 2024: New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations. In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate.			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	31/12/2021		31/03/2026		08/02/2024	Overdue	Not Yet Due	4		January 2024: No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year. Aug 2023: Awaiting next HBOTS meeting.			
Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Assistant Directorate Manager	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise (including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond. Where additional resourcing / facilities are required, these should be factored into the IMTP process.	To review and update workforce plans as appropriate. Workforce is factored into the IMTP	24/02/2022		01/09/2026		08/02/2024	Overdue	Not Yet Due	3		January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to be repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilised at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.	

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensure validity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	30/04/2022		30/04/2026			Overdue	Not Yet Due	3			June 2025 - Same as previous RadIS is no longer being developed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis.January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.			
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all lever accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver's lists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.	30/04/2022		01/12/2025			Overdue	Not Yet Due	3			June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers. Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard. June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working			
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	31/03/2022		01/12/2025			Overdue	Not Yet Due	3			June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution. March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.		
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	PACS & RADIS Manager	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	30/04/2022		01/12/2025			Overdue	Not Yet Due	3			June 2025 - we still do not have a mirrored DR system and won't be developed with Radis no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH if there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution. Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominantly cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUH and a smaller backup in our YAB DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continuity. June 2024- the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the YAB datacentre if there are issues with the GUH datacentre. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24.	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.		
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Care After Death Manager	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and • be fully compliant with the Health Board and DHCW shared service software requirements	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.	31/03/2023		31/12/2025		20/05/2025	Overdue	Not Yet Due	3			April 2025: Decision made to procure dedicated mortuary and CAD services software (following comprehensive review of TCLE 2025 functionality) which will meet all the required recommendations set out by the Risk and Assurance Team and the HTA, and fully integrate with PAS in order to mitigate against the risk of transcription errors due to manual entry. System can provide reports and/or be integrated with Qlik. Procurement underway. No timeline yet provided for 'go-live' date.October 2024: CAD team database was on Qlik for initial period but was removed due to data quality issues and planned recommencement end of Nov 24 beginning Dec 24. TCLE 2025 UAT underway for CAD and Mortuary , no requirement currently for a bespoke database for CAD, Current CAD database will transfer to TCLE upon completion January 2024: Partially completed. This risk has been resolved/removed by some minor changes to the current CAD database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24 November 2023 - new software was not procured due to cost implications .Work undertaken to cleanse database and ensure that relevant fields are completed to enable reports to be produced through Qlik. Work on reporting is currently underway.	IT Infrastructure Team resource capacity may delay the implementation.	November 2023 - Meeting with IT and support has been put in place for basic maintenance of database with reports being run through Qlik Mar 23 Ongoing liaison with Associate Director of Informatics Strategy & Planning	

Internal	2022.12	Records Management	Limited	Director of Digital	DPO & Head of IG Interim ADI – Governance & Assurance	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023		31/10/2025				Overdue	Not Yet Due	7			August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.			
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023		30/09/2025				Overdue	Not Yet Due	5			August 2025 - No further progress on Business Case development, awaiting review of priority business cases by the Executive Committee"January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. "October 2024: CNIO JD reviewed and shared with Digital Director and Assistant Director of Nursing for consideration. March '24 - no confirmation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Executive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relaunch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met			
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023		30/09/2025				Overdue	Not Yet Due	5			August 2025 - Further work was required on the clinical leads paper following feedback from the Director of Nursing and Director and Director of Allied Health Professions (AHPs) & Health Science. This will now be taken to the Executive Committee in September following further refinement."April 2025 - Clinical workshop has been completed and paper on clinical engagement is being brought to the Executive Committee in May 2025. Clinical Council now meeting." "January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. "October 2024: Clinical engagement model still not approved. Council being reformed Dec '24. Workshop being undertaken with clinical leads in early November to discuss arrangements going forward. March'24 - Dependency on agreement of clinical engagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of stakeholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend		
Internal	2022.20	Tredegar Health & Wellbeing Centre 2023	Limited	Chief Operating Officer	Project Director	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	01/06/2023		31/07/2025		20/05/2025		Overdue	Not Yet Due	4			"April 2025: ""The leases are now reduced from 4 to 3 leases but the main sticking point is the service charge. It has now been agreed that the contractors will only pay for their demises. Unfortunately a new risk has come to the surface. The Welsh Risk Pool has questioned if they can indemnify contractors in ABUHB buildings. Both ABUHB W&F and SES supported by legal and Risk are working through the issues with the Welsh Risk Pool, it is estimated an agreement will be in place by the end of April 25.Dentist – is happy to sign once he has the Service agreement cost. He has also asked about reduction in rent. I think we can achieve this by spreading the furniture repayment across a longer period. He has also agreed to take ownership of the dental chairs and will replace himself when required. Meeting held with the dentist 01/04/25 to confirm no change. Pharmacist – Happy to sign once the full service charge costs are finalised. Meeting held with the Pharmacy 01/04/25 to confirm no change. Glan Yr Afon – SOA completed SES with no change to square meterage. Tredegar – The lease is no longer applicable at this time. Tredegar Practice reverted to a managed Practice as of 01/04/25. Lease negotiations will recommence, when the Practice is taken over by a contractor sometime in the future."January 2025: "All 4 lessees are there or there about, the main sticking point is the service, once advised if it's the demises and shared space or just the demises, we will be able to advise cost which will allow HB to move forward.Dentist – is happy to sign once he has the Service	None	N/A	
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Head of Informatics Service Management	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	30/11/2024		30/06/2025				Overdue	Overdue	4			January 2025 CMDB is now much more mature, with over 54000 assets and may interdependencies recorded allowing a service view to be taken of large elements of infrastructure. Further review to be undertaken in the summer.			

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Single Quotation and Tender Actions –1st April 2025 to 1st September 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Alex Curley – Head of Procurement

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

This report provides the Audit, Risk and Assurance Committee with an update in relation to the single tender / quotation action requests submitted to Procurement and is a standing report covering these key issues as part of the Committee's work plan for the year. The paper reports the outcome of these requests.

Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 1st April 2025 to 1st September 2025.

Cefndir / Background

It is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Chief Executive for consideration. The Deputy Head of Procurement will provide a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for



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

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

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

There have been 8 requests submitted during the period with an annual value of £305,049.40 Ex VAT. The overall value of these 8 awards was £425,635.20 Ex VAT.

Category under the SFI justifying the use of STA	Occurrences (no.)	Value (£/annum)
Follow-up work where a supplier has already undertaken initial work in the same area (and where the initial work was awarded from open competition);	0	-
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	7	359,435
The need to retain a particular contractor for genuine business continuity issues (not just preferences	0	0
An interim agreement prior to joining an all-Wales Collaborative Agreement.	0	-
In line with Policy and justified STA	7	359,435
Not in accordance with STA rationale	1	66,200

Of the 8 approved requests there was 1 classified as goods only, 1 classified as services, and a further 6 classified as maintenance. 7 of the 8 requests for single tender were due to only one provider being able to fulfil the requirement this is particularly prevalent for the maintenance agreements where access to spare parts or software updates are only available from the original equipment manufacturers.

One request was not endorsed by Procurement as the request was retrospective following trials undertaken by the division. A decision had already been made to purchase the equipment following the trial which was undertaken outside of a procurement process. Work has been undertaken with the division to ensure there is early engagement with procurement before commencing any trials in the future. It is procurements understanding that there is potential competition in this market area whilst although different technology could have been explored as part of a procurement process. A full lessons learnt review is being performed to ascertain



any further improvements that can be made to address the risk of trials being entered into which would either favour or prioritise one vendor over potential others.

The Other seven STAs were all confirmed as appropriately raised and approved.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Finance Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	



Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Appendix A - Summary of Single Tender/Quotation Actions											
Date of Request	Reference No	Description	Anticipated Annual Value (ex VAT)	Total Contract Value (Ex VAT)	Supplier	Type	Category	Reason for request	Advice from Procurement	Endorsed	CEO & DoF Approval Date
27/03/2025	ABU-STA-58977	Procurement of Pintuition Machine	£66,200.00	£66,200.00	Sirius Medical	Goods	Retrospective	The equipment will allow for wireless localisation of impalpable breast lesions prior to breast conserving surgery. It will improve the efficiency of the service by allowing localisation to take place at any time prior to surgery rather than committing radiology for support on the day of surgery. Capital funding, WG consumable funding means that the HB will save £118,500 ex vat in 2025/26	Trials of equipment have been undertaken outside of a procurement process and without procurement involvement. Despite the clinicians recommending one provider as the preferred option procurement are not able to endorse this as an STA when there are known competitors within the market. Procurement appreciate that consumables have been purchased for this equipment but early procurement engagement would have ensured that any evaluation would have been completed within a procurement process.	No	25/03/2025
17/04/2025	ABU-STA-59113	Haemonetics Maintenance	£40,162.75	£40,162.75	Haemonetics	Maintenance	One Provider	Maintenance and support for the Haemonetics hardware & software blood transfusion systems - used to run the Blood Transfusion service within ABUHB.	Genuinely one supplier available for this award.	Yes	22/04/2025
17/04/2025	ABU-STA-59126	Airedale Chiller Maintenance at Grange and HSDU	£45,155.50	£90,355.00	Airedale	Maintenance	One Provider	Maintenance for chillers (x6) across GUH and HSDU for 2 years. The need to retain Airedale as supplier is due to critical business continuity requirements. The chillers maintained by Airedale are vital components of the Health Board's infrastructure, directly supporting clinical environments where temperature control is essential for the safe operation of medical equipment, patient care, and pharmaceutical storage.	The STA is approved on the ground of business continuity. The supplier is the only one with direct access to parts for maintenance and knowledge of the system.	Yes	30/04/2025
03/07/2025	ABU-STA-59832	Maintenance for Qty 5 Echogen Fibros scanner's (Serial Numbers F90361, F90362, F93617, F92974, F96348)	£6,445.00	£32,225.00	Echosens UK	Maintenance	One Provider	Echosens UK are the OEM of the Fibros scan Mini. They are the only company manufacturing these, as a result when procuring new capital equipment they have been awarded via STA.	The STA is appropriate as the only provider who maintain this equipment is the original manufacturer	Yes	07/08/2025
26/07/2025	ABU-STA-150214	Money Transmission Services - Government Banking	£100,000.00	£100,000.00	Natwest	Services	One Provider	Money Transmission Services - Government Banking is mandated by HMRC - The contract is negotiated by HMRC and a MOU and contract documentation is signed by the health Board - the reason for this STA is to ensure good governance before the contract is entered into.	The use of NatWest is mandated by HMRC - The contract was awarded by HMRC and the reason for the STA is to ensure good governance. Once the STA has been approved the memorandum of understanding and contract documentation will be signed and the Health Board will be onboarded to the new contract.	Yes	31/07/2025
19/06/2025	ABU-STA-59501	Maintenance of Vyair Lung Function machines	£24,803.15	£74,409.45	Vyair	Maintenance	One Provider	Vyair are the only provider that can service and maintain their equipment as OEM, particularly as the contract encompasses software. 21st July 2025-29th February 2028	The manufacturer is the only provider who can maintain these devices and as such the STA is appropriate	Yes	07/08/2025
24/04/2025	ABU-SQA-59156	Maintenance of Cellular Pathology Equipment - Sakura Tissue Tek Prisma Plus H & E Stainer	£5,571.00	£5,571.00	Sakura Finetek	Maintenance	One Provider	Sakura is the sole supplier due to having the rights of the software upgrade therefore this is a genuine OEM of the market. Service contract on Essential Cellular Pathology Equipment. The contract will provide preventative and breakdown cover for the SakuraTissue-Tek Prisma Plus H&E stainer. A contract is essential to comply with ISO15189	Sakura is the only provider with access to software updates for this equipment as the original equipment manufacturer therefore an SQA is an appropriate course of action.	Yes	29/04/2025

13/05/2025	ABU-SQA-59268	Maintenance of Qty 4 SealSAFE specimen management systems	£16,712.00	£16,712.00	A Menarini Diagnostics Ltd	Maintenance	One Provider	A Menarini Diagnostics Ltd, are the only certified company within the UK to be able to service these SealSAFE systems. It is important that this equipment is properly serviced in order to give correct and reliable results, and to maintain ISO certification. This contract was procured under an SQA last year (SQA/MJ/001/24-25) There is also an Annual Service agreement for Qty 1 Seal SAFE in the Histology department (CSS Division).	A Menarini Diagnostics Ltd, are the only certified company within the UK to be able to service these SealSAFE systems. It is important that this equipment is properly serviced in order to give correct and reliable results, and to maintain ISO certification. This contract was procured under an SQA last year (SQA/MJ/001/24-25) There is also an Annual Service agreement for Qty 1 Seal SAFE in the Histology department (CSS Division).	Yes	30/05/2025

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Progress Report September 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance and Procurement
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 update the Audit, Risk and Assurance Committee (ARAC) of the work undertaken by the Counter Fraud Team in order to provide assurance that this work remains effective.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In order to remain compliant with the NHS requirements of the Government Functional Standards S013 the Counter Fraud Department are required to report the progress of their work to the ARAC.

Cefndir / Background

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by Counter Fraud is set around four key principles:

Key Principle 1: Strategic Governance - to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit & Risk Assurance Committee will continue.

Key Principle 2: Inform and Involve – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud, bribery and corruption in the NHS. Effective use of multi-media channels in order to reach staff across the Health Board will be vital to effective delivery of this principle.

Key Principle 3: Prevent and Deter – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.

Key Principle 4: Hold to Account - to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated. Also, to make those responsible pay back the losses in order that this money can be placed back into patient care.

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the WG directions, NHS bodies are also obliged to demonstrate compliance with the Government Functional Standards 013 - Counter Fraud (GovS 013), which came into effect from 1st April 2021.

1. Inform and Involve

Corporate Induction

Counter Fraud awareness at Corporate Induction remains a mandatory requirement. Subsequently all new starters have an immediate input into Counter Fraud when commencing employment with ABUHB. The statistics in relation to the amount of those who have taken part in Corporate Induction are not available at this time. Liaison will be made with WOD to ascertain when these figures will be available.

E Learning

Since February 2024, the ESR Counter Fraud E-Learning module has been mandated for ABUHB staff. During Q1 798 members of staff have completed the learning. When benchmarked against other NHS Organisations, since mandating training, ABUHB can be seen to be performing well. (See tables)

Health Body (Mandated E-Learning)	Staff Completion Q1	No of Employees * (As at 31/12/2024)	Month Mandated
ABUHB	798	15,592	Feb 2024
BCUHB	1,047	21,323	April 2021
HDdUHB	609	12,193	May 2021
VEL	891	1,873	April 2025
WAST	245	4,398	Aug 2023
Health Body (E-learning not yet mandated)			
CVUHB	5	17,561	
CTMUHB	5	13,204	
DHCW	3	1,249	
HEIW	0	628	
NWSSP	73	6,117	
PTHB	0	2,646	
PHW	7	2,610	
SBUHB	103	14,673	
TOTAL	3,786	114,067	

Health Body	2022/23	2023/24	2024/25
ABUHB	87	5,646	6,620
BCUHB	2,295	4,334	9,727
CTMUHB	22	27	39
CVUHB	12	56	23
DHCW	0	962	340
HDdUHB	5,109	2,299	4,289
HEIW	0	19	7
NWSSP	5	119	1,073
PHW	28	69	46
PTHB	49	4	2
SBUHB	99	325	214
VEL	81	32	4
WAST	22	3,451	1,009
TOTAL	7,809	17,343	23,393

Fraud Awareness Presentations

Fraud presentations during this period have seen a significant improvement. In total **15** in person presentations have been delivered across the workforce. These have included general fraud awareness sessions, manager specific sessions, and bespoke presentations to specific departments.

Departments met include:

- Urgent Care Divisional Management
- Senior Nursing Teams from various departments
- Cross-Divisional Directors
- New Doctors
- Workforce and OD

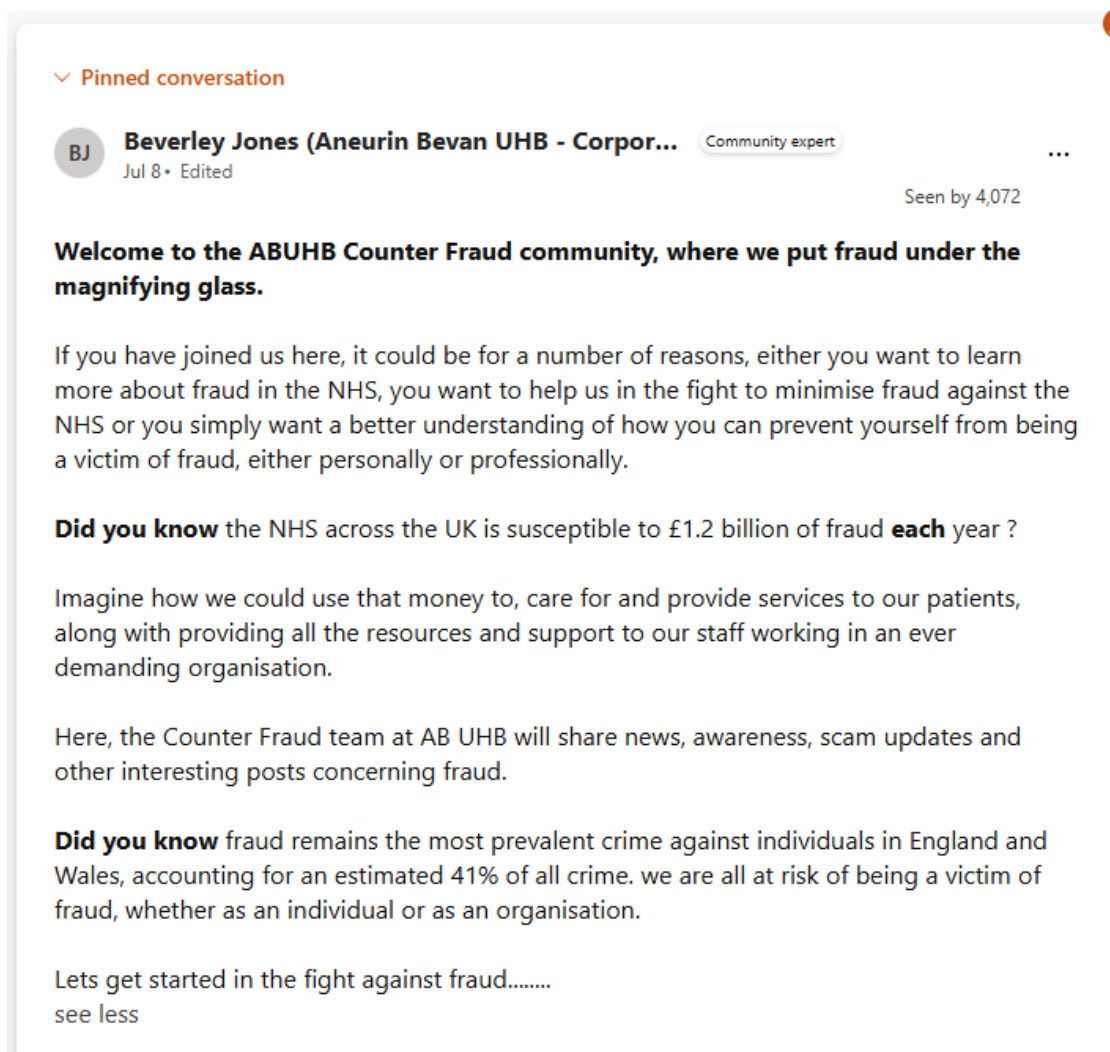
Digital

A new Digital Awareness Strategy has been introduced that focusses on three main avenues. All are supported by the MS Office suite of Apps.

1. AB Pulse
2. Viva Engage
3. Sway

The Counter Fraud Pages hosted on AB Pulse continue to be updated and remain available to all staff.

A Viva Engage Counter Fraud Department channel has now been created. This has allowed the team to reach a wide audience in an impactful way – 15 posts have so far been created and the channel has created 116 new members. A screen shot of an example post is provided below.



In addition to the work carried out on the Digital Pages and Viva Engage, a monthly newsletter has been distributed across the organisation via the Communications Team. The topic areas covered since commencement in June are, Agile Working, Overpayments of Salary and Prescription Fraud.

2. Hold to Account

Investigations & Referrals

The team has received a total of **69** referrals / contacts requiring Counter Fraud advice in this reporting period. All have been assessed and actioned. Of these, **21** have been promoted to investigation. **22** cases have been finalised and closed.

The investigations have resulted in **4** disciplinary sanctions (2 dismissals, 2 written warnings) and 6 civil recoveries.

At 01/09/2025 **18** cases were open and being actively investigated by the team.

9 cases are being actively worked on, **4** are complete and awaiting Disciplinary outcomes, and **5** are complete and awaiting civil recovery.

A sanitised table of cases for 25-26 is at **Appendix 1**

Of note – three protracted investigations are ongoing. Both involve patients in the community setting:

1. Illegitimate duplication and creation of prescriptions within a GP Practice
2. Selling of Diabetes equipment provided by ABUHB x2

1 Interview Under Caution has been carried out with a community patient.

Of the investigations carried out by the team **2** have resulted in Disciplinary sanction.

2 civil recoveries have been made totalling **£9,258.97**

1 Fraud Loss Prevention has been recorded totalling £3,389.64 – resulting from direct investigative intervention re weight loss medication.

Overpayments of Salary

9 referrals have been made to the team between 01/04/2025 and 01/09/2025 totalling **£94,213.16**. None of these have been promoted to formal investigation for fraud/theft offences. All have been returned to Payroll for recovery via the ABUHB Accounts Receivable team.

Of note – there has been a noticeable decrease in the number of 'Significant Overpayments of Salary' year on year - over the same period in the previous financial year **19** referrals were received totalling **£167,378.89**.

NFI

December 2024 saw the release of the latest data from the National Fraud Initiative. A total of 295 matches, relevant to the Counter Fraud Department, have now been assessed. Only 5 matches remain open. These await responses from the matched agency. This year's exercise has resulted in identifying one employee who has been carrying on out work for another organisation that is suspected fraudulent. That employee is now subject to an internal disciplinary process.

Further to this, the exercise identified 11 staff as having a connection to a trade creditor of ABUHB and were not recorded on the organisation's official declaration of interest register. An email has been sent to all individuals concerned and their line manager requesting that a Declaration of Interest is submitted. No fraud was identified in relation to these matches.

In addition, 52 staff were identified as having secondary employment and were not listed on the organisation's official declaration of interest register. Emails have been sent to request that the Declaration of Interest form be submitted.

3. Prevent and Deter

Alerts and Bulletins

6 Fraud Alerts have been disseminated throughout the period of reporting. These included topic areas relating to GP Prescriptions, suspicious patients, and impersonation of medical professionals. All necessary parties were informed.

Fraud Prevention Notice

One FPN has been issued by the NHS Counter Fraud Authority. This related to Payment Diversion Fraud. Response actions undertaken and support and awareness materials distributed to key stakeholders accordingly.

Local Proactive Exercises (LPE) / Risk Assessment

There are now 12 LPE's being carried out by the department into the areas listed below. All are subject to Risk Assessment initially and if appropriate further proactive work.

- Staff Leavers – Uniform, ID badges etc
- WP10 Hospital Prescription Security
- WP10 Community Prescription Security
- Staff Expense Claims
- Weight Loss Medication mis-prescribing
- Agile Working
- Overpayments of Salary
- Petty Cash
- Omnicell Storage
- Diabetes Pump/Sensor Equipment controls
- Consultant and SAS Doctor Job Planning
- Agency Worker – Pre employment checks

There have been numerous positive outcomes arising out of this work such as the development of targeted awareness campaigns and disruption activity.

Of note, the Weight loss medication mis-prescribing exercise is now complete. As a result of the work carried out into this area, 31 interventions were made where these medications were being wrongly prescribed to community patients. All GP contractors have been contacted and remedial action taken to ensure that this did not continue. Subsequently a saving of over **£65,000** has been made for this financial year.

A formal Fraud Risk Management process has now been implemented to allow better understanding of this area of work across Divisions. It is intended that this will be brought to the next ARAC meeting in the Fraud Risk update.

4. Strategic Governance

Regular contact has been maintained between the Head of Counter Fraud, Director of Finance and Fraud Champion throughout the reporting period, ensuring a top-down approach to developing an effective Counter Fraud Culture within the organisation.

The Head of Counter Fraud has attended all Counter Fraud Steering Group meetings to date but will no longer sit on this group in the future due to the new Terms of Reference being implemented. The LCFS representatives will now consist of the Chair and Vice Chair of the Counter Fraud Liaison Group from (WAST and SBU) All Local Intelligence Network (LIN), Post Payment Verification (PPV) and Workforce Policy Group meetings have been attended by a representative of the team.

5. Other

The Q1 NHS Wales Operational report compiled by the Counter Fraud Service Wales is included for reference at Appendix 1. This report provides bench marking data from across all NHS Wales organisations.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to take assurance from the information provided in this report that the Counter Fraud provision remains effective, compliant and focussed.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	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 Choose an item.

APPENDIX 1

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01521	Claiming payment for shifts not worked	28/07/2023 - CO		Full investigation carried out and case file submitted to CPS. CPS declined to prosecute. The matter has been referred back to HR for consideration of disciplinary proceedings.
INV/23/01520	Failing to notify non- payment of salary sacrifice	28/07/2023 - CO		Referred to Accounts Receivable for financial recovery
INV/23/02427	Salary Overpayment	27/10/2023 - CO		Referred back to AR for financial recovery. No offences identified
INV/24/00857	Theft from Omnicell	05/04/2024	15/08/2025	Fully investigated and IUC carried. Full admission - Proportionate for disciplinary only - Warning
INV/24/00944	Leave fraud	16/04/2024		Managerial Issues only. Referred back for disciplinary
INV/24/01205	Salary overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01199	Salary Overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01290	Mass Vacc recruitment	21/05/2024		Negotiated reduced payment tba
INV/24/02846	EMPLOYEE ALSO Working for Charity but getting paid by HB AND CHARITY	08/11/2024	23/07/2025	Disciplinary warning and redeployed
INV/24/02857	Patient believed to have sold medication on that was prescribed to her	12/11/2024	01/07/2025	Full investigation carried. Subject interviewed and admitted offence. Dealt with on a Civil Basis. Recovery of £282.47 achieved and prevention of £3389.64 made as a result of CF intervention.
INV/24/03033	Member of staff - theft of prescription from ward and attempting to have it disseminated at community phartmacy	27/11/2024		Awaits Disciplinary
INV/24/03222	Staff member who provides training suspected of not carrying out her duties and making false representations	16/12/2024	17/07/2025	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/25/00329	NFI - working for Concil at same time as HB	06/02/2025		Awaits Disciplinary
INV/25/000508	working as a barmaid in a local club while on sick	19/02/2025	19/02/2025	No Offences Disclosed
INV/25/00819	WClaiming for extra hours not worked	19/03/2025		false reporting, case closed
INV/25/00849	Suspected to be claiming for shifts not worked	19/03/2025		Unable to prove offences
INV/25/000847 Duplicate INV/25/00116	Self allocation of shifts and overtime fraud allegation	19/03/2024	15/04/2025	Awaits outcome of disciplinary investigation

INV/25/000848	Family sending medication to subject who now resides in Pakistan	19/03/2025	08/04/2025	Fully investigated. Information passed to relevant GP practice. Now closed
INV/25/000904	Local Care Provider	25/03/2025	04/04/2025	Intelligence passed to Gwent Police. Not NHS Related
INV/25/01027	Suspicion over veracity of application form	02/04/2025	15/05/2025	NFA
INV/2501069	Suspicion over Prescription Issue to obtain benefits	08/04/2025	15/04/2025	Intelligence passed to Gwent Police.
INV/25/01088	Salary overpayment	10/04/2025	17/07/2025	referred to AR, full payment made
INV/25/01259	Intel from NHS CFA - subject is from overseas has no right to remain and has signed up with GP surgery	07/05/2025	04/06/2025	Information shared with Police and Home Office. No offences NHS. All required actions carried out
INV/25/01374	Suspicion of Non-Dispensed items not being endorsed on prescriptions, specifically Dapagliflozin . Information supplied by R Evans.	16/05/2025	18/07/2025	No evidence gathered to substantiate - Closed NFA
INV/25/01471	Allegation both parties receiving free NHS treatment when not entitled	28/05/2025		No offences - with Overseas Patient team for recovery
INV/25/01454	GP HCA accessing patient records and reprinting WP10s (predominantly Co-Codamol/Zapain)	23/05/2025		Case Ongoing
INV/25/1483	Multiple issues re dispensing	28/05/2025	04/06/2025	NFA - no offences identified. Information shared with Community Pharmacy team.
INV/25/1869	theft of fentanyl / storage of fentanyl via CIU	03/07/2025	18/07/2025	No Offences Identified
INV/25/1969	Overseas Patient	14/07/2025	18/07/2025	No Offences Identified
INV/25/1973	Selling on Codeine	15/07/2025	23/07/2025	Intelligence passed on to Gwent Police
INV/25/2127	Submission of suspect prescriptions	23/07/2025		Case Ongoing
INV/25/2134	Allocation of shifts not worked	25/07/2025	15/08/2025	No Evidence found to substantiate claims
INV/25/2175	Selling Medication	28/07/2025	29/07/2025	Intell Report - Passed to Gwent Pol and GP Practice
INV/25/02424	Failing to disclose medical condition	13/08/2025	15/08/2025	No offences identified
INV/25/02246	Diabetes Meds and Kit sold on Facebpook	31/07/2025		Case Ongoing
INV/25/02208	Diabetes Meds and Kit sold on Facebpook	30/07/2025		Case Ongoing
INV/25/2409	Suspicion of Lying on App Form	12/08/2025		Enqs Commenced

INV/25/2455	Not managing sickness leave of employees	18/08/2025		Enqs Commenced
INV/25/2512	Allocation of WLI shifts in SPA time	22/08/2025		Enqs Commenced



Counter Fraud Services in NHS Wales

Operational Performance Report 2025/26

Quarter 1 – 1st April to 30th June 2025

Contents		
Section	Item	Page
	Introduction	3
1	Resources	3
1.2	Local Counter Fraud Specialists (LCFS)	3 to 4
1.3	NHS Counter Fraud Authority (NHSCFA)	5
2	Proactive Work: Media Reports and Risk Reviews conducted by LCFSs (1 st April to 30 th June 2025)	6
2.1	Counter Fraud Presentations and Number of Contacts made to LCFSs (1 st April to 30 th June 2025)	7
3	Counter Fraud Awareness E-Learning Staff Completion Figures (1 st April to 30 th June 2025)	8
4	NHS Counter Fraud Service Wales - Statistics / Operational Outcomes (1 st April to 30 th June 2025)	9
4.1	NHS CFS Wales Financial Investigations (1 st April to 30 th June 2025)	10
5	LCFS - Statistics / Operational Outcomes (1 st April to 30 th June 2025)	11 to 12
6	Working in Partnership	13
7	Five Year Operational Outcome Comparison	14 to 15

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 1 of 2025/26 (1st April to 30th June 2025). The NHS Counter Fraud Authority (NHSCFA) report to Welsh Government (WG) on the specialist support services provided to NHS Wales via their Service Level Agreement (SLA) with 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 team consists of 5.93 wte experienced investigators and 0.8 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 employer is Velindre University NHS Trust, a listed 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 suitably qualified LCFS who are the primary point of contact for all economic crime concerns within their health body. The LCFSs have a key proactive role in raising fraud awareness, identifying risks, and preventing fraud within their health bodies via Local Proactive Exercises (LPEs), 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 Q1 of 2025/26. This is consolidated from data provided to CFS Wales by the Lead LCFS at each health body. In the larger health bodies, the health boards with the most LCFS resources are SBUHB at 3.2 wte and 0.6 admin support, and ABUHB with 3.40 wte. This is reconfirmed via the ratios of LCFS : NHS staff in the table below, while CTMUHB (0.12) and C&VUHB (0.13) have the lowest ratios of LCFS : Staff in the larger health bodies.

HEIW, Powys and WAST are the best resourced within the smaller health bodies with 0.62, 0.45 and 0.45 LCFS wte respectively, while NWSSP has the lowest ratio at 0.16.

C&VUHB LCFS Team also provide an LCFS service to Velindre, HEIW, DHCW and PHW, while SBUHB LCFS Team also provide an LCFS service to CTMUHB and PTHB.

Larger Health Bodies	LCFS Annual WTE	Admin Support Annual WTE	Annual Planned LCFS Days	Q1 LCFS Days	YTD LCFS Days	Annual Staffing budget	Staff Headcount (at 31.12.24) *	LCFS wte per 1,000 NHS staff
Aneurin Bevan UHB (ABUHB)	3.40	0	701	187	187	£227,069	15,592	0.22
Betsi Cadwaladr UHB (BCUHB)	3.00	0.5	610	123	123	£210,285	21,323	0.14
Cardiff & Vale UHB (CVUHB)	2.30	0	505	126	126	£162,238	17,561	0.13
Cwm Taf Morgannwg UHB (CTMUHB)	1.60	0.2	616	101	101	£159,577	13,204	0.12
Hywel Dda UHB (HDUHB)	2.00	0	440	102	102	£119,067	12,193	0.16
Swansea Bay UHB (SBUHB)	3.20	0.6	704	176	176	£177,484	14,673	0.22
SHAs and Trusts								
Digital Health & Care Wales (DCHW)	0.39	0	85	21	21	£27,315	1,249	0.31
Health Education & Improvement Wales (HEIW)	0.39	0	85	21	21	£27,315	628	0.62
NHS Wales Shared Services Partnership (NWSSP)	1.00	0	210	48	48	£53,602	6,117	0.16
Powys THB (PTHB)	1.20	0.2	308	77	77	£93,526	2,646	0.45
Public Health Wales (PHW)	0.45	0	100	25	25	£32,135	2,610	0.17
Velindre NHS Trust (VUNHST)	0.45	0	100	25	25	£32,135	1,873	0.24
Welsh Ambulance Service Trust (WAST)	2.00	0	420	105	105	£120,000	4,398	0.45
TOTAL	21.38	1.5	4,884	1,137	1,137	£1,441,748	114,067	Average is 0.24
NHS Counter Fraud Service Wales (CFS Wales)	5.93	0.8	1,299	274	274	£490,068		
ALL WALES TOTAL	27.31	2.3	6,183	1,411	1,411	£1,931,816		

* Staff Headcount data is obtained from Welsh Government Stats Wales website. This is the most recent data available at the time of reporting.

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 when a workplan and budget was agreed for 2025/26. The funding amount for 2025/26 is £264,188. NHSCFA provide separate quarterly and annual reports to WG and CFS Wales to account for the specialist support services provided to NHS CFS Wales and LCFs 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.

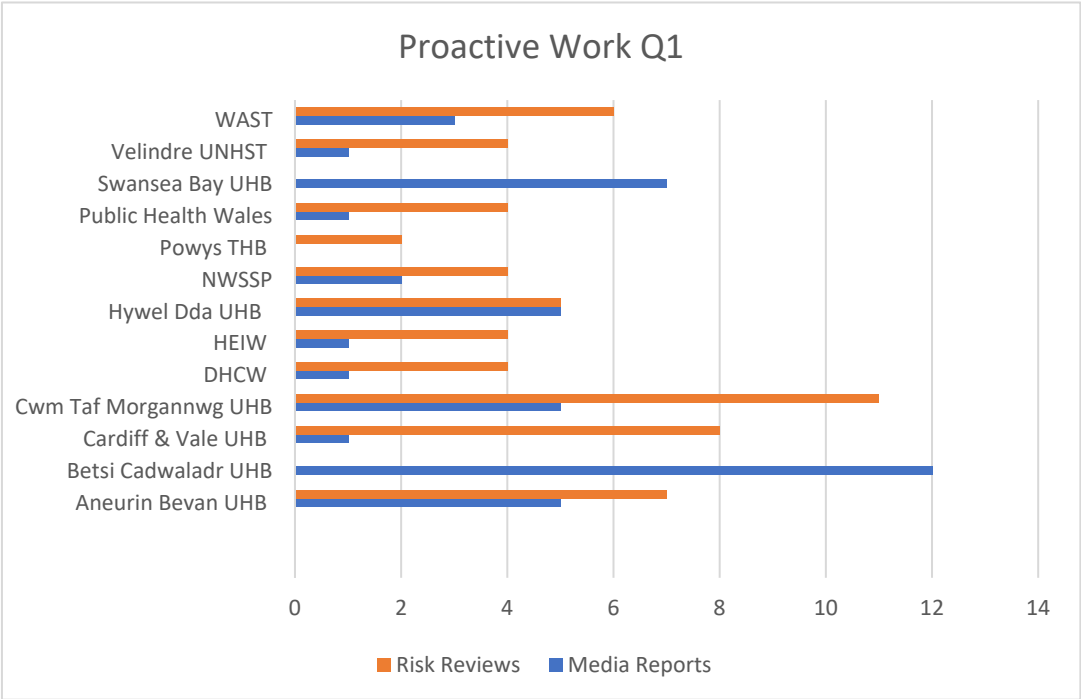
NHS counter fraud colleagues from England, Northern Ireland, Scotland, and Wales hold a Four Nations Meeting to review counter fraud strategies, workplans and emerging NHS fraud trends and risks. It was agreed that future meetings would be held annually, the next meeting is in Edinburgh in November 2025.

2 Proactive Work: Media Reports and Risk Reviews conducted by LCFs during Q1 of 2025/26

The following table summarises some of the pro-active work completed at each health body during Q1 of 2025/26. LCFs are required to promote successful investigations via media reports on the staff intranet, social media websites and staff newsletters as a deterrent to fraud. Risk Reviews include fraud proofing policies and Local Pro-active Exercises (LPEs) to reduce or deter fraud.

During Q1, the most media reports were generated by Betsi Cadwaladr (12). The LCFs undertook a total of 59 risk reviews and LPEs within their organisations. CTMUHB completed the most risk reviews or LPEs (11) followed by C&VUHB (8), while BCUHB and SBUHB reported that no risk reviews or LPEs were completed in Q1. The quarterly total of media reports fluctuates as it is dependent on reports on ongoing court cases and the CFA, CFS Wales and LCFs successfully promoting the court case outcomes in the media or newsletters.

Proactive Work / Media Reports & Risk Reviews	Proactive Work Q1	
	Media Reports	Risk Reviews/LPEs
Aneurin Bevan UHB	5	7
Betsi Cadwaladr UHB	12	0
Cardiff & Vale UHB	1	8
Cwm Taf Morgannwg UHB	5	11
DHCW	1	4
HEIW	1	4
Hywel Dda UHB	5	5
NWSSP	2	4
Powys THB	0	2
Public Health Wales	1	4
Swansea Bay UHB	7	0
Velindre UNHST	1	4
WAST	3	6
TOTAL	44	59

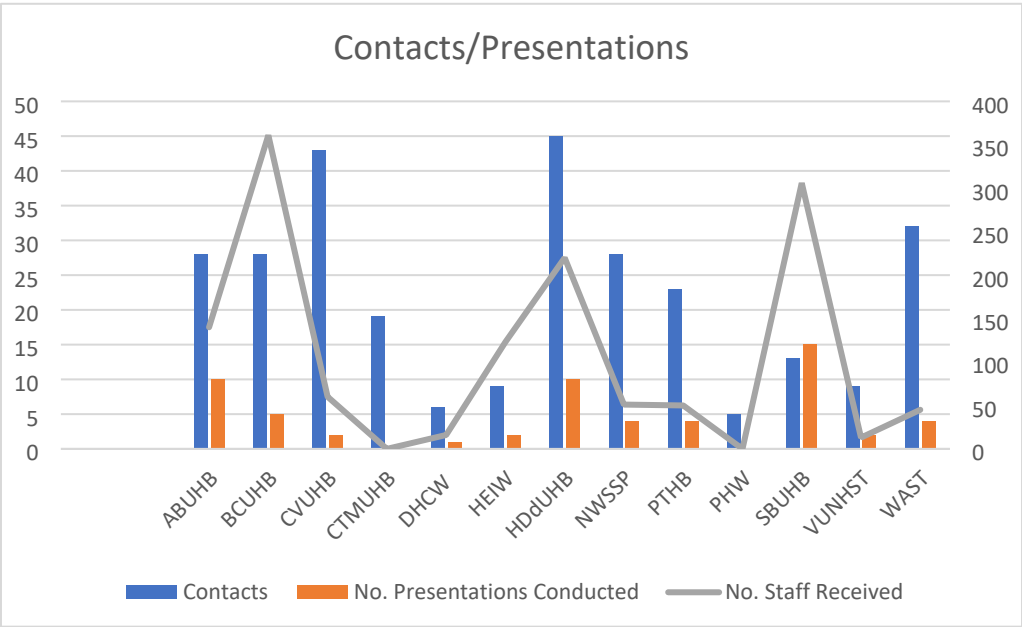


2.1 Number of Contacts made to LCFs requiring advice on fraud related queries and Counter Fraud Presentations during Q1 of 2025/26

The table below summarises the total fraud query contacts made to each health body during Q1 of 2025/26, via telephone calls, MS Teams or email. The LCFs received a total of 288 enquiries in Q1. During Q1, the health body that received the most contacts was Hywel Dda (45), followed by CVUHB (43) and WAST (32). While DHCW (6), HEIW (9) and VEL (9) have reported the lowest number of fraud related contacts, but this is largely due to the relatively small size of their organisations.

The table also summarises the presentations delivered to NHS staff during Q1. ABUHB LCFs 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 Q1 a total of 1,385 staff received 59 fraud awareness presentations in NHS Wales. The highest number of presentations was at SBUHB (15) which were delivered to 306 staff. There were also a considerable number of staff who received presentations at BCUHB (361 staff via 5 presentations) and HDUHB (220 staff via 10 presentations).

Contacts / Presentations	Contacts Q1	Presentations Q1	
		No Conducted	No Staff
Aneurin Bevan UHB*	28	10	140
Betsi Cadwaladr UHB	28	5	361
Cardiff & Vale UHB	43	2	60
Cwm Taf Morgannwg UHB	19	0	0
DHCW	6	1	16
HEIW**	9	2	123
Hywel Dda UHB	45	10	220
NWSSP	28	4	51
Powys THB	23	4	50
Public Health Wales	5	0	0
Swansea Bay UHB	13	15	306
Velindre UNHST	9	2	13
WAST	32	4	45
TOTAL	288	59	1,385



* 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.

3 Counter Fraud Awareness E-Learning Staff Completion Figures 1st April to 30th June 2025

The data below (Table 3.1) 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 Q1. ABUHB, BCUHB, HDdUHB & WAST have mandated the Fraud E-Learning training module and therefore their completion data is higher.

Table 3.2 displays the increasing number of staff who have completed the E-Learning module over the last three financial years. The low numbers of staff completing the training in Q1 at some large health bodies CVUHB (5), CTMUHB (5), with no staff completing the training at PTLHB or HEIW is a cause for concern. This will be discussed at the next Counter Fraud Liaison Group (CFLG) meeting, while the significant increase of Velindre Staff completing the E-Learning training in Q1 (891) since they mandated the training in April 2025 is noted.

The NHS Wales Fraud E-Learning module was updated and re-launched in mid-April 2025. The Welsh language version of the training module has recently been finalised by CFS Wales and NWSSP and is now available for Q2.

Table 3.1

Health Body (Mandated E- Learning)	Staff Completion Q1	No of Employees * (As at 31/12/2024)	Month Mandated
ABUHB	798	15,592	Feb 2024
BCUHB	1,047	21,323	April 2021
HDdUHB	609	12,193	May 2021
VEL	891	1,873	April 2025
WAST	245	4,398	Aug 2023
Health Body (E- learning not yet mandated)			
CVUHB	5	17,561	
CTMUHB	5	13,204	
DHCW	3	1,249	
HEIW	0	628	
NWSSP	73	6,117	
PTHB	0	2,646	
PHW	7	2,610	
SBUHB	103	14,673	
TOTAL	3,786	114,067	

*Source: Welsh Govt – Headcount/Staff directly employed as at 31/12/24

Table 3.2

Health Body	2022/23	2023/24	2024/25
ABUHB	87	5,646	6,620
BCUHB	2,295	4,334	9,727
CTMUHB	22	27	39
CVUHB	12	56	23
DHCW	0	962	340
HDdUHB	5,109	2,299	4,289
HEIW	0	19	7
NWSSP	5	119	1,073
PHW	28	69	46
PTHB	49	4	2
SBUHB	99	325	214
VEL	81	32	4
WAST	22	3,451	1,009
TOTAL	7,809	17,343	23,393

4 NHS CFS Wales Statistics / Operational Outcomes – 1st April to 30th June 2025

The table below summarises the CFS Wales operational data and sanctions secured in Q1. The CFS Wales team were investigating **28** cases at the start of the quarter and were dealing with **27** active cases at the end of Q1 with **10** new referrals received and **11** cases closed during the reporting period. The total recovered by CFS Wales in Q1 was **£35,472**.

The 12 active financial investigations currently conducted by CFS Wales listed at Para 4.1 are in addition to the **27** active CFS Wales investigations in the table below.

NHS CFS Wales Team (CFS Wales) – Q1 2025/26													
NHS Organisation	No of open cases as at 31/03/2025	No of referrals received	No of cases closed	No of open cases at 30/06/2025	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
									Criminal			Disciplinary	Civil
									Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	3	0	0	3	£0	£0	£0	0	0	0	0	0	0
Betsi Cadwaladr UHB	4	2	3	3	£0	£0	£0	0	0	0	0	0	0
Cardiff & Vale UHB*	4	1	1	4	£0	£80	£0	2	0	0	0	0	0
Cwm Taf Morgannwg UHB	6	4	4	6	£31,136	£31,136	£0	0	0	0	0	0	0
DHCW	0	1	0	1	£0	£0	£0	0	0	0	0	0	0
Hywel Dda UHB	4	0	1	3	£0	£0	£0	0	0	0	0	0	0
HEIW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Powys THB	1	1	0	2	£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	1	2**	5	£0	£4,196	£0	1	1	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	28	10	11	27	£31,136	£35,472	£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.*

***Includes one investigation returned to the health board due to the work invested by the SBUHB LCFS.*

4.1 NHS CFS Wales Financial Investigations – 1st April to 30th June 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) with a third staff member currently undertaking FI training, and three Financial Intelligence Officers (FIO). The table below indicates the number of active CFSW Wales financial investigations at the end of Q1. These are in addition to the **27** CFS Wales active investigations. These are specialist financial investigations conducted by CFS Wales AFIs to support ongoing CFS Wales and LCFS investigations. In total, 20 FIO enquiries were undertaken by the FIO and AFIs in Q1. FIO enquires can include intelligence checks with financial institutions, Suspicious Activity Reports (SARS) or credit reference checks.

NHS CFS Wales Financial Investigations - Active Investigations and FIO checks Q1										Cumulative (01.04.25 to 31.03.26)				
Organisation	FIO Checks QTR 1	Bank Authorities Q1	FI Investigations as at 31/03/25	Referrals	Closures	FI Investigations as at 30/06/25	Q1 Investigation Orders	Q1 POCA Confiscation Hearings	Recoveries Q1	FIO Checks YTD	Bank Authorities YTD	Investigation Orders YTD	POCA Confiscation Hearings YTD	Recoveries YTD *
ABUHB	1	0	0	0	0	0	0	0	£0	1	0	0	0	£0
BCUHB	3	0	1	0	0	1	3	0	£0	3	0	3	0	£0
CVUHB	2	0	1	1	0	2	0	0	£80	0	0	0	0	£80
CTMUHB	4	0	3	0	1	2	0	0	£0	4	0	0	0	£0
DHCW	0	0	0	0	0	0	0	0	£0	0	0	0	0	£0
Hywel Dda UHB	0	0	2	0	0	2	0	0	£0	0	0	0	0	£0
HEIW	0	0	0	0	0	0	0	0	£0	0	0	0	0	£0
NWSSP	0	0	0	0	0	0	0	0	£0	0	0	0	0	£0
PTHB	5	0	0	0	0	0	0	0	£60	5	0	0	0	£60
PHW	0	0	0	0	0	0	0	0	£0	0	0	0	0	£0
SBUHB	5	4	4	1	0	5	1	1	£4,196	5	4	1	1	£4,196
VUNHST	0	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	£0
TOTAL	20	4	11	2	1	12	4	1	£4,336	18	4	4	1	£4,336

5 LCFS Statistics / Operational Outcomes – 1st April to 30th June 2025

The table below summarises the NHS Wales LCFS operational data and sanctions secured in Quarter 1 of 2025/26. The LCFSs were investigating a total of 135 cases at the start of the quarter, 92 new referrals were reported with 78 cases closed and 5 cases transferred to CFS Wales during the reporting period, leaving a total of 143 cases under LCFS investigation on 30th June 2025.

The LCFS investigations secured 4 civil sanctions and 6 disciplinary outcomes in Q1, with recoveries of £48,483 for NHS Wales. HDdUHB recovered £14,858 while CTMUHB recovered £10,508. During Q1, the LCFS’ conducted 12 Interviews Under Caution (IUCs). The LCFS extrapolated data for estimated fraud prevented via LPEs has been included for Q1; ABUHB prevented £67,874 and HDdUHB prevented £9,111.

BCUHB & SBUHB have the highest number of active investigations with 27 open cases at the end of Q1. BCUHB (15) had the highest number of new referrals during Q1 followed by SBUHB (14) and HDUHB (14). BCUHB closed the highest number of cases in Q1 (15), followed by HDUHB (13) and CTMUHB (11).

Local Counter Fraud Specialists in NHS Wales – Q1 2025/26														
NHS Organisation	No of open cases as at 31/03/25	No of referrals received	No of cases closed	Cases transferred to CFS Wales	No of open cases at 30/06/25	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
										Criminal			Disciplinary	Civil
										Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	19	9	10	0	18	£282	£0	£67,874	0	0	0	0	0	0
Betsi Cadwaladr UHB	28	15	15	1	27	£206	£206	£0	0	0	0	0	1	0
Cardiff & Vale UHB	13	11	9	1	14	£5,433	£5,433	£3,230	0	0	0	0	2	0
Cwm Taf Morgannwg UHB	14	5	11	1	7	£10,508	£10,508	£0	1	0	0	0	1	1
DHCW	1	1	1	1	0	£0	£0	£0	0	0	0	0	0	0
Hywel Dda UHB*	11	14	13	0	12	£14,858	£14,858	£9,111	3	0	0	0	1	2
HEIW	0	2	2	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	1	5	1	0	5	£0	£0	£0	0	0	0	0	0	0
Powys THB	6	11	4	1	12	£7,373	£5,339	£0	1	0	0	0	0	0
Public Health Wales	0	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	20	14	7	0	27	£13,512	£8,639	£0	5	0	0	0	0	1
Velindre University UNHST	0	1	0	0	1	£0	£0	£0	0	0	0	0	0	0
WAST	22	4	6	0	20	£500	£500	£500	2	0	0	0	1	0

TOTAL	135	92	79	5	143	£52,672	£45,483	£80,715	12	0	0	0	6	4

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.*

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 Q1, CFS Wales staff attended virtual meetings with WG, NWSSP, NHSCFA, PPV, Lead LCFSs, CFSG Sub-Groups, Audit Wales and CPS. The newly formed Counter Fraud Liaison Group (CFLG) which consists of CFS Wales Heads and Lead LCFSs met on two occasions in Q1. 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 was scheduled for May 2025 but was rearranged due to the unavailability of key speakers, this has now been rearranged for 23rd September 2025 to allow for higher attendance.

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 routinely using Clue, which is a marked improvement on the old FIRST CMS system.

7 Five Year Operational Outcome Comparison

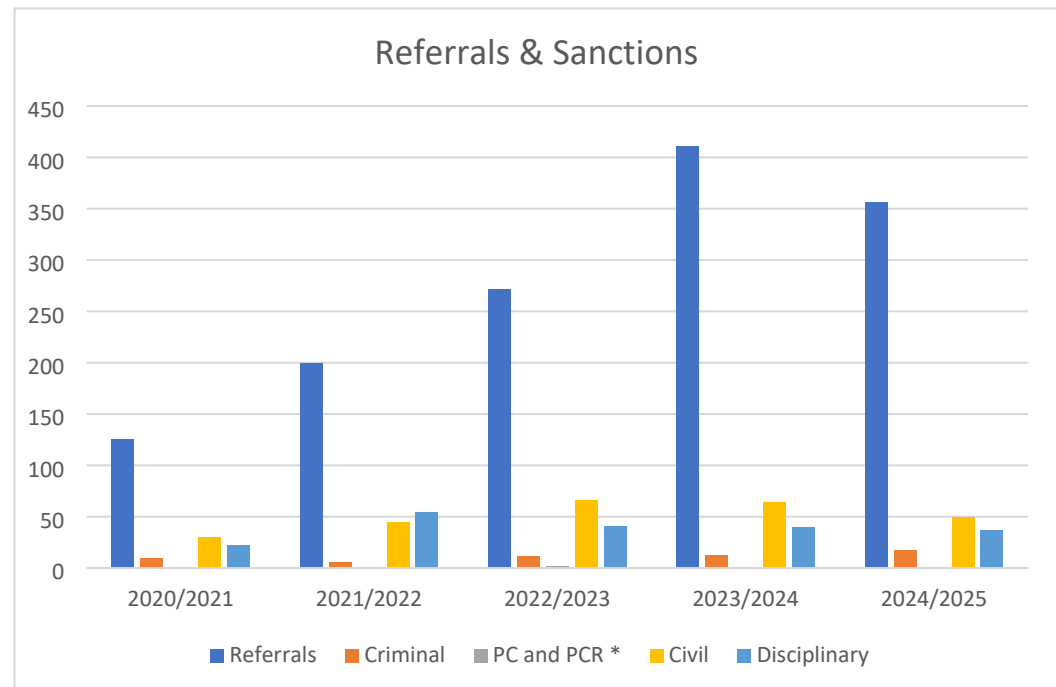
The following table and graph indicate the operational outcomes combined for CFS Wales and LCFS for the 5-year period 1st April 2020 to 31st March 2025.

A total of 1,362 referrals have been investigated in the five-year period which have led to 60 criminal sanctions (including PCRs*), 253 civil recoveries and 194 disciplinary outcomes which have secured £4,198,140 in financial recoveries for NHS Wales. The general increase in referrals received over the last five years reflects the increased focus on fraud awareness and prevention work. The number of referrals in 2023/24 (411) is the highest annual total in the last five years and has increased significantly from the low of 125 in the pandemic period of 2020/21.

The slight decrease in the number of referrals (356 in 2024/25: 411 in 2023/24) is noted but the significant 50% increase in criminal sanctions (18 in 2024/25 :12 in 2023/24) reflects the improvement in investigation work and the backlogs in the criminal justice system. The recoveries secured in 2024/25 increased (£780,537: £672,250) in 2023/24. There has also been a slight decrease in the number of civil sanctions (49:64) and disciplinary outcomes (37:40) secured under the parallel sanctions policy. This trend is not a cause for concern and may partly reflect the increased focus on preventative work (LPEs and Risk exercises) rather than investigations by some LCFS teams.

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	£780,537	17	1	49	37
TOTAL	1,362	£4,198,140	54	6	253	194

* Police Community Resolution (PCR) was introduced in 2020/21 and included as a criminal sanction like a Police Caution (PC).





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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Fraud Risk Assessment Process
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Gareth Lavington, Head of Counter Fraud

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

Er Sicrwydd/For Assurance

To appraise the Audit Risk and Assurance Committee of the formal Fraud Risk Assessment Process utilised in ABUHB, to provide assurance that the Health Board is meeting its obligations in relation to Fraud Prevention in line with the newly introduced Economic Crime and Corporate Transparency Act 2023, and the Government Standard Requirements.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Head of Counter Fraud is responsible for delivering a Counter Fraud service that aligns with NHS internal standards and complies with external legislation, including the Economic Crime and Corporate Transparency Act 2023 and Welsh Government Directions 2005.

A key component of this compliance is the Fraud Risk Assessment process. While historically underutilised, it is now recognised as central to fraud prevention and risk mitigation. Over the past 12 months, the Counter Fraud team has enhanced this function, with formal risk assessments now routinely shared with Divisions for remedial action.

This increased visibility has occasionally led to confusion regarding roles and responsibilities. To address this, the process has been formalised in the document at Appendix 1. The objective is to foster a more collaborative approach between

Counter Fraud and other services, strengthening efforts to reduce fraud and losses across the organisation.

Cefndir / Background

While fraud prevention has long been integral to Counter Fraud teams, formal fraud risk assessment became a distinct focus in 2021 following the introduction of new requirements by the NHS Counter Fraud Authority (NHSCFA). These replaced the previous standards and aligned with the Government Counter Fraud Functional Standard.

Since then, NHS organisations have been required to implement measures to prevent, detect, and manage fraud, bribery, and corruption. These are structured around 12 Requirements, with Requirement 3: Risk Assessment & Management being particularly relevant. It includes:

- Risk Assessment: Regular evaluation of fraud, bribery, and corruption risks.
- Monitoring & Mitigation: Ongoing oversight of risk mitigation efforts at a senior level.

Aneurin Bevan University Health Board (ABUHB), like all NHS bodies, must annually report compliance with these standards via the Counter Fraud Functional Standard Return and is subject to periodic reviews by the NHSCFA Quality Compliance Team.

In June 2022, the Law Commission published Corporate Criminal Liability: An Options Paper, which led to the enactment of the Economic Crime and Corporate Transparency Act (ECCTA) 2023. This introduced a new corporate offence: Failure to Prevent Fraud, aimed at promoting stronger fraud prevention practices across sectors, particularly within large organisations.

Under Section 201 of ECCTA 2023, a 'large organisation' is defined as meeting two or more of the following criteria:

- Over 250 employees
- Annual turnover exceeding £36 million
- Total assets over £18 million

To demonstrate reasonable procedures, organisations are expected to implement a fraud prevention framework guided by six principles—one of which is Risk Assessment.

Asesiad / Assessment

Aneurin Bevan University Health Board (ABUHB) qualifies as a large organisation under the Economic Crime and Corporate Transparency Act 2023 and is therefore required to implement adequate fraud prevention measures. The "failure to prevent fraud" offence takes effect from 1 September 2025.

During the last reporting period, ABUHB Counter Fraud achieved a Green Compliance rating in NHS Counter Fraud Authority Component 3 (Risk Assessment)

under the Government Counter Fraud Functional Standards. The organisation has conducted thorough local risk assessments to identify fraud, bribery, and corruption risks, and has implemented proportionate counter measures aligned with the level of risk identified.

Risk assessments follow the Government Counter Fraud Profession (GCFP) methodology and are managed in accordance with ABUHB's risk management policy. Progress is overseen by the Executive Director of Finance and reported to the Audit Committee.

The formalisation of the fraud risk assessment process provides assurance of continued compliance with legislative and regulatory requirements, while supporting Divisions in understanding and fulfilling their responsibilities.

Argymhelliad / Recommendation

Fraud risk assessment enhances ABUHB's overall fraud prevention strategy by fostering a stronger anti-fraud culture. It is recommended that ARAC members note this paper for assurance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA
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	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:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

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	Yes, outlined within the paper
• 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/	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 Choose an item.

FRAUD RISK ASSESSMENT PROCESS

Purpose

To outline the requirements for ABUHB to comply with the statutory counter fraud risk identification duties placed upon it as a public organisation.

Understanding fraud risks enables senior leaders to make informed decisions regarding controls, policies, and resource allocation. It also supports the development of effective fraud response plans and training initiatives.

1. Introduction

This document outlines the structured approach used by Aneurin Bevan University Health Board (ABUHB) to identify, assess, and mitigate fraud risks across key operational areas. It should be read alongside the Fraud Risk Process Flowchart (Appendix 1).

2. Background

As a publicly funded organisation, ABUHB has a statutory duty to ensure resources are used appropriately. Fraud risk assessments help identify vulnerabilities and enable proactive measures to prevent financial loss and protect patient care.

Fraud can impact services directly (e.g., financial loss through employee, procurement or payroll fraud) or indirectly (e.g., reputational damage). Assessments also support compliance with relevant legislation and standards, including:

- NHS Counter Fraud Authority (NHSCFA) Standards
- Welsh Government Directions
- Economic Crime and Corporate Transparency Act 2023
- Government Functional Standard 013: Counter Fraud

A robust fraud risk framework promotes integrity, accountability, and stakeholder confidence as well as demonstrating compliance with statutory requirements.

3. Fraud Risk Assessment Process

3.1 Identification of Fraud Risks

The Head of Counter Fraud maintains a Fraud Risk Profile (FRP) to manage identified risks. Risks are categorised as:

- **Inherent Risks:** Identified using NHSCFA guidance and assessed for relevance to ABUHB.
- **Emerging Risks:** Identified through investigations, intelligence sharing, or operational insights.

Each risk is assessed and prioritised by the Head of Counter Fraud. The Counter Fraud team is responsible for evaluating, reporting, and recording risks. Ownership of the risk lies with the relevant Division/Department, which decides whether to implement recommended actions.

Assessment methods may include:

- Stakeholder interviews
- Workshops
- Policy and procedure reviews
- Data audits

Following assessment, the Local Counter Fraud Specialist (LCFS) reports the risk using recognised government methodology, ensuring alignment with ABUHB's Risk Management Policy.

3.2 Fraud Risk Reporting

Risks are documented using the template in Appendix 2, which includes:

- Actor, Action, Outcome
- Risk Scoring: Based on likelihood and impact using ABUHB's risk matrix
- Current Controls
- Gaps in Assurance
- Mitigation Recommendations
- LCFS Actions (e.g., awareness campaigns, ongoing reviews)

Completed assessments are reviewed and signed off by the Head of Counter Fraud, then shared with the relevant Division/Department and Executive Lead. The Division/Department is responsible responding to the report using the template in Appendix 3 and for determining the implementation of recommendations. **The Division/Department must outline their response to the recommendations made and where the recommendation is not to be implemented describe the alternative mitigating actions to be established, or if no action is to be taken justify the decision.**

3.3 Monitoring and Review

Fraud risks are reviewed monthly, quarterly, or annually, depending on their score. Actions are assigned to the relevant LCFS. A formal risk review document, using the template in Appendix 4, will be completed, and where appropriate this will be shared with Division/Department and further liaison will be sought.

3.4 Reporting and Communication

The Head of Counter Fraud ensures transparent reporting through:

- Executive Lead reports
- Audit Committee and Senior Responsible Officer/Executive Lead (DoF) reports
- Internal recording via Datix Web
- External reporting to NHSCFA

4. Useful Links for further reading

[ABUHB RISK MANAGEMENT POLICY AND PROCEDURE](#)

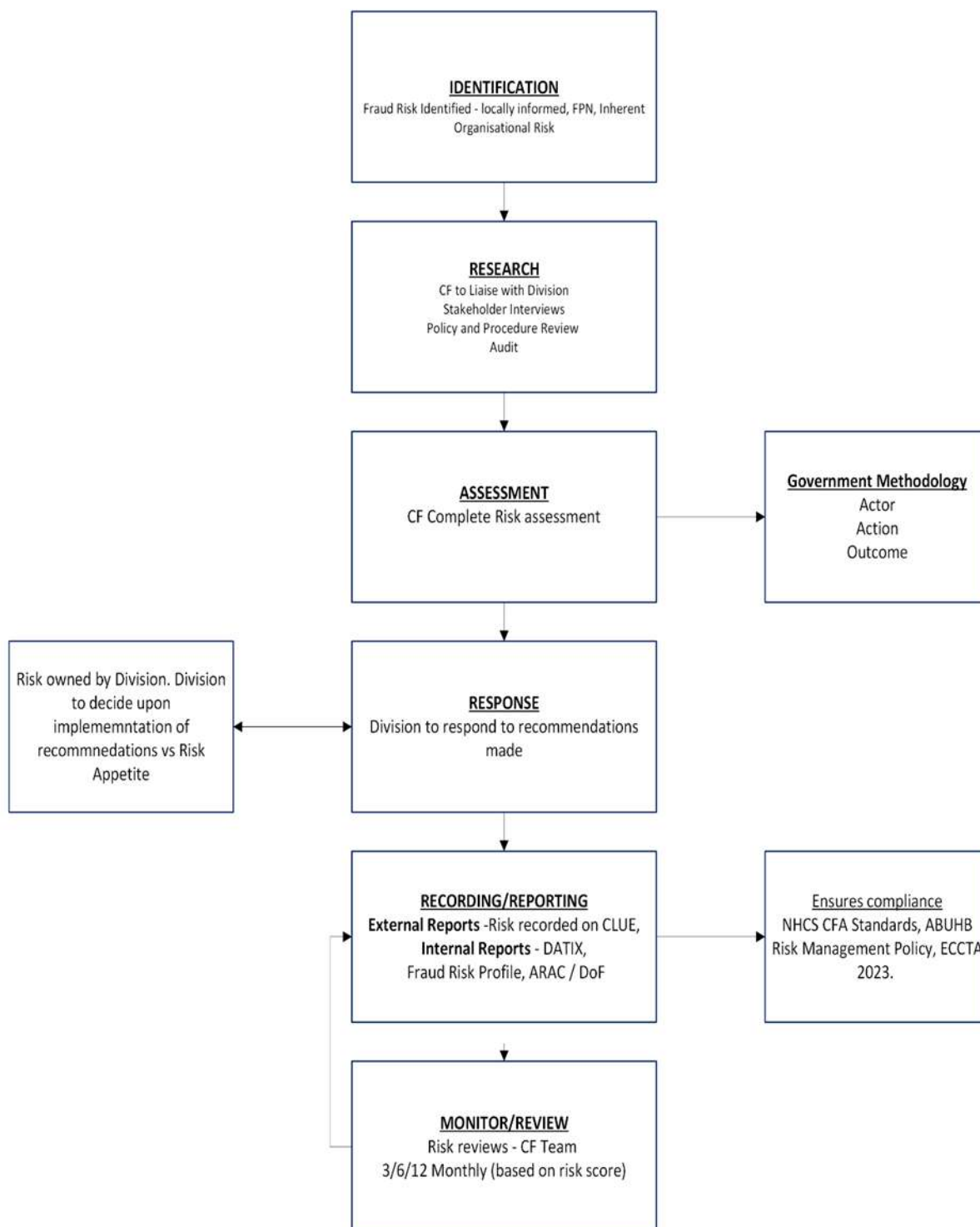
[ABUHB RISK MANAGEMENT FRAMEWORK](#)

[FAILURE TO PREVENT FRAUD OFFENCE | NHS COUNTER FRAUD AUTHORITY](#)

[OFFENCE OF 'FAILURE TO PREVENT FRAUD' INTRODUCED BY ECCTA - GOV.UK](#)

Appendix 1

ABUHB Fraud Risk Assessment FlowChart



Appendix 2

FRAUD RISK ASSESSMENT FORM

Risk Owning Organisation:	Aneurin Bevan UHB	Location of Risk:	
Risk Owning Directorate / Dept :		Date Form Completed:	

Risk Title

Description of Risk:
Describe identified fraud risk using the Actor, Action, Outcome format.
Actor:
Action:
Outcome:

Assessment of control measures in place:
<i>List/Describe measures currently in place that mitigate the risk</i>
Risk score <u>with</u> current control measures in place and no action or remedy (Use Risk Scores Rationale template at bottom of form)
Likelihood () x Consequence () =

Gaps in Assurance/Control with current control measures in place:
<i>If no change is made to the current control measures, describe the weaknesses that may allow fraud to occur.</i>

Recommendations to reduce risk :

Is there a requirement to escalate:
<i>Put here any supporting information to justify whether the risk can be managed locally or whether it needs to be escalated</i>

Proposed Actions to be undertaken by Counter Fraud Team (Counter Fraud Department to complete)
<i>Include here any proposed actions that are to be carried out by Counter Fraud Team. E.g. Arrange and conduct awareness sessions to staff, provide support materials to relevant cohorts of staff</i>

Signature of Assessor	
Date of Assessment	
Risk Owner	
Signature of Head of Counter Fraud	
Date of Datix Entry	

Risk Scoring Rationale

Please use the below grid to score the risk. This should be used in together with the **ABUHB Risk Assessment Scoring Guidance Document** at the following link - [Risk Scoring Guidance](#)

Risk Scoring Matrix					
Likelihood Frequency / Probability ↓	Consequence/Impact →				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain Probability > 91%	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely Probability 61-90%	4 (Low)	8 (Moderate)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible Probability 41-60%	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely Probability 11-40%	2 (Low)	4 (Low)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare Probability 1-10%	1 (Low)	2 (Low)	3 (Low)	4 (Low)	5 (Moderate)

Guide to completion and process

1. Risk Assessor to complete assessment and forward to Head of Counter Fraud for review.
2. Head of Counter fraud to review and return to assessor signed off or with remedial action required.
3. When complete, Risk Assessor to share with Division with Response Document.

4. When response received add to DATIX Web Risk Register.

Appendix 3

Fraud Risk Assessment Response Document – Risk Owner to Complete

This form is for use by the risk owner / person with delegated responsibility to give responses to the corresponding fraud risk assessment including comments on the risk assessment and to detail any action to be taken or already taken in response to the identified risk.

If there are any queries in how to complete the document or what to include, please contact Gareth Lavington (Gareth.Lavington3@wales.nhs.uk) or Beverley Jones (Beverley.Jones19@wales.nhs.uk).

Risk Owning Organisation:		Location of Risk:	
Risk Owning Directorate / Dept :		Date Form Completed:	
Risk Title and current risk Score			

Any comments regarding the Risk Assessment (*Risk owner to complete*)

If you have any comments or identify any inaccuracies regarding the risk assessment, specifically the control measures in place, please provide details here.

Proposed Actions to be undertaken within the Risk Domain (*Risk owner to complete*)

Please provide details of proposed actions (including timescale) to be introduced to reduce the risk. If no actions are to be taken then provide justification for this decision.

Signature of Person Completing the Return (Risk Owner / Delegated Person)

Name:

Job Title:

Signature:

Date Completed:	

FOR COMPLETION BY COUNTER FRAUD

Review of Response Document	
From the comments provided is there a need to adjust the original Risk Assessment?	Yes ☐ No ☐
If there a need to adjust the current risk score?	Yes ☐ No ☐
Has this document been added to the CF Risk Spreadsheet	Yes ☐ No ☐
<i>Comments:</i> 	

Signature from Counter Fraud	
Name:	
Job Title:	
Signature:	
Date Completed:	

Appendix 4

Fraud Risk Assessment Review Document

This form is for use by the LCFS in reviewing existing recorded fraud risks. Risk reviews will be carried out by the review date set according to the risk score. It is the responsibility of the LCFS to review the recorded risk and identify whether any recommended or other changes have been made or adopted that alter the risk score.

Once complete this document will be forwarded to the Head of Counter Fraud for review. If appropriate the Risk Review will be sent onward to the relevant Divisional/Department contact for response.

If there are any queries in how to complete the document or what to include, please contact Gareth Lavington (Gareth.Lavington3@wales.nhs.uk) or Beverley Jones (Beverley.Jones19@wales.nhs.uk).

Risk Owning Organisation:		Location of Risk:	
Risk Owning Directorate / Dept :		Date Original Risk Recorded:	
Risk Title and existing risk Score			
Likelihood x Impact			

Have any of the recommendations made in the original Risk Assessment been adopted? If yes please list (LCFS to complete)

Have any other changes impacted the original risk assessment? If yes please list (LCFS to complete)
<i>e.g. New Policy / Procedure /Process introduced, new facilities introduced, new software introduced.....</i>

New Risk Score
Likelihood x Impact

Are there any new recommendations to reduce the risk? If yes please list (LCFS to complete)

Signature of Person Completing the Review (Risk Owner / Delegated Person)

Name:	
Job Title:	
Signature:	
Date Completed:	

FOR COMPLETION BY HEAD OF COUNTER FRAUD

Further Action required:

From the comments provided is there a need to escalate with Division?	Yes ☐ No ☐

Has this been actioned? (if yes please provide date and method of communication below)	Yes ☐ No ☐

Comments:

Signature from Counter Fraud

Name:	
Job Title:	
Signature:	
Date Completed:	

FOR COMPLETION BY DIVISION

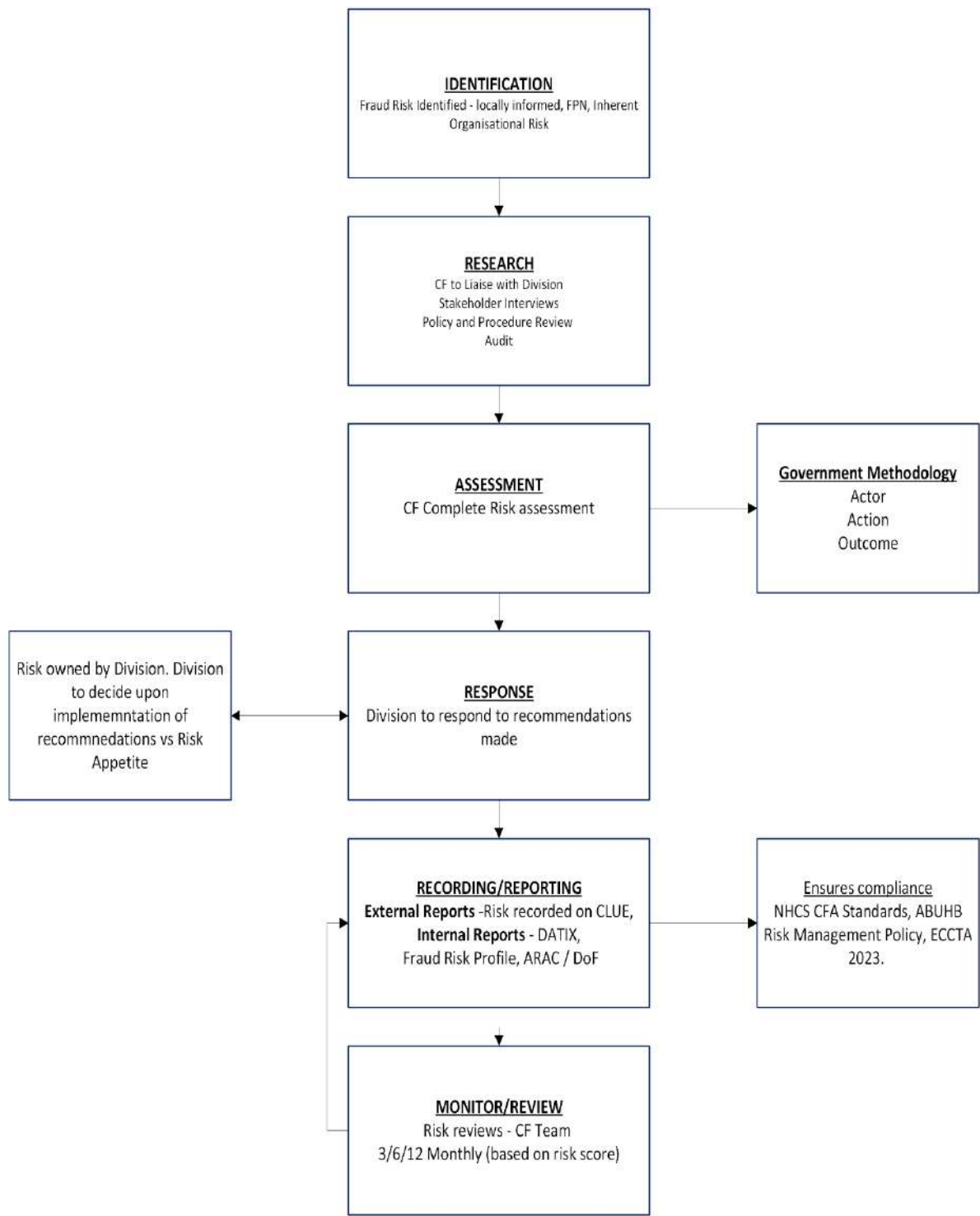
Any comments regarding the Risk Review (Risk owner to complete)

If you have any comments or identify any inaccuracies regarding the risk review, please provide details here.

Proposed Actions to be undertaken within the Risk Domain *(Risk owner to complete)*

Please provide details of proposed actions (including timescale) to be introduced to reduce the risk. If no actions are to be taken then provide justification for this decision.

ABUHB Fraud Risk Assessment FlowChart



DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Welsh Health Circular Tracking and Ministerial Directions Enforced
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

The paper presents the Audit, Risk and Assurance Committee with an overview of the current position relating to the implementation of Welsh Health Circulars (WHC) and Ministerial Directions (MDs) enforced within Aneurin Bevan University Health Board.

Cefndir / Background

Welsh Health Circulars

A Welsh Health Circular (WHC) is health guidance, issued by Welsh Government to NHS Wales health bodies and professionals as a circular. Whilst issued as guidance, WHCs will often include expected actions to be implemented by respective organisations and individuals. The publication of WHCs can be seen at [Health circulars | GOV.WALES](https://gov.wales/health-circulars).

For Aneurin Bevan University Health Board, WHCs are received from Welsh Government and issued via the Corporate Governance Team for action to the respective director leads/professional groups.

Ministerial Directions

Acts of Parliament, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI). Non-Statutory Instruments (NSI), otherwise known as Ministerial Directions (MD) are legislative in character; they alter legal rights and duties, however they are not SIs. NSIs, which are issued by Welsh Ministers, include codes of practice and guidance. The publication of MDs can be seen at [Publications | GOV.WALES](#).

For Aneurin Bevan University Health Board, the website is regularly reviewed, by the Corporate Governance Team, for new Ministerial Directions and circulated to the lead Executive Director.

Asesiad / Assessment

Annual reporting of compliance with WHCs and MDs is included within the Annual Governance Statement. However, to ensure a more robust process to monitor the status of WHCs throughout the year, a WHC Tracker has been established, with progress against the tracker reported to the Audit, Risk and Assurance Committee twice a year.

Work has continued to ensure that the database is updated regularly. To support the assessment of actions, clarification was provided as follows:

Completed:

Action/guidance embedded into day-to-day practice and continual (no end point)
Specific task required in the guidance completed

In Progress:

Actions underway to embed into day to day practice
Actions being undertaken to achieve the task required

The Corporate Governance team has also undertaken an assessment of the database against the above criteria, based on the progress updates provided.

An overview of progress, as at the end of August 2025, is provided below:

WHC	TOTAL	COMPLETE	IN PROGRESS	NO UPDATE	% completed
2023	43	42	1	0	97.7
2024	46	43	3	0	93.5
2025	25	13	3	9	52.0

The full tracker is provided as Appendix One, however, those WHCs assessed as 'in progress' or where an update has not yet been provided, are highlighted below:

In Progress	Update required

WHC No	Name of WHC
WHC/2023/045	Recording of Dementia Read Codes
WHC/2024/002	Standards for Competency Assurance of Non-Medical Prescribers in Wales
WHC/2024/040	Adopting a patient and family initiated escalation approach
WHC/2024/042	Introduction of the 'Dictionary of Medicines and Devices' (DM+D) as a foundational standard in all NHS bodies in Wales.
WHC/2025/002	Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration
WHC/2025/006	Recording of Mental Health Outcome Measures
WHC/2025/008	Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales
WHC/2025/017	Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)
WHC/2025/020	National Influenza Vaccination Programme 2025-26
WHC/2025/021	Introduction of routine vaccination programmes for prevention of mpox and gonorrhoea
WHC/2025/022	National Covid 19 Vaccination Programme
WHC/2025/025*	Overseas Visitors' Eligibility to Receive Primary Care
WHC/2025/026*	The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings
WHC/2025/027*	Changes to supply of Gluten Free foods in Wales; All Wales Gluten Free Subsidy Card scheme
WHC/2025/028*	Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49
WHC/2025/029*	Introduction of Nirsevimab passive immunisation against Respiratory Syncytial Virus (RSV) in at risk infants for upcoming 2025/26 RSV Season

*WHC issued within last 6 weeks

In addition, the tracker notes Ministerial Directions which have been issued. As these are enforced, progress tracking is not undertaken.

	Ministerial Directions		
	2023	2024	2025
Total Number issued	19	24	19

Following a review of the database, the Executive Committee and Audit, Risk and Assurance Committee requested that deadlines be added to the database. A review of WHCs issued confirmed that deadlines are not often provided however, where they are they are now included within the database. If a deadline for action is not provided in the WHC, Executive leads are requested to determine an appropriate timescale for completion for inclusion in the database however these are not routinely provided.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to discuss the current position, taking assurance that the Health Board has a system in place to receive, manage and report against Welsh Health Circulars and Ministerial Directions.

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 Termiau:	Included within the report

Glossary of Terms:	
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Ministerial Direction	Date Issued	Summary	Lead Executive	Date sent to exec	Link
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	10/02/2025	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	10/02/2025	These directions raise payments to dental foundation trainees and trainers for 2022 to 2023	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	10/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025 GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025	10/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2023 to 2024	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.2) Directions 2025 GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025	11/02/2025	Directions to local health boards on amendments to the general medical services contract	Finance	19/02/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2025 GOV.WALES
Statement of general ophthalmic services remuneration and fee directions: 2025	11/02/2025	The statement provides for the normal general ophthalmic services payments and claims process	Finance	19/02/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 GOV.WALES
The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	18/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Finance	19/02/2025	The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025 GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025	18/02/2025	Rises in NHS dental contract payments and payments to dental foundation trainees and trainers for 2024 to 2025	Finance	19/02/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) (No.3) Directions 2025 GOV.WALES
Statement of general ophthalmic services remuneration and fee directions: 2025	21/02/2025	Update of entry no 7	Finance	03/03/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 GOV.WALES
The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025	21/02/2025	Update of entry no 2	Finance	03/03/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2025 GOV.WALES
The Wales Infected Blood Support Scheme (amendment) Directions 2025	28/03/2025	Amendment to the Infected Blood Support Scheme	Finance	08/04/2025	The Wales Infected Blood Support Scheme (amendment) Directions 2025 GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 2) Directions 2025	22/04/2025	Relates to the payments being made by Local Health Boards to a GMS Contractor under a GMS contract	Finance	25/04/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025 GOV.WALES

The Primary Medical Services)Intra-Periarticular Injections)(Directed Supplementary Services(Wales) Directions 2025	19/05/2025	Directed supplementary service (DSS) to manage specific musculoskeletal conditions	COO	21/05/2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025 GOV.WALES
The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025	19/05/2025	Directed supplementary service (DSS) to manage dermatological lesions.	COO	21/05/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 GOV.WALES
The Primary Care (Contracted Services: Immunisations)(Influenza) Directions 2025	30/05/2025	The underlying purpose of the Scheme is to enable the provision of services to administer nfluenza vaccinations and immunisations to persons aged 16 and above	Public Health	04/06/2025	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 GOV.WALES
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No 3) Directions 2025	09/06/2025	Directions to local health boards on amendments to the general medical services contract	Finance	10/06/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025 GOV.WALES
Amendments to Model Standing Orders and Model Standing Financial Instructions - NHS Wales (WHC/2023/032)	24/06/2025	Review of previously issued documents to ensure they remain accurate and current.	Finance	07/07/2025	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) GOV.WALES
Directions to Local Health Boards as to the statement of financial entitlements (Amendment)(No 4)Directions 2025	23/07/2025	Amendment to Statement of Financial Entitlements	Finance	04/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025
Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment)(No 5)Directions 2025	08/08/2025	Amendment to Statement of Financial Entitlements	Finance	12/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025

WHC/2023/001	16/01/2023			Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024	Letter to health boards on the actions they need to take to make progress on hepatitis B and C elimination	Action	Director of Public Health	Implementation of Joint Recovery Plan underway through cross-divisional and multi-agency Implementation Group that reports to Public Health Protection Programme Board. The 2024/25 plan and 13 key actions were reviewed at the multi agency steering group meeting on 5 December 2024, where completed actions were closed and ongoing or outstanding actions would form part of the plans for 2025 onwards. There is ongoing commitment to the delivery of the JRP through collaborative working across the health board, Area Planning Board, drug and alcohol services, community pharmacies and criminal justice partners. The next phase will be the preparation of a three year plan, developed in collaboration with key stakeholders at a planned event in March 2025. This will be developed pending a further detailed review of the previous plans, and review of the summary of the progress towards meeting WHO targets for Hep B & C, to align priorities for the next phase. Particularly during this phase; Prevalence, incidence, testing and treatment HBV and HCV by increasing testing within high risk groups through outreach clinics, community health events where BBV testing is available, testing for people in contact with the criminal justice system through probation testing events, and ongoing commitment to the in-reach BBV testing model through community pharmacies in Gwent. Other key priorities will be to improve our data in line with discussions with PHW at the BBV Elimination: Data Task & Finish Group.	complete	Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024 (WHC/2023/001) GOV.WALES
WHC/2023/002	31/01/2023		N/A	Faecal immunochemical testing (FIT) in symptomatic colorectal cancer referral	Letter to health boards on faecal immunochemical testing (FIT) for suspected bowel cancer (new guidance/thresholds)	Action	Medical Director	This was actioned within AB before the WHC circulation and discussed at cancer Board on the 18th January	complete	https://www.gov.wales/sites/default/files/publications/2023-01/new-lower-gastrointestinal-fit-national-optimal-pathway.pdf
WHC/2023/003	04/04/2023		01/05/2025	Guideline for the Investigation of Moderate or Severe early developmental impairment or intellectual disability (EDI/ID)	clinical guideline for the investigation of moderate or severe early developmental impairment or intellectual disability (EDI/ID) in children. It is provided to support clinical	Action	Medical Director	Completed This has been disseminated to all Paediatric medical staff (community and general, consultants, trainees, ANPs and Specialty	Complete	https://www.gov.wales/sites/default/files/pdf-versions/2023/4/3/1681288392/early-
WHC/2023/004	08/03/2023		N/A	COVID-19 spring booster 2023	Provision of additional spring COVID-19 booster dose for our most vulnerable citizens.	Action	Director of Public Health	Implemented as required and on target for delivery as and uptake as planned	Complete	https://www.gov.wales/sites/default/files/publications/2023-03/whc202304-covid-19-spring-booster-2023-english_0.pdf
WHC/2023/006	31/03/2023		01/04/2024	Commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020	guidance on the commencement of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 on 1 April 2023.	Action	Director of Nursing Medical Director Director of Therapies and Health Science	Quality Strategy and Patient Experience and Involvement Strategy approved and implementation underway. Training session held for Board members. Also issued to Director of Nursing & Director of Therapies and Health Science	Complete	https://www.gov.wales/sites/default/files/publications/2023-04/commencement-of-the-health-and-social-care-quality-and-engagement-wales-act-2020_0.pdf
WHC/2023/007	31/03/2023		01/06/2023	Patient testing framework, updated guidance	Updated guidance April to September 2023	Action	Director of Public Health	Implemented and interpreted locally. On-going discussions in place with PHW regarding support from AWARE in relation to care home testing.	complete	https://www.gov.wales/sites/default/files/publications/2023-03/patient-testing-framework-updated-guidance.pdf
WHC/2023/008	25/09/2023	18/09/2023	18/09/2023	SaBTO FAIR III recommendations to tissue and cell donation process	Implementation of the recommendations outlined in the FAIR III report for any living or deceased tissue or cell donations	Action/Information	Medical Director	The tissue donation consent process is handled by NHSBT. The referral forms used by ABUHB do not ask any questions relating to consent that are impacted by the FAIR III recommendations. The ABUHB forms are predominantly an initial screening referral tool that then allows NHSBT to contact patient's families and proceed with the formal consent process.	Complete	Advice on tissue and cell donation (WHC/2023/008) GOV.WALES
WHC/2023/009	06/04/2023		N/A	COVID-19 vaccination of children aged 6 months to 4 years in a clinical risk group	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which recommended the vaccination for COVID 19 of children aged 6 months to 4 years in a clinical risk group. Health Boards will start to invite eligible children for vaccination in May 2023	Action	Director of Public Health	Implemented as required, and incorporated into all COVID vaccination campaign planning/programmes.	complete	https://www.gov.wales/sites/default/files/publications/2023-04/covid-19-vaccination-of-children-aged-6-months-to-4-years-in-a-clinical-risk-group-whc202309.pdf

WHC/2023/011	27/04/2023		Apr-28	Guidance on Self-harm: assessment, management and preventing recurrence	NICE guidance	Information	Chief Operating Officer	All GP practices in ABUHB made aware of the NICE guidance. The key recommendations associated with safeguarding, consent and confidentiality are part of the wider contractual Clinical Governance Toolkit and revalidation requirements of practitioners. All departments within MH&LD are aware of the NICE Guidelines, with information distributed for awareness through different methods within each department. - Within Primary Care Mental Health Support Services, registrants have conversations about risk with people referred as part of the 'Brief Review of Your Needs' BRYN conversation and use the CORE 10 (an evidence-based therapy tool) to inform conversations about risk & safety if a full assessment is required; CORE 10 is also used as an outcome measure. Along with use of MIND and Melo, there is evidence that this support is used regularly. - Within Secondary Care Mental Health services, the Wales Applied Risk Research Network (WARRN) is used as the primary risk formulation tool, which is also evidence based. - Additionally, within Adult Mental Health Crisis services, the Health Board has worked with Improvement Cymru as part of a national piece of work to pilot Person Centred Safety Planning in services. Colleagues across the Division are invited to attend awareness training sessions based on the findings of the annual National Confidential Inquiry into Suicide and Safety in Mental Health, to inform risk formulation and management. - Several of the liaison and CRHTs are now trained in DBT skills and CBT along with having access to multi-disciplinary peer supervision for repeat attendees to allow a formulation and reconsideration of	complete	Guidance on Self-harm (WHC/2023/11) GOV.WALES
WHC/2023/012	02/05/2023		Apr-24	NHS Wales financial monitoring returns, 2023 to 2024	Monthly financial monitoring return guidance and associated templates	Action	Director of Finance and Procurement		Complete	NHS Wales financial monitoring returns, 2023 to 2024 (WHC/2023/012) GOV.WALES
WHC/2023/013	17/05/2023		2028	Health and Care Quality Standards 2023	Replacing Health and Care Standards - WHC/2015/015	Action	Director of Nursing		Complete	Health and Care Quality Standards 2023 (WHC/2023/013) GOV.WALES
WHC/2023/015	09/05/2023		N/A	COVID-19 Vaccination observation periods	A letter to health workers regarding COVID-19 vaccinations	Action	Director of Public Health	Information cascaded and SOPs updated	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/covid-19-vaccination-observation-periods-vaccination-following-recovery-from-covid-19.pdf
WHC/2023/016	12/05/2023		N/A	Implementing the move to one dose of the HPV vaccine in Wales	Letter to health professionals confirming changes to the HPV vaccination programme	Action	Director of Public Health	School based Programme: ABUHB School Nursing Service acyioned the requirements of WHC/2023/016 'Implementing the move to one dose of the HPV vaccine in Wales', the changes are included in our HPV Comms & Engagement plans 23/24. Professionals: ABUHB School Nursing staff updates provided through our training events/updates through school our learning zone/emails/borough meetings. Schools have been updated through our communication when planning the schools sessions. Public: ABUHB School Nursing service prepared parents/carers of the pending changes in our literature sent for HPV in 22/23. We will be utilising the PHW updated literature for our HPV programme and updating our consent forms. We are launching HPV in the spring term and have prepared social media and comms messaging to share on all our social media platforms. We have developed new training / education resources for school assemblies.	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/hpv-immunisation-programme-update.pdf
WHC/2023/017	12/05/2023		31/03/2024	NHS Wales Executive National Policy on Patient Safety Incident Reporting and Management	A policy for the NHS in Wales to report, manage and learn from patient safety incidents.	Action	Director of Nursing	12/4/23: The publication of the RDAP has been highlighted and shared with clinical leads across several specialities. Work is ongoing to ensure ABUHB adheres to the four key priorities outlined in the plan.	Complete	https://www.gov.wales/sites/default/files/publications/2023-05/policy-on-patient-safety-incident-reporting-and-management.pdf

WHC/2023/018	14/06/2023		Jun-26	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies	Mandating FHIR as a foundational interoperability standard for all IT and all digital systems/services	Action	Director of Digital	Confirmed we have adopted HL7 / FHIR as a foundational standard and are working closely with the National Data Resource Programme on development of our local capabilities.	Complete	Introduction of HL7 FHIR as a foundational standard in all NHS Wales Bodies (WHC/2023/018) GOV.WALES
WHC/2023/019	09/06/2023	Immediate		In support of prevention of suicide and self harm: GMC and NICE Guidance on Information disclosure for the protection of patients and others	GMC and NICE Guidance on information disclosure for the protection of patients and others	Information	Medical Director	This was issued via the All Wales Alert system on 9th June 2023 and cascaded to: GP Practice Managers, GP OOHs, Sessional GPs, HB Primary Care Managers, Medial Committees, Independent Hospitals / Hospices / Prisons	Complete	In support of prevention of suicide and self-harm (WHC/2023/019) GOV.WALES
WHC/2023/021	08/08/2023		08/08/2028	Consent to Examination or Treatment - Update	Replaces WHC/2017/036 - retired with immediate effect	Action	Medical Director	Completed: WHC and relevant information to consent is available on HB intranet / SharePoint. The Consent Policy being updated to reflect up to date information. Newsletter issued bringing together up to date information on consent in one place. Poster also created and distributed. Audits being undertaken to provide assurance e-learning module on Decision Making and Consent in Wales.	Complete	Consent for examination or treatment: update (WHC/2023/021) GOV.WALES
WHC/2023/022	22/06/2023		30/06/2026	Armed Forces Covenant - Healthcare Priority/Special Consideration for Veterans/ Ex Armed Forces Personnel	Update and clarify guidance on Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41	Action	Director of Workforce & OD	Action plan in place to implement the requirements of the WHC	Complete	Armed Forces Covenant healthcare priorities (WHC/2023/022) GOV.WALES
WHC/2023/023	22/06/2023			The National Influenza Immunisation Programme 2023-24	Detailed guidance for the flu vaccination programme 2023-24	Action/Information	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	complete	The National Influenza Immunisation Programme 2023 to 24 (WHC/2023/023) GOV.WALES
WHC/2023/024	28/06/2023			Change of vaccine and cohort expansion for shingles vaccination programme (From September 2023)	Information about forthcoming changes to the NHS Wales shingles vaccine programme	Compliance/Action/Information	Director of Public Health	Proposed changes to the shingles programme included in our annual update training since June 23. This is delivered to Practice Nurses, HCSW and District Nurses. Cascaded all correspondence from PHW to practices, including training resources, PGD's etc. Scoped all GP practices for their implementation plans. Encouraged practices to prioritise the 50+ years, immunocompromised. Discussions held re the possibility of running shingles clinic in covid-19 vaccine centres (resource permitting)	Complete	Changes to shingles vaccinations (from September 2023) (WHC/2023/024) GOV.WALES
WHC/2023/025				Cancer Waiting Times Rules for SCP				13/4/23: LT Message sent to all practices on 6/5/22 . This theme is also included in the work programme for the medicines management team for this coming year.	Complete	Suspected cancer pathway: guidelines (WHC/2023/025) GOV.WALES
WHC/2023/026				NHS FRAMEWORK FOR RESEARCH AND DEVELOPMENT – Research Matters – What excellence looks like in NHS Wales	Introduction of the new Research and Development (R&D) Framework, in a drive to embed and integrate research into all aspects of health and care services in NHS Wales	Action	Medical Director	Complete: The ABUHB R&D strategy was developed in consultation with HCRW and fully supported and approved by the Board in November 2022 which shows that research is not seen as an additional activity but is a core function. Developing an implementation plan as included a series of stakeholder events including patients and public, the purpose being to map and explore our stake holders expectations. This has helped define clear focus areas and timelines for implementation and adds value to the service we provide. Collaboration with our partners and stakeholders is key to its success and we are committed to ensuring that we nurture those who display early talent to become strong research leaders. The first year has included engagement within the wider organisation to raise awareness of the strategy and our vision, as well as putting foundations in place to support implementation. The next steps are to defining work streams, delegating leads for projects and ensuring we can measure progress. Progress and performance monitoring will ensure we can regularly update, review and revise our implementation plan.	Complete	NHS framework for research and development (WHC/2023/026) GOV.WALES

WHC/2023/028				Withdrawal of WHC 2019/042 re Annual Quality Statements	Removing the requirement to prepare Annual Quality Statements as a result of the revised reporting arrangements introduced under the Duty of Quality.	Action	Director of Nursing	Noted	Complete	Withdrawal of WHC/2019/042 regarding annual quality statements GOV.WALES
WHC/2023/029	21/08/2023			Winter Respiratory Vaccination Programme: Autumn and Winter 2023 to 2024	Details of the next winter vaccination program	Action	Director of Public Health	Information cascaded and delivery plans adjusted accordingly. GPs advised through local and national communication lines	Complete	Winter respiratory vaccination programme 2023 to 2024 (WHC/2023/029) GOV.WALES
WHC/2023/031			31/03/2024	AMR & HCAI Improvement Goals for 2023-24	Continuing to work towards the goals of the current 5 year National Action Plan.	Action	Director of Nursing		Complete	Consultation Template (gov.wales)
WHC/2023/032	09/10/2023		Mar-24	Amendments to Model Standing Orders and Model Standing Financial Instructions	Supercedes WHC/2020/011 & WHC/2021/010	Compliance/Action	Director of Corporate Governance		Complete	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) GOV.WALES
WHC/2023/033				Vaccine Products to be used in the Autumn 2023 covid-19 Vaccination Programme	Further COVID-19 vaccine information following WHC/2023/029	Compliance/Action	Director of Public Health	Tissue donation discussed at each Organ Donation Committee. Report on progress from Information cascaded SOP's & delivery plans updated	Complete	WN (Year) Number (gov.wales)
WHC/2023/034	25/09/2023			NHS Welsh Sustainability Awards	Information regarding NHS Welsh Sustainability Conference and awards	Action	Director of Finance		complete	NHS Welsh Sustainability Conference and Awards (WHC/2023/034) GOV.WALES
WHC/2023/035	03/11/2023		Oct-26	Update of guidance on clearance and management of healthcare workers living with a bloodborne virus (BBV) and a reminder of health clearance for	Update to WHC/2019/023 issued in July 2019	Action	Director of Workforce & OD	Actioned	Complete	Health workers with bloodborne viruses (BBV), and TB clearance (WHC/2023/035) GOV.WALES
WHC/2023/036	20/09/2023			Speaking up Safely Framework - NHS Wales	Publication of the Framework for Speaking up Safely in NHS Wales	Action	Director of Workforce & OD	Published on the Health Board's Intranet Site	Complete	NHS Wales speaking up safely framework (WHC/2023/036) GOV.WALES
WHC/2023/037	26/09/2023		31/12/2023	Patient Testing Framework for Autumn/Winter 23	Update to WHC issued in March 2023	Action	Director of Public Health	The Patient Testing Framework for Autumn/Winter 2023 was received and discussed within the appropriate Leadership meeting. This concluded that no further action was required within the existing sampling provision (ABUHB Health Protection Service) or within pathology. The updated framework was cascaded to the wider Health Board the senior Leadership Team via emails and the use of the staff Intranet, in conjunction with IPAC's updated staff risk assessment. Additionally, a local collaborative Winter Pressures plan has been developed to ensure that a robust approach is available should demand increase over the winter period. Samples Undertaken: Sept - 18, October - 40 Nov up to 7/11/2023- 9	Complete	Patient testing framework for autumn/winter 2023 (WHC/2023/037) GOV.WALES
WHC/2023/038	09/11/2023	Immediate effect		Healthy Start eLearning Course	Bite size training course for health professionals to raise awareness of Healthy Start Scheme	Action	Director of Workforce & OD	Course live on ESR	Complete	Healthy Start eLearning course (WHC/2023/038) GOV.WALES
WHC/2023/039	Nov-23		30/10/2026	Independent Authorisation of Blood Component Transfusion (IABT)	Policy to equip appropriate health care professionals who are not medical practitioners for the role of blood component transfusion.	Action/Information	Medical Director	Committee (HTC). The HB current policy and standard operating procedures for prescribing blood are to be reviewed in light of the WHC. The Health Board employs several non-medic BCT Authorisers who have undertaken the appropriate Wales training and compliance assessment. Each BCT Authoriser has a Consultant mentor, retains a portfolio of practice and is regularly assessed to ensure that their practice	Complete	Independent authorisation of blood component transfusion (IABT) - 2023 to 2026 (WHC/2023/039) GOV.WALES
WHC/2023/040	09/11/2023		N/A	The NHS Wales:Newborn and Infant Physical Examination Cymru (NIPEC)	A new set of guideleines and standards for the Newborn and Infant Physical examinations for implementation by health boards in Wales	Action	Director of Nursing	• Relevant staff have attended webinar • staff identified to support and take forward • Review of ABUHB guideline to incorporate standards • New digital system flags NIPE check within 72 hours • Impemented standards and work is ongoing to ensure compliance. Audit of complaince will be undertaken in December 2024. Audit review underway for completion 28th Feb 2025	Complete	The newborn and infant physical examination Cymru (WHC/2023/040) GOV.WALES
WHC/2023/041	11/01/2024		31/12/2026	Refresh of the rare disease action plan 2022 to 2026	A refresh of the NHS's actions and measures to improve care and outcomes for rare diseases in Wales.	Action/Information	Medical Director	The HB recognises the actions required and has identified there are 5 specific actions that involve the HB and which have been acted upon: - The HB has representation on clinical networks at Wales level -	Complete	Refresh of the rare disease action plan 2022 to 2026 (WHC/2023/041) GOV.WALES

WHC/2023/043	14/12/2023	31/01/2024		Vaccination of Healthcare Staff to Protect Against Measles	In response to a measles outbreak, to ensure all staff have immunity or vaccination for measles and that mitigations are in place where this is not possible.	Compliance/Action	Director of Public Health	The MMR staff Catch up Task & Finish group has closed. Updates regarding ongoing work and response to the requirements outlined in the WHC formed part of the wider Measles & MMR Oversight Meetings. All staff who work in high risk areas have had an MMR immunisation history check via their Occupational Health record and GP immunisation history which was made available on Welsh Immunisation System (WIS). All staff who have not received a full 2 doses of MMR, or where the MMR immunisation history is unknown, have been invited for an immunisation via text, email and targeted communications. A second invitation was sent via text in July 2024. Clinics were mobilised at various locations for easy access. Occupational health continue to provide weekly drop in sessions where staff can access their MMR vaccination. An audit of all staff MMR vaccination / recorded natural immunity to measles has been done using Occupational Health Records. However the process to check all staff MMR immunisation status via the WIS system has not been possible to date. MMR uptake reports by division/department were shared with Divisional Directors, Divisional Nurses and General Managers, providing uptake data at a divisional and departmental level; this outlines the number of staff who remain at risk in those areas and clear routes for vaccination for divisional leads to cascade to staff in their area. Divisional Leads can also request a pop-up MMR clinic in their area if required. The WHC has been reinforced with primary care providers detailing steps to be taken to ensure that staff who are not fully vaccinated should make an appointment for their MMR. The health board immunisation team are supporting this offer which has also been extended to community pharmacies, dental practices and optometry. A review of the staff MMR	Complete	Vaccination of healthcare staff to protect against measles (WHC/2023/043) GOV.WALES Change to the influenza (flu) vaccination programme 2023 to 2024 (WHC/2023/044) GOV.WALES Recording dementia read codes (WHC/2023/045) [HTML] GOV.WALES
WHC/2023/044	11/12/2023		N/A	Influenza (flu) Vaccination Programme deployment 'mop up' 2023-2024	Request to health boards to support Primary Care services with targeted flu 'mop up' work from January 2024	Action	Director of Public Health	Implemented in January 2024 as required. Borough pop-up clinics targeted 25% of GP practices with lowest flu vaccine uptake.	complete	
WHC/2023/045	20/02/2024		31/12/2026	Recording dementia read codes	Guidance for medical staff on recording read codes for memory tests - extension to WHC/2022/007 issued in February 2022	Action	Director of Nursing	The Health Board are working towards completing accurate read codes for memory tests. To date READ codes: READ codes are incorporated in all GP correspondence as standard practice within OAMH including liaison psychiatry. Once reviewed within the MAS system a READ Code is supported through MAS on behalf of external services. LD services primary care team are reviewing READ Codes for LD specifically Improvement Cymru are looking to work with MAS on delivery of the READ Code Bitesize communications. Work has started on scoping if a national pathway is needed and whether there are barriers to allocating a READ Code. Base line survey and understanding of barriers due to be completed end of September. Update to be provided in due course. Dementia READ codes are not visible to all secondary care teams. The Health Board are aiming to identify people living with dementia much easier and hopefully, discharge planning will start with 72 hours as per expected national standard. The Health Board has created a dementia alert on CWS, this is to help and support identification of dementia patients in the general hospital setting and help us to improve dementia care in the general medical wards. We will work with memory clinics and link with old age psychiatry to aim for Dementia Codes to be added at the time of diagnosis We are promoting dementia alert on WPAS, so that we can see how patients with dementia are in the hospital at any given time. Local action plan in place. This will be discussed in the Hospital Dementia	In Progress	
WHC/2023/046	13/12/2023		N/A	All-Wales Control Framework for Flexible Workforce Capacity	Coordinating action to reduce Agency Workforce Expenditure in Wales	Action	Director of Workforce & OD	Actions in place for phase 1 and reported to WG	Complete	
WHC/2023/047	21/12/2023	05/01/2024		Influenza vaccines and eligible cohorts for the 2024 to 2025 season	Letter to health professionals about the 2024 to 2025 national influenza vaccination programme	Compliance/Action	Director of Public health	Incorporated into plan development for 2024/25 season. Vaccine stock ordered in accordance with eligible cohorts and vaccine advice as per JCVI	complete	
WHC/2023/048	08/01/2024	Immediate		Health Board allocations for 2024 to 2025	Notes Health Boards' funding arrangements for the coming financial year	Compliance	Director of Finance		Complete	Health board allocations for 2024 to 2025 (WHC/2023/048) GOV.WALES

WHC/2023/10	07/07/2023			Certification of vision impairment	Guidance on the process for certifying patients as partially sighted or blind	Compliance/Action	Chief Operating Officer	Current progress: - The WHC was issued to optom practices via SSP and forms part of WGOS 3 – this is the continuation of the Low Vision service, with the addition of Certification of Vision Impairment. This came into force from 20th October, with legislative change and can be performed by Optometrists who are listed to provide WGOS 1, 2 and 3 inclusive and comply with the eligibility requirements under WGOS 3: Low Vision - WGOS 3 – Low Vision Assessment - NHS Wales ABUHB current position: •35 practices •48 practitioners	complete	Certification of vision impairment (WHC/2023/010) GOV.WALES
WHC/2023/30	22/08/2023			New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034	The Centre for Perioperative Care's new safety standards with a recording and resources from a meeting around the topic.	Action	Medical Director	Complete: Responsibility lies with the Division and Directorate leads from a governance perspective. The recent paper provides an update on the wider improvement work of which NarSSIPS2 will be included. The Divisions have assigned posts dedicated to this work and report through their normal accountability processes to the Theatre and Anaesthetics lead and Lead nurse.	Complete	New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) (WHC/2023/30) GOV.WALES

WHC No	Date Issued	Action required by	Review Date		Name of WHC	Summary	Status	Lead Executive (issued to)	Progress	Rating	Link
WHC/2024/001	10/01/2024				Changes to the way individuals who are at highest risk from Covid-19 access lateral flow tests	While the GOV.UK site for lateral flow tests and reporting results is closing, people can get tests and report results	Information	Director of Public Health	Implemented as planned. Citizens being advised during antiviral triage on how to obtain tests from local pharmacies. Information also disseminated via ABUHB Social Media channels. Care homes informed of change to access – can still be used to expedite access to antiviral treatment. Local pharmacies participating in scheme supported by PCCS Pharmacy Advisor.	Complete	Changes to getting COVID-19 tests and treatment for people at most risk (WHC/2024/001) GOV.WALES
WHC/2024/002	05/03/2024	30/09/2024	01/04/2026	244	Standards for Competency Assurance of Non-Medical Prescribers in Wales	Developed by HEIW following a review of the non-medical prescribing policies currently in place in NHS organisations.	Action	Director of Nursing & Director of AHP's & Health Science	Phased implementation approach. Electronic Register being updated by leads. Phased approach action plan developed for all disciplines with regular meetings and good representation from most professional groups. Next steps: determine maintenance of electronic register, roll out compliance for DSP and self-assessment, RPS framework - competency document has been agreed by the group for use - roll out in the next phase	In Progress	
WHC/2024/004	12/02/2024				Assurance of aseptic preparation of medicines in NHS Wales (Sterile preparation of medicine)	Makes clear the accountability and responsibility of health boards in relation to the unlicensed preparation of aseptic	Action	Medical Director	 Sterile preparation of medicine in NHS Wales (WHC/2024/004) [HTML] GOV.WALES	Complete	Sterile preparation of medicine in NHS Wales (WHC/2024/004) [HTML] GOV.WALES
WHC/2024/005	01/02/2024				Private obesity surgery and the Welsh NHS	Clarifies the roles and responsibilities of Welsh NHS providers for patients who have undergone bariatric surgical procedures in the private sector.	Compliance	Medical Director	Not been implemented as it is not possible to implement the WHC at this current time. Welsh Govt has arranged a meeting with HB's and subject matter experts to consider ways in which to address the mismatch between capacity and demand to allow future	Complete	Private obesity surgery and the Welsh NHS (WHC/2024/005) GOV.WALES
WHC/2024/006	22/03/2024				National Clinical Guidance for Stroke, for the UK and Ireland	A partial update of the 2016 fifth edition	Action	Medical Director & Director of AHP's & Health Science	Complete - ongoing work informed by WHC	Complete	The national clinical guideline for stroke (WHC/2024/006) GOV.WALES

					Guidelines for managing patients on the suspected cancer pathway				implementation of Welsh Health Circular 2024/007 on the management of cancer pathways. The WHC 2024/007 required that the Health Board implement, with immediate effect, the latest version of the Guidelines for Managing Patients on the Suspected Cancer Pathway published and issued on 10th April 2024. There was a requirement to provide a gap analysis of Health Board compliance with the WHC to the Cancer Board highlighting compliance and non-compliance and our plan to become compliant. Update: -The guidance was received by ABUHB services for their information and action -The guidance was circulated to the cancer tracking team in Cancer Services ensuring they were fully aware of the changes within it -Changes to the guidelines were minimal -The only changes were to what could be counted or not counted as first definitive treatments (FDT), which is closely monitored in Cancer Services as 'pathway stops' -The summary below was further circulated to all divisions who are responsible for cancer pathways on 21 June 2024 for their convenience Table 1. The following Enabling treatments are NOT classed as First Definitive Treatments Tumour site: Procedure All Sites: Iron tablets.			Suspected cancer pathway: guidelines (WHC/2024/07) GOV.WALES
WHC/2024/007	09/04/2024					This document provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target.		COO		Complete		
WHC/2024/008	02/02/2024	31/07/2024		287	Vaccination against measles - urgent action	Urgent action to mitigate the risk of a measles outbreak in Wales	Action/Compliance	Director of Public Health	Complete - ongoing work informed by WHC	Complete	Vaccination of children to protect against measles (WHC/2024/008) [HTML] GOV.WALES	
WHC/2024/009	08/02/2024				Covid 19 spring booster vaccination programme 2024	The Welsh Government has accepted the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI), which has advised a spring COVID-19 booster vaccination should be offered to our most vulnerable citizens in 2024. The primary aim of the COVID-19 vaccination programme is the prevention of severe COVID-19 disease (hospitalisation and mortality).	Action	Director of Public Health	Blended model of delivery with Primary Care and community pop-up clinics. Commenced on 2nd April in line with WHC and JCVI requirements. All eligible patients have been offered a vaccine current uptake stands at 78.1% not including the members of the population that have opted out; 65.4% including total eligible population - this is 2nd highest uptake amongst Welsh health boards. The use of multiple community pop-up clinics has posed challenging operationally for staffing requirements to fulfil the appropriate reg to non-reg ratios and logistically for delivery of vaccine. This model has been reviewed and feedback incorporated into planning for Autumn 2024/25 campaign.	Complete	COVID-19 spring booster 2024 (WHC/2024/009) [HTML] GOV.WALES	
WHC/2024/010	27/02/2024				Welsh Sustainability Conference and Awards - New dates	Amendment of date recognising winter pressures and to capitalise on a full financial year or project delivery	Action	Director of Finance		Complete	NHS Welsh Sustainability Conference and Awards: new date (WHC/2024/010) GOV.WALES	

WHC/2024/011	06/03/2024		01/04/2027		Changes to dietary advice on feeding young children	Changes to Welsh Government dietary advice for young children aged 1 to 5 years following acceptance of recommendations made by the Scientific Advisory Committee on Nutrition (SACN) in its report on 'Feeding young children aged 1 to 5 years'	Action	Director of Public Health	Response from Dietetics This was disseminated across dietetics to the appropriate areas- which included paediatric dietetics. This guidance and practice have therefore been adopted and utilised in providing individual advise to children and families. This guidance has also been included in updated training delivered by Hayley Lavery in the early years settings. Response from Healthy and Sustainable Preschool Coordinators After receiving the Welsh Health Circular we shared with settings, Early Years Teams and umbrella organisations across Gwent. It has been built into the Agored Cymru Food and Nutrition 2 day Training and update sessions for Childcare Settings, delivered by ABUHB Dieticians. We have also shared with settings, the updated Gold Standard Healthy Snack Award criteria from the Dieticians, incorporating the changes. The changes are discussed during setting visits and reminders sent via newsletters and emails. The circular has been sent to Healthy Schools Leads in Gwent. Information is discussed during meetings attended by HSPSS Officers, for example, EYDCP and Network Events.		Changes to Welsh Government dietary advice for young children (WHC/2024/011) GOV.WALES	
WHC/2024/012	19/03/2024	01/07/2024	01/10/2025	309	Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement		Compliance/Action	Director of Nursing	Ongoing work informed by WHC	Complete	 final All-Wales career spanning approach to	Nursing preceptorship and restorative clinical supervision: position statement (WHC/2024/012) GOV.WALES
WHC/2024/013	11/04/2024				Governance on interim appointments to Executive and Senior Positions	One Wales approach to the key features of employment to support equity and transparency in recruitment, employment and remuneration	Compliance	Director of Workforce & OD	Pilot of RCS complete, evaluation and paper for phased implementation across the organisation being drafted for approval (end of February 2025).	Complete		
WHC/2024/014	07/05/2024		30/04/2027		Introduction of the Office of National Statistics' (ONS) Register of Geographic Codes (RGCs) as a foundational standard for use across NHS Wales Bodies	WG formally mandating the use of the register of geographic codes across NHS Wales bodies as a strictureal standard for coding geohraphic data in all IT and digital systems/services	Compliance	Director of Digital	We are compliant with the use of ONS codes in areas where it is appropriate to use them. There are however some areas where ONS conflicts with codes required for statutory reporting . In these instances, we must comply with NHW Wales data standards until ONS and NHS Wales align coding standards.	complete		Introducing ONS geographic codes for use as standard in NHS Wales (WHC/2024/014) [HTML] GOV.WALES
WHC/2024/015	01/04/2025	30/04/2025			People's Experience Framewok and People's Experience Survey	Part of a national approach to enhance patient satisfaction and healthcare delivery. This WHC aims at making the framework more inclusive and understandable. Remains applicable until next iteration in 2028	Action	Director of Nursing	SBAR developed and to be shared at the July Quality Management Group	Complete		
WHC/2024/016	12/04/2024				Healthy Child Wales Programme: for school aged children	A new unified operating model for school nursing services which provides a programme of planned universal health contacts for all compulsory school aged children (5-16) regardless of setting.	Action / Information	Director of Nursing	Launched April 2024. With a 2 year implementation period, with x4 national working streams. Ongoing work informed by WHC	Complete		Healthy Child Wales Programme: for school aged children (WHC/2024/016) GOV.WALES
WHC/2024/017	28/03/2024	Different dates per section		#VALUE!	Implementation of the Non-pay elements of the 2022-24 Collective Agreement	A control framework for the delivery in partnership of certain non-pay elements of the development of which were aspects of our collective agreement 2022-24	Action	Director of Workforce & OD	Final return to be submitted 24/01/25 which was completed in partnership and supported by the TUPF. Priority areas agreed following a development session in Sept 24. Bespoke working groups and action plans implemented to continue to progress the Collective Agreement. Feedback expected from Welsh Partnership Forum (RE: further reporting and/or national guidance) in March/April 2025.	Complete		Implementation of the non-pay parts of the 2022 to 2024 collective agreement (WHC/2024/017) [HTML] GOV.WALES

WHC/2024/019	17/04/2024		Oct-24	Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales	Interim amendments to the Model Standing Orders for Local Health Boards and NHS Trusts in Wales	Action	Director of Corporate Governance		Complete	Changes to standing orders in health boards and NHS trusts (WHC/2024/019) GOV.WALES
WHC/2024/020	13/05/2024			New Treatment fund: directions on the exemptions for health boards and trusts	What local health boards and NHS trusts must do to make medicines and other interventions available.	Compliance/Action	Medical Director	The New Treatment Fund commenced in January 2017 and the value of the grant has not increased since then. The money is received annually and distributed immediately and forms part of the core budget of operational divisions. The exemptions set out in the WHC are procedural and have been incorporated in to the standard operating procedures of the Hospital Medicines Group.	Complete	New treatment fund: directions on the exemptions for health boards and trusts (WHC/2024/020) [HTML] GOV.WALES
WHC/2024/021	25/11/2024			Welcome to Wales: Policy Guidance Framework	Establishes and directs a standard for a consistent approach to providing essential information to support Internationally Educated Nurses (IENs)	Action	WOD & Nursing	As part of our onboarding process, IENs are provided with the minimum essential information (as outlined in the WHC) as well as additional support with housing, transport and increased pastoral support before and after they arrive. The Practice Educator Team wrap around new IEN's to strive for a first-time OSCE pass rate, with a clear and supportive clinical induction and development programme. The HB supports additional time in temporary accommodation (when arriving) so nurses can focus on OSCE preparation, reducing any anxiety of securing longer term housing during this time. The pastoral app is being utilised, with information populated by the recruitment and practice educator team.	Complete	Integration framework for internationally educated nurses (WHC/2024/021) GOV.WALES
WHC/2024/022	24/04/2024		Apr-27	Dispute Arbitration Process - Guidance for Disputed Debts (Invoices and service agreements) within NHS Wales: 2024/25-2026/27	This approach aims to continue to increase certainty of NHS Wales contracted income and expenditure assumptions and allow early resolution of issues		Director Of Finance	In place	Complete	Disputed debts between NHS organisations: guidance (WHC/2024/022) GOV.WALES
WHC/2024/024	21/05/2024		N/A	Implementation on the agreed approach to preventing Violence and Aggression towards NHS staff in Wales	To inform organisations of the refreshed 'Obligatory responses to violence in healthcare document' including the requirements to implement and report upon violent incidents as set out in document.	Action	Director of Therapies & Health Sciences	•V&A incidents are reported via Datix Cymru Incident Management System. •Systems in place to support the reporting of incidents to the Police where appropriate. •Partnership working with Gwent Police, VPR Lead chairing monthly incident meetings, sitting on RCRP forums. •VPR Team in process of developing VPR Strategy to align policies and set targets including analysing reporting data. •ABUHB is one of the key partners working with the AVC and Betsi Cadwaladr HB to create a set of Welsh Standards which will ensure effective incident reporting. Recruited November 2024 x1 Violence Prevention & Reduction Lead	Complete	Anti-violence collaborative obligatory responses document (WHC/2024/024) GOV.WALES
WHC/2024/025	04/06/2024		Apr-25	NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25	Health boards and trusts in Wales are required to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan. This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2024/25, which shall also be available via the Welsh Government website.	Info/Action	Medical Director	Clinical Audit Outcomes Report form part of the quarterly Quality Report. Mid-year review scheduled for Sept ARA Comm.	Complete	Consultation Template (gov.wales)

WHC/2024/026	22/05/2024	Apr-25		2024/25 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance	This guidance refers to the monitoring return spreadsheet and accompanying narrative that all organisations (Local Health Boards (LHBs), Special Health Authorities (SHAs) and Trusts) will need to complete, to report their 2024/25 financial performance. There are a number of changes to the format of the returns from those issued previously.	Compliance	Director of Finance	Compete	Complete	NHS Wales financial monitoring guidance 2024 to 2025 (WHC/2024/026) GOV.WALES
WHC/2024/027 WHC/2024/028	19/06/2024 12/06/2024	Until replaced N/A		All Wales Critical Care Escalation Guidance for the Management of Large Unplanned Increases in Demand	Publication of revised All Wales Critical care Escalation Guidance. These guidelines replace all previous versions of escalation and emergency planning guidance for critical care services issued by the Welsh Government.	Information	Director of Strategy, Planning & Partnerships	Guidance only - picked up at Division	Complete	Critical care escalation guidance (WHC/2024/027) GOV.WALES
				The National Influenza Immunisation Programme 2024-25	Revised version of WHC/2023/047 The National Influenza Immunisation programme 2024-25 will once again form part of a single Winter Respiratory Vaccination Programme (WRVP) alongside the COVID-19 autumn vaccination programme. A WRVP Welsh Health Circular will be issued once the JCVI's final advice on the 2024-25 COVID-19 programme is published	Compliance/Action	Director of Public Health	Plans were submitted to VPW. Locally information has been disseminated to all providers. Prison service responsible for immunising the prison population; the health board's vaccination service offered COVID-19 vaccines to care homes, except where GPs offered COVID-19 and flu vaccinations in Monmouthshire care homes. GPs were responsible for delivery of flu vaccinations in care homes, but would have been supported by district nursing teams in some parts of Gwent. The Winter Respiratory Staff Flu Vaccination programme launched on 1st October 2024, using a tripartite delivery model: Peer vaccinators (flu champions), occupational health and the health board vaccination service. The total number of staff reported to have received a flu vaccine is 5,493. This represents 36.15% uptake amongst all staff. Although uptake is suboptimal, for staff with direct patient contact, it is higher than other health boards in Wales at the end of Dec 2024. The Winter Respiratory Staff Flu Vaccination Working Group continues to meet to agree mitigation measures to increase influenza vaccination amongst staff including: Ongoing communications; published weekly news stories on the intranet; routes to vaccination; posters; staff text message reminders and initiatives such as 'walk the wards'. The	Complete	The national influenza immunisation programme 2024 to 2025 (WHC/2024/028) GOV.WALES
WHC/2024/029	11/06/2024			Certification of Vision Impairment in Primary and Community Care	4 changes to the existing Certification of Vision Impairment Wales (CVIW) form	Compliance	COO	Following completion of relevant HEIW training module, 34 practices are now providing the WGOS 3 service with provision across all 5 boroughs, enabling patients to be certified as visually impaired by WECS optometrists rather than by consultant ophthalmologist. https://www.nhs.wales/sa/eye-care-wales/eye-care-docs/whc-2023-10-certificate-of-visual-impairment-in-primary-and-community-care-pdf/	Complete	Certification of vision impairment in primary and community care (WHC/2024/029) (gov.wales)

WHC/2024/030	03/07/2024	01/07/2025		Published weight management medication pathway	An addendum to the 'All Wales weight management pathway' and in response to the National Institute for Health and Care Excellence (NICE)'s approval of new medications for weight management.	Action	Director of Public Health	The WHC was reviewed at time of publication within the Adult Weight Management Service (AWMS). The service is currently prescribing weight loss medications as part of the Level 3 AWMS pathway and is predominantly in accordance with the addendum published. 2 differences to compliance with the addendum are noted: >the Level 3 AWMS is self-referral and not HCP referral as outlined in the All Wales Weight Management Pathway. This has been reviewed internally and not altered. The self-referral process is written, reviewed and managed by MDT staff and is a safe and effective process that improves DNA and clinic utilisation enhancing available capacity to treat patients. It has also reduced the referral to treatment time compared to previous HCP model. >Hospital dispensing of weight loss medication. Aneurin Bevan University Health Board does not have the infrastructure to do this but has worked with NWSSP to allow hospital prescription WP10HP to be dispensed in community pharmacies which maintains the commercial access agreement price for Health Boards. Since this WHC was published the AWMS has had to make amendments to provision for weight loss medications due to limitations on resources and significant demands for this treatment. As a result, the Level 3 AWMS is not currently compliant with the WHC and NICE guidance	complete	Published weight management medication pathway (WHC/2024/030) [HTML] GOV.WALES
WHC/2024/031	17/06/2024	N/A		Agency workforce reduction programme and control framework 2024 to 2025	Coordinating action to reduce agency workforce expenditure in Wales	Action	Director of Workforce & OD	Actioned - Variable Pay Programme Board TOR updated in line with WHC	Complete	Agency workforce reduction programme and control framework 2024 to 2025 (WHC/2024/031) [HTML] GOV.WALES
WHC/2024/032	25/06/2024			Intoduction of RSV Vaccination programme	New routine RSV vaccination programme from September 2024 to protect both infants and older adults	Action	Director of Public Health		Complete	Introduction of RSV vaccination programme 2024 (WHC/2024/032) [HTML] GOV.WALES
WHC/2024/033	02/08/2024			The Winter Respiratory Programme 2024/25	To set out the detail of the Winter Respiratory Vaccination Programme (WRVP) 2024/25 and our expectations for the coming season.	Compliance/Action	Director of Public Health	WHC now expired	Complete	Winter respiratory vaccination programme 2024 to 2025 (WHC/2024/033) GOV.WALES
WHC/2024/034	28/08/2024	01/09/2024	264	Directions to apply the national Framework for the Commissioning of Care and Support in Wales: Code of Practice to local health boards and NHS Truhs - August 2024	Legislation to be complied with re the Commissioning of Care Support in Wales	Compliance			Complete	National framework for commissioning care and support (WHC/2024/0234) GOV.WALES

WHC/2024/035	17/09/2024				Standardising the management of acute deterioration	Agreed standardisation of EWS across Wales to be implemented immediately	Action	Medical Director Director of Nursing Leeanne Lewis and Stephen Edwards Leading	health boards' sepsis management practices with updated NICE, NR51, and AoMRC guidelines. The Health Board's Sepsis working group will be divided into smaller task and finish groups to focus on specific areas for successful implementation of the early warning score (EWS). Key Initiatives: NEWS2 Implementation: A driver diagram exercise will identify barriers and actions for successful NEWS2 implementation. Task and finish groups will focus on implementation, education, measurement/audit, and digital aspects. An education panel will create standardized training resources for clinicians. Digital Workshop: Scheduled for January 28th to review digital specifications and demo packages for NEWS2. A new sepsis screening tool will be tested and reviewed for suitability. Sepsis Communication Campaign: Launched in November 2024 to promote sepsis awareness among staff. Maternity and Neonatal: Workshops and task groups are addressing implementation barriers and developing education packages. BadgerNet's NEWTT2 and MEWS templates are delayed until mid-2025 due to regulatory processes. Paediatrics: Initial meetings to explore requirements for implementing all-Wales PEWS by September 2025. PEWS is not yet used in emergency settings, but efforts are underway to develop suitable protocols.	Complete	Standardising the management of acute deterioration (WHC/2024/035) GOV.WALES
		244									
WHC/2024/036	30/08/2024	30/09/2024	30/09/2025		Oxygen Cylinders: regulation 28 report and patient safety notice 041 reminder	Directions to local health boards and NHS trusts following a regulation 28 prevention of future deaths report and oxygen cylinders patient safety notice (PSN) about oxygen cylinders.	Action	Director of Public Health	Leeanne is co-ordinating an update but we can say: Aneurin Bevan University Health Board can report that it has taken forward the actions set out in the Welsh Government guidance document letter, 'Oxygen cylinders: regulation,28 report and patient safety notice 041 reminder (WHC/2024/036)' of 31st August 2024, through development of an appropriate action plan, with the oversight from its Medical Gases Safety Group, to mitigate the risks identified. Pending comprehensive resolution of all issues, progress and actions will be reviewed fortnightly. Although the Health Board mandates medical gas training for its staff using or handling medical gases (not just cylinders), there is difficulty in it ensuring that staff complete the BOC free online training in the operation of oxygen CD cylinders that is specified in the letter. The Health Board's medical education teams, with oversight from the Medical Gases Safety Group, have discussed the content of alternative training which has been deemed appropriate as a more practicable alternative for mitigation of the risks, and access to this and the recording of training compliance levels in ESR is being put into place.	Complete	Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036) GOV.WALES
WHC/2024/037	24/09/2024		30/09/2025		Winter Respiratory Framework 2024 to 2025	Set out clear expectations of the Health & Social care system in responding to respiratory viruses this winter.	Action		Local information on preparedness was disseminated to partners. WHC informed winter planning. The health board responded to this WHC through its contribution to other WHCs relating to the WRVP and RSV campaigns. Prescribers working in primary care prescribed, and community pharmacists supplied, antiviral medicines for the prophylaxis and treatment of influenza for people in at risk groups, as per CMO alert CEM/CMO/2024/09.	Complete	Winter respiratory framework 2024 to 2025 (WHC/2024/037) GOV.WALES

WHC/2024/038	20/09/2024			Healthcare associated infections and antimicrobial resistance goals 2024 to 2025	Sets out the improvement goals for 2024/25 reflecting on data from the previous year and the new targets set out in the new AMR national action plan	Action/ Information	Director of Public Health questioned on 14/01 that it should sit under Jenny - awaiting confirmation	2024. With the exception of Klebsiella blood stream infections, ABUHB continue to be above Welsh Government trajectory and will not achieve the required reduction. Ongoing Infection Prevention & Antimicrobial Resistance Committee with divisional action plan. Established a Strategic Improvement Group supported by the Executive team. Delivered training via webinars reaching out across the HB to include Care Homes. Infection Prevention Team continue to be supported by the RIF to support the wider community. Supported quality improvement faculty within Medicine for the reduction of C difficile and oral hygiene. Antimicrobial volume reduction in primary & secondary care unlikely to be achieved in 24/25. 'Access' category target already achieved in primary care, but limited progress in secondary care by FYE. Antimicrobial action plan updated in line with new targets. Influenced draft CEPP (GP incentive scheme) to include audit of repeat antibiotic prescriptions for 25/26 FY. Met with Assistant Primary Care Divisional Director for Partnerships & agreed co-production approach for high prescribing localities to include education and a bundle for practices to implement. Working with Assistant Director for Quality and Patient Safety to embed AMS indicators into divisional assurance for secondary care. Variety of smaller projects in progress to drive incremental gains. 33% staff shortages in AMS team as of February 2025 are of	Complete	Healthcare associated infections and antimicrobial resistance goals 2024 to 2025 (WHC/2024/038) GOV.WALES
				Pre-Transfusion Sample taking Compliance with the confirmatory sample rule	To ensure Health Boards are complying with their policies and procedures in relation to pre-transfusion sample taking	Action/ Information		email 3/10/24 Lisa Evans: To discuss at weekly meeting, 100 % compliance with this has always been our aim and the driver for many of the targeting teaching the transfusion practitioner do. Sadly 100% compliance has yet to be achieved, agree an ERASE might focus things		
				Adopting a patient and family initiated escalation approach	Person centred approach to (Call 4 Concern) allowing immediate help and advice in instances of deteriorating health	Action	Director of Nursing	Summary of the current progress: Live on A4, C4, B0, C0, and ICU discharges at GUH. Current model: CCOT/ANP handles the entire call once contacted by the switchboard. Calls to date: 5 (2 from recently discharged patients, 3 from current in-patients). Issues raised: Worsened back pain after being boarded on the ward, Impact on mental health due to boarding on the ward and MFFD but family required a second handrail for discharge. NEWS scores: Between 0 and 2, no Outreach review indicated by standard criteria. Time to manage calls: 90 minutes on average (compared to 60 minutes for usual CCOT deteriorating patient review). Driver diagram: Completed with ABCI support, awaiting publication and stakeholder review. Next steps: Expand working group: Include PALS, switch/flow coordinators, and managers of the pilot ward in future meetings. Continue GUH adult expansion: Focus on data gathering and refining the model. Modify switch flowchart. Collaborate with local HB leads: For learning and problem-solving, pending further NHS Executive input. Revise C4C call pathway: Ensure the right people are involved at the right stages.		
WHC/2024/039	03/10/2024	31/09/2026							Complete	Pre-transfusion sample taking (WHC/2024/039) GOV.WALES
WHC/2024/040	03/10/2024								In Progress	Adopting a patient and family-initiated escalation approach (WHC/2024/040) GOV.WALES

WHC/2024/041 WHC/2024/042	30/10/2024 30/10/2024	31/10/2026 04/11/2027		Ambulance patient handover guidance	A statement of intent for Health Boards to deliver when managing the ambulance patient handover process	Compliance	COO	Discussed at the Enhanced Monitoring weekly flow meeting on the 30th of October, this area of focus is part of our broader system flow programme, which is aligned with patient care. It receives regular attention as patient handover is a crucial performance measure, reviewed weekly and routinely with WG. General assessment, points 1 – 6 we are generally compliant with. Points 7 – 8 require works which are ongoing via our Enhanced Monitoring reporting systems.	Complete	Ambulance patient handover guidance (WHC/2024/041) GOV.WALES
				Introduction of the 'Dictionary of Medicines and Devices' (DM+D) as a foundational standard in all NHS bodies in Wales.	Introduction of a classification of unique identifiers and textual descriptions for medicines and medical devices	Compliance	Director of Digital		In Progress	Introduction of the 'Dictionary of medicines and devices' (WHC/2024/042) GOV.WALES
WHC/2024/043	14/11/2024			Pertussis Vaccine Offer for Healthcare Workers	Active offer of Pertussis Vaccine to all HCW's, due to recent increase in pertussis and to protect the most vulnerable	Compliance/A	Director of Public Health questioned on 14/01 that it should sit under Jenny - awaiting confirmation	Occupational health send annual letters to HCWs who have not received a pertussis-containing vaccine in the last 5 years and have regular contact with pregnant women or young infants (defined as those under 3 months of age). There are two priority groups: Priority group 1: HCWs with regular and close contact with severely ill young infants and women in the last month of pregnancy, including clinical staff working with women in the last month of pregnancy (e.g. in midwifery, obstetric and maternity settings); and neonatal and paediatric intensive care staff who are likely to have close and/or prolonged clinical contact with severely ill young infant Priority group 2: HCWs with regular clinical contact with young, unimmunized infants in hospital or community settings, including clinical staff in general paediatric, paediatric cardiology or paediatric surgery settings, and those working as home visitors. HCWs who are pregnant should be vaccinated in accordance with the recommendations for pregnant women set out above.	Complete	Pertussis vaccination for healthcare workers (WHC/2024/043) GOV.WALES
WHC/2024/044		31/12/2025		Mandatory E-Learning Module - Anti-Racism	All staff in public sector and funded bodies to receive mandatory training on anti-racism	Action	Director of Workforce & OD	We are currently waiting for the national competency to go	Complete	Anti-racism e-learning module (WHC/2024/044) GOV.WALES
WHC/2024/045 WHC/2024/046	18/11/2024 04/12/2024			Spotting Sepsis in Children Awareness Leaflet	A leaflet for parents and care providers of children to help spot the signs and symptoms of sepsis	Action	Medical Director	email 27/11/24: Matthew Kvedaras / Yvette Cloette informed - looking at Sepsis leaflet. Thinking of changing our leaflet to just explaining open access and then signposting / giving Sepsis leaflet although I would err toward the "Spotting the Sick child" leaflet (from the Sepsis trust). High on to do list to sort out exactly what we include as we do not want to over burden families with too many leaflets Sepsis Strategy drafted	Complete	Spotting sepsis in children, awareness leaflet (WHC/2024/045) GOV.WALES
				Influenza (Flu) Vaccination mop up 2024 2025	Targeted flu mop up intended to maximise uptake in all adult groups, particularly those in a clinical risk group	Action	Director of Public Health	Bottom 25% performing GPs identified and targeted communications to their patients with information of walk-in community clinics offered by the Vaccination Service. Offer continues.	Complete	Change to the influenza vaccination programme 2024 to 2025 (WHC/2024/046) GOV.WALES

WHC/2024/047	18/12/2024		COVID-19 Spring Vaccination Programme 2025	The latest advice from the Joint Committee on Action Vaccination and Immunisation (JCVI), which has advised a spring COVID-19 vaccination should be offered to our most vulnerable citizens in 2025.	Action	Director of Public Health	Ongoing work informed by WHC	Complete	COVID-19 spring vaccination programme 2025 (WHC/2024/047) GOV.WALES
							by 27/01/25: Action recommendation following the publication of the Infected Blood Inquiry (IBI) report 20 May 2024. Focus on finding the undiagnosed patients. Two specific recommendations for health boards to take forward for patients who may have had a blood transfusion. 8(a) - When doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C 8(b) - As a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion		Infected Blood Inquiry: carrying out recommendation 8a and 8b (WHC/2024/050) GOV.WALES
WHC/2024/050	20/12/2024		Infected Blood Inquiry: Implementation of Recommendation 8a and 8b	Update to the recommendation within the IBI that focuses on finding undiagnosed patients.	Action	Medical Director	Advise Primary Care of the requirement to action	Complete	
WHC/2024/051	27/01/2025		Health Board allocations 2025 to 2026	Allocation letter, revenue tables and explanatory notes	Compliance	Finance Director		Complete	Health board allocations: 2025 to 2026 (WHC/2024/051) GOV.WALES

WHC No	Date Issued	Action required by	Review Date		Name of WHC	Summary	Status	Lead Executive (Issued to)	Progress	Rating	Link
WHC/2025/001	05/03/2025	05/03/2025			NHS Wales Sustainability Conference and Awards 2025	Conference and awards to promote the principles of sustainable healthcare and support the incorporation of sustainable practices into clinical care	Action	Finance & Procurement		Complete	NHS Wales sustainability conference and awards (WHC/2025/001) GOV.WALES
WHC/2025/002	27/02/2025	30/09/2025			Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration	Sets out the expectation in relation to standardising the management of acute deterioration in local Health Boards, NHS trusts and primary care providers.	Action	Medical	Sepsis campaign launched 30/04/2025 includes "Spotting the Unwell Child" leaflet distributed and a social media campaign. Dep Med Dir joined national CRG. Session delivered to understand national ESR training moving from NEWS to NEWS2 and refresh around recognising Sepsis. Project Management required - to make step change in observation tools and opportunity for QI to ensure timely and proportionate responses to NEWS2 scores. Education packages in development for Nursing/Allied health care professionals and medical colleges, with presentations to "train the trainers" meeting rescheduled to 25/06/2025. PEWS education launched in May for joint MDT sessions and "PEWS" champions prepared to support the workforce. NEWT2 training packages due to release week commencing 16/06/2025 ahead of 14/07/2025 implementation. MEWS training packages in development, with a deadline July 2025. Digital testing for CareFlow to commence 16/06/2025, with the Sepsis module postponed until new V5 (NICE 2024 compliant) is available. Project Management required to make a step change in observation tools and ensure timely and proportionate response to NEWS2 scores. Pilot SBAR in preparation for Emergency Department - GUH NEWS2 pilot, exploring opportunities and risks. Communication to be sent out to divisions/CD/Lead nurses/Senior nurses to encourage staff to undertake ESR NEWS2 learning. Awareness and information page under development, aimed to launch on 17/06/2025 with information around the EWS changes and implementation dates.	In Progress	Timelines and responsibilities for Early Warning Scores (EWS) (WHC/2025/002) GOV.WALES
WHC/2025/004	14/04/2025				National Clinical Audit Plan	This circular provides a copy of the National Clinical Audit and Outcome Review Plan for 2025/26	Information/Action	Medical		Complete	NHS Wales national clinical audit and outcome review plan 2025 to 2026 (WHC/2025/004) GOV.WALES
WHC/2025/005	07/03/2025				Climate Emergency Spread & Scale Leadership Day & Adaptation	To complete scoping and have plans in place prioritising short and long term actions regarding climate emergency crisis. To submit entries for Wales Sustainability Awards.	Action	Finance & Procurement		Complete	Climate emergency leadership day and adaptation (WHC/2025/005) GOV.WALES
WHC/2025/006	06/05/2025				Recording of Mental Health Outcome Measures	Guidance in relation to adopting the use of Patient Reported Outcome Measures (PROMs) in mental health services.	Action	COO	Update needed	In Progress	Recording of mental health outcome measures (WHC/2025/006) GOV.WALES
WHC/2025/007	06/03/2025	30/10/2025			Amendments following interim review to the Model Standing Orders for Local Health Boards, NHS Trusts and Special Health Authorities in Wales	Amendments to WHC/2024/019	Compliance	Corporate Governance		Complete	
WHC/2025/008	25/06/2025				Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales	Part 4 of the Public Health Wales Act 2017. Local Authorities are responsible for managing/enforcing this mandatory licensing scheme. PHW are responsible for investigations. The document outlines the role of the Health Board when an individual presents with adverse health effects associated with a special procedure.	Information/Action	Public Health	Update needed	No Update	Licensing scheme for special procedures in Wales (WHC/2025/008) GOV.WALES
WHC/2025/010	11/04/2025				Arrangements for the prescribing of antiviral and neutralising monoclonal antibody treatments for COVID-19	The National Institute for Health and Care Excellence (NICE) recommends the use of the antiviral medicine nirmatrelvir and ritonavir (Paxlovid®) and the neutralising monoclonal antibody treatment sotrovimab as options for treating COVID-19 in adults if they are at an increased risk for progression to severe COVID-19, as defined in Technology appraisal guidance TA878	Action	Public Health	A working group has been in place to manage the transition for the clinical assessment and prescribing of antiviral medication from a dedicated Health Board service into GMS and GP OOH. The Health Board has liaised with community pharmacies to ensure sufficient stocks of nirmatrelvir/ritonavir (Paxlovid®) are available including Level 2 pharmacies holding urgent essential medicines. Clinician and pharmacies have been encouraged to remind eligible people of the availability of free LFD test kits and how to access them through community pharmacies. Local pathway in place for IV sotrovimab for patients who are contraindicated or unsuitable for Paxlovid. Webinar delivered to GP practices and community pharmacies covering NICE eligibility criteria, access to LFD testing kits, drug and dosing information, side effects (inc. reporting via Yellow card scheme), dosing recommendations for renal impairment, considerations for contraception, pregnancy and breastfeeding, drug interactions (inc. University of Liverpool COVID-19 Drug Interaction Checker) and referral for IV sotrovimab. Webinar also covered ILI notifications to allow sampling for multiplex PCR testing in enclosed setting (i.e. care homes and HMP Usk/Prescoed) and the Health Board support available for management of COVID-19 outbreaks. PC HeaRT providing transition cover for Paxlovid until 16 June 2025. Additional CPD Workshop for Urgent Primary Care occurring 17 June 2025. PC HeaRT Clinicians available to provide ongoing advice to GMS and providing secondary clinical review upon referral for Sotrovimab and will feedback to GMS if felt Paxlovid is more appropriate.	Complete	Changes to prescribing antiviral and antibody treatments for COVID-19 (WHC/2025/010) GOV.WALES

WHC/2025/011	11/04/2025				Introduction of the NHS Wales digital health identity standard for primary care	The NHS Wales Digital Health Identity Standard for Primary Care (NHS Login) sets out a consistent approach to identity management in GP practice. It describes why a person should prove their identity to access digital health services.	Information	Digital		Complete	Identity verification for digital health services in primary care (NHS login) (WHC/2025/011) GOV.WALES
WHC/2025/012	29/05/2025				Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards and NHS Trusts in Wales, and Chapter 12 for Health Education and Improvement (HEIW) and Digital Health and Care Wales (DHCW)	The Welsh Government has made amendments to the model documents issued in July 2023 to comply with the https://www.legislation.gov.uk/wsi/2025/99/made and https://www.legislation.gov.uk/ukpga/2023/54/contents	Compliance	Finance & Procurement		Complete	Interim changes to NHS model standing financial instructions (WHC/2025/012) GOV.WALES
WHC/2025/013	24/04/2025				Financial Monitoring Return Guidance	NHS Wales monthly financial monitoring return guidance and associated templates	Compliance	Finance & Procurement		Complete	NHS Wales financial monitoring return guidance: 2025 to 2026 (WHC/2025/013) GOV.WALES
WHC/2025/015	22/04/2025				People's Experience framework	The current framework for ensuring service user experience - renamed and refreshed, with the addition of a local self-assessment tool.	Action	Nursing	SBAR prepared for quality management group for presentation July - Self assessment completed	Complete	People's experience framework (WHC/2024/015) GOV.WALES
WHC/2025/016	06/05/2025				Update on NHS Wales Vaccination programme against respiratory syncytial virus (RSV)	Immediate action required to address the low uptake of RSV immunisation in older adults and pregnant women	Action	Public Health	Action plan developed to address each priority area outlined in the WHC. Actions include working with low performing GP practices to understand which ones, where commissioned, have an active offer specifically for rising 75 years and 75-79 year olds. This includes and is not exhaustive of. Sending individual patient activation letter and information leaflet to all older adults who have not taken up the offer of a vaccination via their GP. Vaccination Service will be supporting practices by offering drop in session and service provision in practices who are not offering the RSV vaccine. A proof of concept will be carried out where the Vaccination Service will provide a vaccinator to be based in Ante Natal clinic to provide a quick and easy access to the vaccine.	Complete	Update on RSV vaccination programme 2025 (WHC/2025/016) GOV.WALES
WHC/2025/017	06/05/2025				Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)	Implementation of the use of tranexamic acid in line with guidance and tranexamic acid should be included on surgical lists	Action	Medical	Clinical Director Pharmacy issued guidance. To be considered for inclusion in Theatres Safety Briefing for June 2025 in order to formalise progression to the implementation stage on the theatre checklists	In Progress	Tranexamic acid use: recommendation 7a of the Infected Blood Inquiry (IBI) (WHC/2025/017) GOV.WALES
WHC/2025/018	09/05/2025				Tirzepatide (Mounjaro) for the management of obesity and overweight	Tirzepatide to be made available by the NHS to people who meet appropriate clinical criteria and the time frame for this to be done	Action	Public Health	In principle, Public Health and Dietetics colleagues agreed to comply with WHC. Mounjaro will be made available via the Level 3 weight management service, to those who are eligible. However, there has been no additional funding allocated for Mounjaro. The current capacity of the Level 3 Weight Management Service is 25 new patients per year and waiting time is over 5 years. It was also agreed to prioritise the high risk patients waiting for abdominal wall surgery referred by the surgeon.	Complete	Tirzepatide (Mounjaro) for the management of obesity and overweight (WHC/2025/018) GOV.WALES
WHC/2025/019	12/05/2025				Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme	To optimise the rotation of children in Wales, significant changes to the routine childhood vaccination schedule and to the selective HepB programme starting from July 1 2025 with further changes commencing January 1 2026	Action	Public Health	outline childhood vaccination schedule A task & finish group set up to support the introduction of changes to the routine childhood schedule. The group is putting in place the following in readiness for the changes taking place from 1st July 2025: •Dedicate Pulse site to host professional resources and new guidance relating to changes in the routine schedule •Hotline number for immediate responses to queries from GP practices •Changes to all online and printed professional and patient facing materials to reflect changes in the schedule •Flow chart and checklist for each immunisation appointment for use by Practice Nurses •Unscheduled immunisations forms to record vaccinations administered in line with the new schedule •Read only access to CYPriS for GP practice staff NB. There is a national risk within the system due to the delay in updates to CYPriS (NHS IT system) which means that invitation letters will contain outdated information and scheduled forms sent to GP practices will also contain incorrect information. This will increase the risk of errors and will require more time for vaccinators in general practice to check the new schedule and follow it manually until CYPriS is updated. Selective Hep B programme A group has also been set up to develop the new 2-dose neonatal pathway for babies born to Hep B infected pregnant women. This pathway will include the Hep B surface antigen test required between 1 year of age and 18 months. This pathway will be in place from 1st July 2025.	Complete	Changes to routine childhood and selective neonatal hepatitis B vaccinations (WHC/2025/019) GOV.WALES
WHC/2025/020	06/06/2025				National Influenza Vaccination Programme 2025-26	Detailed guidance for the influenza (flu) vaccination programme for the coming autumn and winter	Compliance/Action	Public Health		No Update	The national influenza immunisation programme 2025 to 2026 (WHC/2025/020) GOV.WALES
WHC/2025/021	03/06/2025				Introduction of routine vaccination programmes for prevention of mpox and gonorrhoea	The Welsh Government has accepted advice from the Joint Committee on Vaccination and Immunisation (JCVI) to introduce a routine targeted vaccination programme for the prevention of Gonorrhoea alongside a routine vaccination programme against Mpox for those at highest risk	Action	Public Health		No Update	Introduction of routine vaccinations for mpox and gonorrhoea (WHC/2025/021) GOV.WALES
WHC/2025/022	26/06/2025				National Covid 19 Vaccination Programme	Detailed guidance for the COVID-19 vaccination programme for the coming Autumn 2025	Compliance/Action	Public Health		No Update	The national COVID-19 vaccination programme autumn 2025 (WHC/2025/022) GOV.WALES
WHC/2025/023	13/06/2025				PPE Stockpile volumes in England & Wales	Update on target volumes for PPE stockpiling in Wales	Information	Nursing		Complete	PPE stockpile volumes in Wales (WHC/2025/023) GOV.WALES

WHC/2025/025	11/07/2025				Overseas Visitors' Eligibility to Receive Primary Care	Clarifies the circumstances when overseas visitors are entitled to free primary care. Replaces WHC 2021/026	Compliance/Action	COO		No Update	Overseas visitors' eligibility to receive free primary care (WHC/2025/025) GOV.WALES
WHC/2025/026	04/08/2025				The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings	The introduction and use of artificial intelligence and machine learning in the form of ambient voice technologies (AVTs) in clinical and practice settings		Digital		No Update	
WHC/2025/027	16/07/2025				Changes to supply of Gluten Free foods in Wales; All Wales Gluten Free Subsidy Card scheme	The implementation of an All Wales Gluten Free Subsidy Card Scheme for patients with a diagnosis of Coeliac disease or dermatitis herpetiformis in Wales	Action	Public Health		No Update	All-Wales gluten free subsidy card scheme (WHC/2025/027) GOV.WALES
WHC/2025/028	09/07/2025				Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49	Eligibility for a shingles vaccine expanded to all severely immunosuppressed individuals over 18	Action	Public Health		No Update	Expansion of shingles immunisation for severely immunosuppressed people aged 18 to 49 GOV.WALES
WHC/2025/029	14/07/2025				Introduction of Nirsevimab passive immunisation against Respiratory Syncytial Virus (RSV) in at risk infants for upcoming 2025/26 RSV Season	WG has accepted advice from JCVI to implement a product change to Nirsevimab, which is now available for the next RSV season, expected October 2025 and to expand the existing RSV high-risk selective monoclonal antibody immunisation programme	Action	Public Health		No Update	Introduction of a new RSV passive immunisation from autumn 2025 GOV.WALES

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Introduction of the Health Board's Audit Handbook
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Health Board is introducing an Audit Handbook (Appendix A), to strengthen staff awareness and understanding of the audit process and its value in ensuring safe, high-quality care.

The Handbook sets out the purpose of audit, the assurance it provides on the effectiveness of operations, and how identified gaps lead to actionable recommendations for improvement.

Cefndir / Background

Originally developed by the Welsh Ambulance Services NHS Trust (WAST), the Handbook has been shared with health bodies across Wales, with permission to adapt its content to reflect local structures and organisational needs.

The document sets out:

- The role of an auditor and how they conduct their work;
- How audit findings are presented to the Health Board, and;
- The roles, responsibilities, and expectations of both the auditor and the Health Board.

The Handbook is intended to complement and support the Audit Tracking Recommendation Procedure, introduced last year, which ensures timely follow-up on recommendations from completed audits.

The draft Handbook has been shared with both Internal Audit (IA) and External Audit (EA) for comment, and their feedback has been incorporated.

Asesiad / Assessment

While the Audit Tracking Recommendation Procedure introduced last year has improved the follow-up of audit recommendations, there remains a need to increase staff understanding of the audit process, their role within it, and the assurance it provides to the Health Board and wider stakeholders. Limited awareness can lead to missed opportunities to address risks, embed learning, and drive quality improvement.

The Audit Handbook will address this gap by providing a clear, accessible reference for all staff, ensuring a consistent understanding of audit principles, processes, and expectations. By reinforcing the link between audit findings, recommendations, and service improvements, the Handbook will further embed a culture of accountability, transparency, and continuous improvement across the organisation.

The Handbook will be shared with staff via the 'Latest News' section on ABPulse and published the Corporate Governance Hub on ABPulse.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **Note** the introduction of the Audit Handbook, designed to strengthen organisational awareness and understanding of the audit function and its role in providing independent assurance on the Health Board's operations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Audit supports all risks
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. Supports delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

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

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



AUDIT PROCESS AND REPORTING HANDBOOK

Internal and External Audit



INTRODUCTION

This Handbook is intended to equip Aneurin Bevan University Health Board (herein referred to as the Health Board) colleagues with the knowledge you need should you be involved in an audit at the Health Board, whether that is an internal audit or external audit. It also sets out roles and responsibilities including those for senior management and the Health Board's Committees.

Internal audit and external audit are both important components of the Health Board's financial and operational processes, but they serve different purposes and have distinct characteristics.

All NHS Wales organisations must have an internal audit function and that is provided by NWSSP Audit and Assurance Services (herein referred to as Internal Audit). Internal audit provides independent, objective assurance and advisory activities designed to add value and improve governance and operational efficiency, risk management and control for all NHS Wales bodies.

The Auditor General for Wales is the Health Board's external auditor¹ and staff from Audit Wales will deliver an annual programme of statutory audit work that verifies the accuracy, fairness and regularity of the financial statements for the Health Board and the Aneurin Bevan University Health Board Charity. The Auditor General also has a duty to be satisfied that the Health Board has proper arrangements in place to use its resources efficiently, effectively and economically, and uses a programme of performance audit work, including an annual Structured Assessment, to discharge this duty.

Both types of audits play crucial roles in ensuring transparency, accountability, and good governance within an organisation. The findings from internal audit reviews are taken into account by Audit Wales staff when conducting their audits, and likewise structured assessments and other external audit findings are relied upon by Internal Audit when conducting internal audit reviews.

This Handbook does not include other forms of audit such as clinical or quality audits that are undertaken at the Health Board.

It is intended that this Handbook will initially be reviewed within twelve months of its approval date to reflect any changes in process as a result of revisions to the Audit Tracker including automation, repository and reporting. Following that, the Handbook will be reviewed every three years.

¹ *Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions. Audit Wales is not a legal entity and itself does not have any functions

CONTENTS

1. Why Audit is Important	3
2. Internal Audit.....	3
2.1 What is an internal audit?.....	3
2.2 Who is Internal Audit and what do they do?	4
2.3 Why is the particular audit happening?	4
2.4 The stages of an internal audit	5
(a) Planning	5
(b) Fieldwork	5
(c) The Internal Audit Report (draft to final).....	6
(d) Follow Up	10
2.5 Review and Monitoring of Internal Audits	10
3. External Audit	11
3.1 Who is the Health Board's external auditor and what are their statutory duties and powers?	11
3.2 What work does the Auditor General undertake at the Health Board?	11
3.3 How does the Auditor General report their findings?.....	13
3.4 Data Protection	14
4. The Audit Tracker	14
5. Roles and responsibilities.....	15
5.1 Director	15
5.3 Audit interviewees	16
5.4 Director of Corporate Governance	17
5.5 Audit Committee	17
5.6 Board Committees	17
5.7 Executive Team	18
5.8 Internal Audit.....	18
5.9 External Audit	18
6. Annexes	19
7. Version History and Document Control	19

1. Why Audit is Important

Regular audits are an important part of organisational learning and development. They provide valuable assurance to the Board and our key stakeholders on performance. It is important to understand that an audit is not a fault-finding exercise. Internal audits are designed to support you and your teams to identify areas of noncompliance and provide opportunities for improvement. They can be a great celebration of success, particularly where a substantial assurance rating is provided.

Also, when a reasonable assurance rating is given to an audit there are often areas of excellent work recognised.

The annual programme of work conducted by the Auditor General provides assurance for the Board and our stakeholders on the regularity of the financial statements and the efficient, effective and economical use of resources by the Health Board. Whilst an overall rating is not provided by Audit Wales, key findings are highlighted within their reports.

Whilst completed audits do not replace management responsibility, they provide insights provide tangible opportunities for improvement. Because they serve as an additional quality control step, you will be able to pinpoint the root causes of any operational or process issues. Knowing this, you will then be able to improve your processes further.

By conducting audits on a regular basis, we are demonstrating to our people, our patients and our stakeholders that Aneurin Bevan University Health Board takes issues of quality, patient safety, health and safety, and regulatory compliance seriously.

Internal audit reports contribute to our end of year Head of Internal Audit Opinion (see section 2.2).

2. Internal Audit

2.1 What is an internal audit?

Internal audit is an independent assessment of a system or process through an objective examination of evidence. The aim is to give management and the Audit Committee confidence (assurance) that:

- appropriate mechanisms are in place to manage risk and increase the likelihood that organisational goals and objectives will be achieved; and
- those mechanisms, usually set out in organisational policies, procedures and processes, are being complied with.

We have included an Internal Audit Jargon Buster at **Annex 1** to aid in your interpretation of this Handbook and of any internal audits you may review.

2.2 Who is Internal Audit and what do they do?

As set out above, the Health Board's internal audit services are not carried out 'in house' but by the NWSSP Audit and Assurance Services. They deliver their work primarily through the following:

Annual Audit plan

Annually a plan is developed which sets out a range of internal audit reviews that will be conducted at the Health Board that financial year. The plan is aligned to the Health Board's principal risks and is developed in conjunction with your Director and the Executive Leadership Team and following consideration of the key documents such as the principal risk register and Integrated Medium-Term Plan (IMTP).

In proposing areas to audit, Directorates are encouraged not to focus on areas we feel have robust processes, but those that we believe can be improved, made more efficient or are areas of notable risk.

You can find the list of audits planned for each year here [Internal Audit Plan 2025-26](#). Where necessary, particularly to address emerging risks in year, the plan may be adjusted. The plan is approved by the Audit, Risk and Assurance Committee.

Individual audits and advisory reviews

Throughout the year Internal Audit undertake audit and consultancy (or advisory) reviews in line with the annual audit plan. Each report aims to provide an assurance opinion (audit report) or advice (consultancy reports) over a specific system or process.

Recommendations are agreed with management before presenting our reports to the Audit Committee.

Head of Internal Audit Opinion

The Head of Internal Audit Opinion (HOIA Opinion) is provided to the Health Board annually. It is based on the outcome of audit and consultancy work undertaken during the year and other information available to Internal Audit.

The HOIA Opinion contributes to assurances available to the Board to underpin the Board's assessment of the effectiveness of governance and control. It is an integral piece of the Health Board's governance framework, providing assurance to inform the annual governance statement and identifying improvement opportunities.

There is more information on Internal Audit 'who we are?' at **Annex 2**.

2.3 Why is the particular audit happening?

You may be wondering why a particular area or process in your Directorate is being audited. You will see above that an annual audit plan is developed

so it is likely that this process or area of work was identified during the annual risk-based planning process or has become an emerging risk during the year. It may also have been specifically requested, e.g., by management, the Audit, Risk and Assurance Committee, a third party, etc., be a follow-up review (re-examining an area recently tested) or a rotational audit, to ensure sufficient HOIA Opinion coverage across the Health Board.

2.4 The stages of an internal audit

There are a number of stages to an internal audit review. Before work starts on your audit be sure to understand the various roles and responsibilities and your part in it (see section 5).

We have set out below the various stages your internal audit will take. You may be involved in all or some of them. The Internal Audit flow chart at **Annex 2** provides more detail on the stages your internal audit will take for additional reference.

(a) Planning

Whilst the area for the audit will have been identified in the annual audit plan, the specifics of what the audit will cover will be agreed with your director at this first step in the internal audit.

A meeting will take place with the internal auditor assigned to the audit and the Director and an audit brief will then be agreed.

You should consider appointing a person as the central point of contact (POC) for the audit in your Directorate. That person should be involved at this planning stage and throughout to ensure Internal Audit have everything they need, and those that need to contribute to the process are fully informed.

(b) Fieldwork

Fieldwork testing is the process of examining evidence to form an opinion, with respect to the area being audited, systems are designed to mitigate risks identified in the brief, and the mechanisms in place to mitigate those risks are operating effectively.

A kick off meeting will be held with Internal Audit and the Director, and it is advisable to have your POC at that meeting also.

Internal Audit may request a number of documents or interviews with subject matter experts within the Health Board. Your POC should coordinate these interviews and provide internal audit with all documents requested in a timely manner. The POC should keep a log of documents provided.

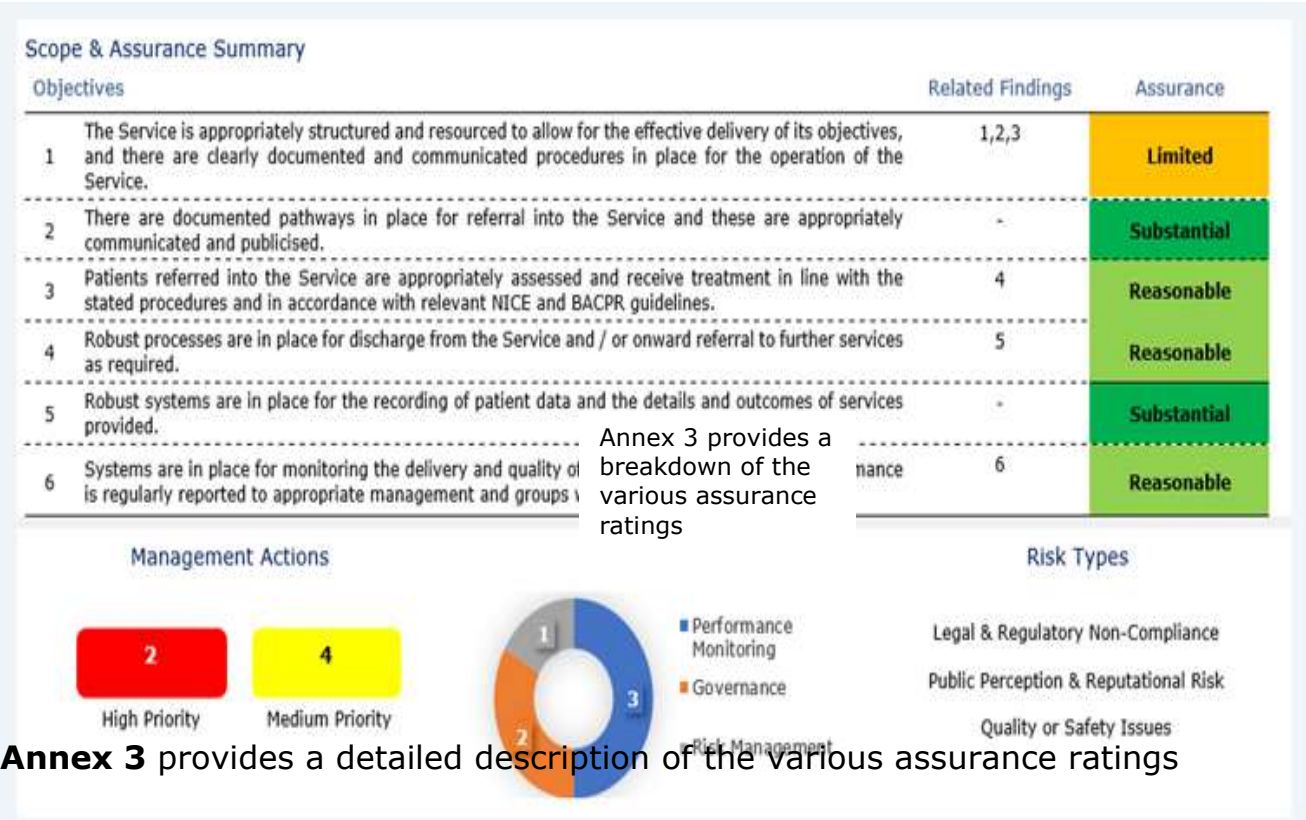
Ensure a timeframe for completion of the fieldwork is agreed. The POC will ensure they are aware of that timeframe and the date the draft report is planned to be released.

(c) The Internal Audit Report (draft to final)

At the conclusion of the fieldwork, Internal Audit will prepare a draft report for discussion, providing both parties with an opportunity to review and discuss the findings, recommendations, and ensure factual accuracy. Once the content has been agreed in principle, Internal Audit will issue a final draft report to the Health Board via the Office of the Director of Corporate Governance. The Health Board will then have **15 working days** to develop and coordinate management responses and associated action plans to address the recommendations.

The report itself will set out the agreed purpose and audit objectives agreed at the planning stage. The executive summary provides a snapshot of the purpose of the audit, an overview of main issues, the overall risk rating, and a breakdown of ratings for the objectives and recommendations.

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has tested, including interviews conducted during the fieldwork. It may look something like this:



Annex 3 provides a detailed description of the various assurance ratings

Internal Audit will provide a conclusion and separate assurance rating on each of the audit objectives agreed at the planning stage, based on the evidence it has tested and the interviews conducted during the fieldwork.

Findings & Agreed Action Plan

Objective 1: The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	Limited

Overview / Summary of Observations

The Community Cardiology Service has no formal documented structure that outlines its position within the overall Health Board organisational structure. The Service is also not currently supported by effective local governance and management arrangements that facilitate its operational decision making and reporting mechanisms. We note that local governance arrangements were in place during the Services' project management and pilot phases, but these have not been continued or developed to support the Service now that it is fully operational.

The Service has Standard Operating Procedures in place that describe the purpose and current operational processes of its three constituent Service areas and

Key Findings made under each objective are then summarised in the appendix.

Key Findings	Risk & Impact	Agreed Management Action
1 Monetary Value Gifts We found two exceptions from 20 sampled where declarations were made after the benefit was approved; one was concerning a trolley for a ward and the other one was a £30 voucher for an individual which was received in the person's absence but was over the £25 threshold and in the form of a gift voucher. Whilst the policy allows, in some instances, gifts to be received (e.g. where it may cause offence to the donor), the declarations should be made (and approved) prior to the acceptance of the gifts. Furthermore, any cash, vouchers etc. should be donated to a charitable fund instead.	Non-compliance with the Standards of Business Conduct Policy through inappropriate gifts accepted.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 14), awareness sessions will be held with managers to set out the requirements of the Policy and ensure these are further cascaded to staff. The Policy also sets out that the importance of continued compliance will be referenced in induction programmes.
	Medium Priority	Expected Evidence of Implementation: Evidence of awareness sessions and inclusion of Standards of Business Conduct in the corporate induction programme.
Theme: Training & Development	Control Operation	Officer: Director of Corporate Governance Date: March 2026

Whilst the key findings from auditors will be based on the evidence provided, it may be necessary to highlight any concerns about the wording, practicality or relevance of management actions. This is particularly the case where the management action cannot be completed fully by the Health Board alone and where the implementation of the management action would require involvement of and / or dependency of third parties. Third party actions may cause significant delays in closing an action, seeing an impact in any improvements, and may require escalation to the Audit Committee.

Recommendations are categorised according to their level of priority and the timeframe within which management actions should be completed. The prioritisation table is set out in Annex 4.

Each key finding must be met with an agreed management action. You will have to respond with a management response within the 15-day window mentioned above.

Management actions are an important consideration and usually the last step in finalising the audit report. Often, they will be obvious and likely a plan or action you already have in train or were planning. Sometimes actions will require careful planning and resourcing.

It is important to remember that the actions you promise to deliver and the dates within which you indicate they will be completed by will be monitored closely not only by your Directorate, but also by the Executive Leadership Team and the Audit Committee. This is primarily done via the audit tracker which is regularly reported into those forums.

It is therefore crucial that management actions are approved by the Director and actions assigned to suitably senior members of the team to enable them to close off actions and escalate them and framed in a way which broadly meets the requirements of **SMART** principles:

- **Specific** – is there an output or a process that is required to address the recommendation
- **Measurable** – what evidence will you be able to provide to demonstrate the action is closed
- **Achievable** – are there resourcing or other challenges that may prohibit the action being completed, or is a third-party involvement required which may provide challenging
- **Realistic** – will the action address the recommendation; does it provide value for money and will it have the desired impact
- **Timebound** – do not over promise and underdeliver. Take account of pressures during the winter and annual leave, as well as the required governance routes for the action before suggesting a date by which the action will be closed off

All dates included for completion of actions must be expressed in terms **DD/MM/YY**.

An example of a SMART management response is shown below.

Objective 4: Feedback received by Divisional Management is recorded effectively, tracked and promptly acted upon.			Reasonable
Overview / Summary of Observations			
As discussed above, a sample of Divisional Assurance, SLT and Divisional Delivery Group meetings were reviewed. Matters or risks had been escalated to Divisional Management and had been recorded in SLT minutes. However, tracking of issues could be further enhanced to provide assurance that issues had been addressed in a timely manner.			
Key Findings		Risk & Impact	Agreed Management Action
4	Feedback A formal process was not in place for the escalation, recording and tracking of key risks, to ensure that Divisional Management can be confident that key risks were escalated to them for consideration and their feedback had been fully implemented/ addressed. This should be considered alongside the development of a divisional process and the recording / tracking of risks referenced above.	Risks may not be addressed.	Agreed Action: We acknowledge the absence of a formal process for the escalation, recording, and tracking of key risks at divisional level, and we agree this has the potential to impact assurance and oversight by divisional management. To address this, the following actions will be taken: Creation of a SLT meeting Action/Decision Log to record: - o All risks escalated from services or teams. - o Divisional-level decisions and actions. - o Whether the risk was escalated further (e.g., to SLT or corporate level). - o Date of review, feedback loop, and closure. Strengthen the Divisional Risk escalation process through the QPS forum. Improved Feedback Mechanism A feedback loop will be embedded so that services that escalate risks receive formal confirmation of actions taken or rationale for non-escalation. Governance Oversight Risk Management processes will be reviewed quarterly and monitored by a divisional risk lead. Expected Evidence of Implementation: • Action/Decision logs with escalation history. • Meeting minutes/notes showing divisional review and feedback.
7			
			• Periodic reviews or audits confirming compliance with the process.
		Medium Priority	Officer: Business Manager/ Assistant Head of Business & Performance
Theme: Governance		Control Design	Date: 27 th June 2025

Recommendations that are rated 'high' must be given priority and should where possible receive a shorter turnaround time to close the recommendation.

Any **differences of opinion** regarding the applicability, relevance, practicality or timeliness of management actions should be fully discussed between auditors and the Director prior to it being submitted for consideration by the Executive Leadership Team and the Audit and other Board Committees. If an agreed way forward cannot be found, the issue(s) should be referred to the Director of Corporate Governance.

Internal Audit aims to issue the final report within ten **working days** of receiving the management responses. The timeline from draft report to final publication is outlined below.

Stage	Description

Draft Discussion Report Issued	Internal Audit will issue the draft report to the designated Lead Executive for review of factual accuracy, with an offer to meet and discuss the findings if required. A period of 5 working days is allocated for this initial review and response.
Draft Report Issued	Internal Audit issues the draft report to the Health Board via the office of the Director of Corporate Governance. A 15 working day turnaround is allocated for submitting management responses.
Management Response Due	The Health Board submits its completed management responses to Internal Audit.
Final Report Issued	Internal Audit issues the final report, incorporating the management responses, within 10 working days of receipt.

Total time to complete the publication process = **6 working weeks**.

An escalation process is in place and will be activated when audits are scheduled for an upcoming Audit Committee meeting and progress on management responses has stalled. Exceptions to initiating this process may apply and will be agreed upon in collaboration with the auditors. For further details, please refer to the Audit Recommendation Tracking Procedure (add link).

(d) Follow Up

Internal Audit conduct a follow up audit annually to verify if a sample of agreed actions have been implemented and whether the actions taken have been effective in mitigating risk.

2.5 Review and Monitoring of Internal Audits

Once the internal audit report is finalised it is reviewed and discussed by the Executive Leadership Team and the Audit Committee. Reports relevant to Board Committees are also presented to their next meeting. Section 5 on Roles and Responsibilities goes into more detail on the focus of these various groups.

Audit recommendations and actions are transposed to the Audit Tracker. Further detail on Audit Tracker appears at section 4 below.

3. External Audit

3.1 Who is the Health Board's external auditor and what are their statutory duties and powers?

The Auditor General for Wales is the statutory external auditor of most of the Welsh public sector. This means that they audit the accounts of county and county borough councils, police, fire and rescue authorities, national parks and community councils, as well as the Welsh Government, its sponsored and related public bodies, the Senedd Commission and National Health Service bodies. At many of these public bodies, including the Health Board, the Auditor General also has a statutory requirement to satisfy themselves that the organisation has proper arrangements in place to secure economy, efficiency, and effectiveness in the use of their resources.

The Auditor General for Wales is a crown appointment and their statutory duties and powers are contained in the following legislation:

- Government of Wales Act 1998
- Government of Wales Act 2006
- Public Audit (Wales) Act 2004
- Public Audit (Wales) Act 2013
- Well-being of Future Generations (Wales) Act 2015²

Further information can be found in:

- [Access rights of the AGW](#)
- [A guide to Welsh public audit legislation](#)

3.2 What work does the Auditor General undertake at the Health Board?

To discharge their statutory duties, the Auditor General undertakes an annual programme of audit work at the Health Board, which is summarised in the Annual Audit Plan. This plan is developed following assessments of the Health Board's principal risks, with a process similar to that described for internal audit above.

The Annual Audit Plan will set out the work the Auditor General intends to undertake to audit the Health Board's accounts and undertake an independent examination of the charitable funds, as well as a programme of performance (or value for money audit work that will typically include:

- Structured Assessment work; and

² In line with the Wellbeing of Future Generations (Wales) Act the Auditor General must carry out examinations of each named organisation's well-being objectives and the steps being taken to meet them. This will apply to the Health Board when it becomes one of the named bodies (anticipated for April 2024).

- Thematic work which may examine issues specific to the Health Board or which is part of a wider examination that is also being taken forward at a number of other bodies.

The Annual Audit Plan, which also sets out the fee the Auditor General must charge for the work, is agreed by the Executive Leadership Team and approved by the Audit Committee and be accessed [External Audit Plan 2025-26](#)

Audited Financial Accounts

The Auditor General for Wales audits the financial statements of the Health Board annually. In addition, Audit Wales staff will undertake an independent audit of the Health Board Charity annually.

The aim of the audit is to verify that the financial statements are prepared in accordance with relevant accounting standards and to provide reasonable assurance that they are free from material misstatements. These certified financial statements are filed with the Welsh Government (Health Board accounts) and Charities Commission (Aneurin Bevan University Health Board Charity) along with the accompanying respective annual reports.

The Welsh Government Manual for Accounts guides the preparation of the Health Board's financial statements and the Finance and Corporate Resources Directorate oversees their preparation and liaises with Audit Wales throughout.

Structured Assessment

The Structured Assessment takes place annually and primarily examines corporate arrangements relating to governance, systems of assurance, planning, and financial management.

A project brief is agreed with the Executive Leadership Team and the Board and follows similar stages to that of an internal audit above.

The Structured Assessment Report assures the Board, our people, the public and key stakeholder that the Health Board has sound corporate governance arrangements and that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

Local performance audit reviews

In addition to the Structured Assessment, the Auditor General may also review certain arrangements at the Health Board in more depth. This audit work is determined as part of the local audit planning process and is specific to the risks facing the Health Board.

All Wales thematic reviews

The Auditor General may also undertake work at the Health Board which is part of a wider thematic review examining a specific issue or service area across all NHS bodies in Wales.

National value for money examinations

In addition to the annual programme of audit work at the Health Board, the Auditor General undertakes a number national value for money examinations each year which focus on a range of topical issues, including those relevant to NHS bodies.

Depending on the topic under review, national value for money examinations may involve the capture of information from the Health Board, and the published outputs from the work may include recommendations for the Health Board to respond to.

3.3 How does the Auditor General report their findings?

Findings from the audit of the accounts, the Structured Assessment, and any additional performance audit reviews are presented in individual reports. These reports are agreed with management and subsequently presented to the Audit Committee and/or the Board.

As with Internal Audit, management actions will be provided in response to any recommendations made in the Auditor General's reports. Progress against these actions will be monitored through the Audit Tracker.

Audit Wales issues a draft report following the completion of fieldwork.

There are two key stages in this process:

1. **Report Clearance** – This stage ensures that the audited area is satisfied with the content of the draft report and that it contains no misstatements or factual inaccuracies. If concerns are raised, a clearance meeting is held to resolve any discrepancies before the report is finalised.
2. **Management Response** – During this period, the Health Board prepares its responses to the recommendations. Audit Wales remains available to support the development of these responses to ensure they meet the required standard.

The table below outlines the typical timeline from draft report to final publication.

Stage	Description
Draft Report Issued	Audit Wales issues the draft report to the Health Board, requesting review and feedback on factual accuracy within 10 working days .
Factual Accuracy Sign-Off	The Lead Executive Director is responsible for confirming the factual accuracy of the report and providing formal sign-off to Audit Wales via email.
Final Report Issued (Pre-Response)	Audit Wales issues the final version of the report to the Health Board within 2 working days of receiving factual accuracy confirmation, along with a request for management responses to be received within 15 working days .
Submission of Management Responses	The Health Board submits its formal management responses to Audit Wales.
Final Report Issued (Post-Response)	Audit Wales issues the final report, including management responses, within 10 working days of receiving them.

Total time to complete the publication process = **approx. 7-8 working weeks**.

3.4 Data Protection

During the course of the Auditor General's audit work, if any personal data is processed, such as during interviews or within Health Board documents, it is done so in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation.

4. The Audit Tracker

A tracker is maintained by the Corporate Governance Directorate to provide a central overview on progress against management actions on Internal Audits and Audit Wales reports. From time-to-time regulator reports may also be included.

Directors and the POC or action owner must ensure the actions are completed by the agreed dates. Of course, it is understandable that

sometimes that is not possible and changes to agreed completion dates are warranted. The Audit Tracker enables a director to propose up to three changes in completion dates. This should not be required if realistic dates are provided in the original audit but where it is needed justification must be provided. The Director should include in the justification the progress to date as well as any risks to a delay in completion of the action.

Directorates should conduct monthly reviews of any audit recommendations for which they are responsible for implementing by including a monthly audit update on their Directorate agenda. This agenda item would also include the initial review of any new internal audit reports.

Updates to the Audit Tracker can be provided by the POC or action owner to the Corporate Governance Directorate, in particular, the Risk and Assurance Team ensuing:

- Where an action is proposed for closure evidence demonstrating that is provided or signposted;
- Where a date change is required, an update is required the rationale for that including progress made since the date of the last review, obstacles to further progress and confirmation, or otherwise, that the revised date is achievable.
- Early warning of any actions not yet due but which may be at risk of delay

N.B. Any changes to dates due must be approved by the Director and subsequently, the Audit Committee.

The Director of Corporate Governance will undertake a formal six-monthly review of the Audit Tracker and will review the progress updates provided. Where it is no longer possible to complete the action the Director of Corporate Governance can support the Directorate to propose amendments to Internal and External Audit.

Where the implementation of a 'high risk' action is delayed beyond 3 months of the originally agreed date the responsible Executive Lead may be invited to attend the next meeting of the Audit Committee to discuss the various issues involved.

Once all recommendations have been implemented to the satisfaction of the Committee they will be classified as completed.

5. Roles and responsibilities

5.1 Director

- Agree the internal audit brief;
- Agree recommendations and develop management responses;

- Ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- Support and empower your team to provide all requested audit evidence in a timely manner;
- Agree a directorate process to track management actions;
- Oversee the implementation of agreed actions;
- Attend Audit Committee to provide assurance to members relating to a no or limited assurance internal audit report;
- Lead a discussion of their audit report in the Board Committees where the subject of the audit is in the remit of that Committee; and
- Ensure monthly review of audits as a standard agenda item on directorate meetings.

5.2 Point of Contact (may be action owner or individual delegated responsibility for Audit Tracking)

- Communicate any issues to auditors which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc;
- Provide auditors with the contact details for everyone involved in the system / process being audited, even if from a different team or division; and
- Update the audit tracker monthly.

5.3 Audit interviewees

- Cooperate and be open and honest with the audit team;
- Clearly explain the process and / or system being audited providing any evidence such as meeting minutes etc as may give wider context;
- Provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner;
- Communicate challenges in providing information and / or pressures within the point of contact in your directorate; and
- Answer to the best of your ability – Auditors know that people can be nervous, and sometimes will forget the answer to a question. It is acceptable to say: “I forget that right now, but here is where I can find that information,” and then to show the auditor the procedure or other information they need. If an employee doesn’t know an answer, it is far worse to make up the answer than to just say, “I don’t know, but I can find out.”

5.4 Director of Corporate Governance

- Facilitate the collation of appropriate management actions to draft audit reports;
- Ensure there is an adequate provision of internal and external audit services;
- Coordinate the development and approval of the annual audit plan;
- Provide final audit reports to Executive Leadership Team, Audit and other relevant Committees;
- Maintenance of audit tracker;
- Coordinate quarterly review of tracker;
- Review evidence of closed actions;
- Prepare progress and tracker reports to ADLT, Executive Leadership Team, Audit Committee and Board Committees;
- Facilitate escalations from Internal Audit or on tracker; and
- Lodge quarterly Welsh Government return of audits.

5.5 Audit Committee

- Facilitate direct and unrestricted access for the Head of Internal Audit and Auditor General for Wales to the Board;
- Receive regular updates over the completion of management actions for audit reports and where appropriate to do so, approve extensions to the completion date;
- Review and recommend Internal Audit Charter for approval by Board;
- Receives the Internal Audit confirmation of independence annually;
- Receives regular reports from Audit Wales and Head of Internal Audit on its activities;
- Agree annual Internal Audit plan;
- Review internal audit reports, Structured Assessments and other Audit Wales reports, and scrutinise of the adequacy of management actions in response to recommendations;
- Scrutinise the progress of audits overall, escalating to the Board any issues of concern; and
- Receive and review Head of Internal Audit Opinion.

5.6 Board Committees

- Receive audits in their remit for information;
- The Committees' Forward Work Programme will include reports that provide assurance on the impact of actions taken in response to audit recommendations — specifically in areas such as quality

improvement, more efficient and effective patient care, strengthened governance, and better use of resources.

5.7 Executive Team

- Review and provide comment on the proposed annual Internal Audit plan;
- Scrutinise the progress of audits overall;
- Review Structured Assessment briefs;
- Receive and review all final Internal Audit reports, Structured Assessment and Audit Wales reports;
- Oversight of the audit framework by way of quarterly dashboard reports; and
- Receive and review Head of Internal Audit Opinion.

5.8 Internal Audit

- Provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively;
- Provide annual Head of Internal Audit Opinion to Audit Committee;
- Provide regular reports on progress to Audit Committee;
- Present annual Internal Audit plan;
- Present finalised Internal Audit reports to Audit Committee;
- Assess a sample of management actions each audit year, to ensure extensions have been authorised, where required and other actions implemented as described; and
- Agree timeframes for the various stages of internal audit work with the Director of Corporate Governance.

5.9 External Audit

- Provide independent assurance on the financial statements and the corporate arrangements for securing economy, efficiency and effectiveness in the Health Board's use of resource.
- Agree the briefs for audit work with the Director of Corporate Governance and/or relevant Director
- Provide regular reports on progress to Audit Committee;
- Present annual Audit plan to Audit Committee;
- Present finalised Audit reports, including the Annual Audit Report to Audit Committee (or other Committees or the Board by agreement);
- Review tracker and raise concerns regarding changes to completion dates for actions to Director of Corporate Governance and/or Audit Committee; and

- Agree timeframes for the various stages of performance audit work with the Director of Corporate Governance and for the audit of the financial statements with the Executive Director of Finance and Corporate Resources.

6. Annexes

Annex 1 – Glossary

Annex 2 – Internal Audit Jargon

Annex 3 – Internal Audit Guidance Infographic

Annex 4 – Audit Assurance Ratings

Annex 5 - Prioritisation of Recommendations

7. Version History and Document Control

Version	Date	Summary of changes	Document Status
v.01	13.08.25	N/A	First edition

Annex 1: Glossary of Terms

Term	Definition
Assurance	From an internal audit perspective, this means providing an independent assessment of a system of process through an objective examination of evidence.
Audit Brief	Documentation that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics., including the audit team, key contacts and timeframes.
Audit Report	Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.
Governance	The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement of objectives.
Executive Lead	Individual within the organisation identified as the lead for the audit, usually a director. Responsibilities include: • Agreeing the audit brief; • Providing management responses to recommendations; • Overseeing the implementation of agreed actions.
Risk Management	A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.
Audit meetings	Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc. Kick-off meeting: usually held at the beginning of the fieldwork phase, audit use this meeting to get a detailed understanding of the system under review. Debrief meeting: at the end of the audit, a meeting will be held with key individuals to debrief on findings.
Control	Any measures put in place by management, the Board or other parties to manage risk and increase the likelihood that organisational goals and objectives will be achieved.
Assurance opinion	The auditors overall view of whether, for the system being audited: • The controls have been adequately designed to mitigate identified risk' and • The controls are operating effectively (i.e., are being adhered to in practice) Assurance opinions are defined in Annex 2.
Recommendations	Recommendations may support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system. Alternately, recommendations may relate to non-compliances within the system e.g., policies and procedures have not been followed.

Annex 2: Internal Audit Jargon



External Quality Assessment

Our latest EQA, conducted in February-March 2023 by the Chartered Institute of Public Finance and Accountancy, confirmed that our work 'fully conformed' to the requirements of the Internal Audit Standards for 2022/23.

Want to know more?

Internet: [Audit & Assurance Services - NWSSP](#)
 Intranet: [Audit & Assurance Services \(sharepoint.com\)](#)

Key documents / information:

- [Global Internal Audit Standards](#)
- [Institute of Internal Auditors](#)
- [Our Assurance Opinion and Action Plan Risk Ratings](#)
- [Our Responsibility Statement](#)

Ask your key contacts for information on:

- Internal Audit Overview
- Our Annual Planning Approach
- Our Internal Audit Plan and Charter

Distilling the jargon

When you know a subject inside-out, it's easy to lose others amongst the jargon. Here's some clarification on some of the audit jargon you might here us using...

Assurance

From an internal audit perspective, this means providing an independent assessment through an objective examination of evidence.

Governance

The combination of processes and structures that the Board puts in place to inform, direct, manage and monitor organisational activities and achievement.

Risk management

A process to identify, assess, manage and control potential events or situations which may hinder achievement of organisational objectives.

Control

Any measure put in place by management, the Board or other parties to manage risk and increase the likelihood that organisational goals and objectives will be achieved.

Control Design recommendation

A recommendation to support improvement in the design of the audited system. Generally, the improvement is needed to improve the mitigation of risks within the system.

Audit Brief

Document that sets out the scope of the audit (i.e., what the audit will cover) and key audit logistics, including the audit team, key contacts and

Executive Lead

Individual within the organisation identified as the lead for the audit, usually a director.

Responsibilities include:

- agreeing the audit brief;
- providing management responses to our recommendations; and
- overseeing the implementation of

Audit meetings

Planning meeting: held during the planning phase to identify and agree the audit scope and timing, etc.

Kick-off meeting: usually held at the beginning of the fieldwork phase, we use this meeting to get a detailed understanding of the system under review.

Debrief meeting: at the end of the audit, we will meet with key individuals to debrief on our findings.

Assurance opinion

Our overall view of whether, for the system being audited:

- the controls have been adequately design to mitigate identified risks; and
- the controls are operating effectively (i.e., are being adhered to) in practice.

Our assurance opinions are defined [here](#).

Operating Effectiveness recommendation

These recommendations relate to where we have identified non-compliances within the system, e.g., policies and procedures have not been followed.

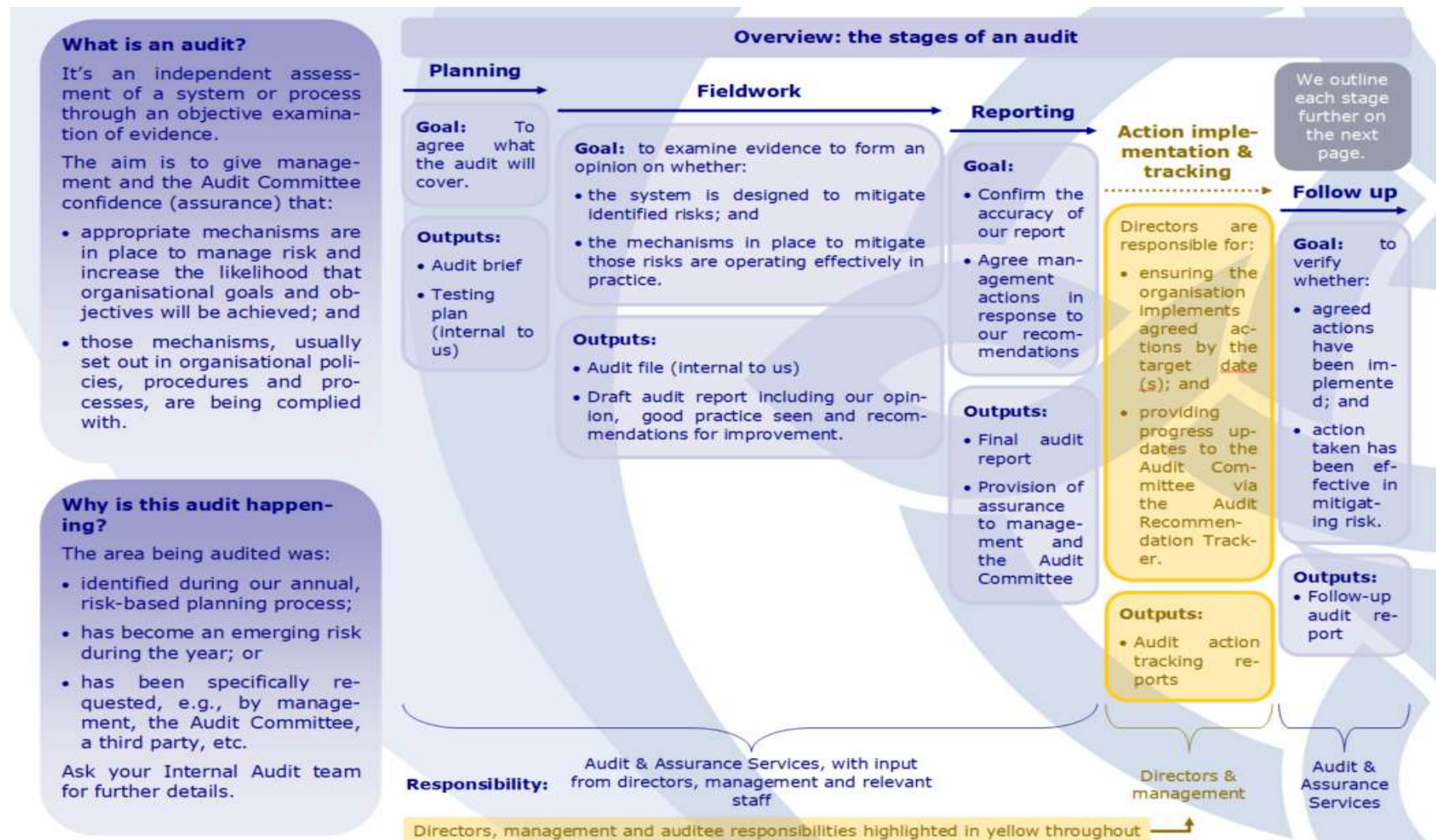
Audit Report

Sets out our audit findings, including good practice identified, recommendations for improvement and management responses.

Your key contacts

Head of Internal Audit: Stephen Chaney Deputy Head of Internal Audit: Eifion Jones

Annex 3: Internal Audit Guidance Infographic



Why am I being asked questions and for evidence?

The new Global Internal Audit Standards require that we must identify sufficient, reliable, relevant and useful information to achieve the objectives of the audit. To do this, we:

- require robust audit evidence to be provided in a timely manner; and
- must critically examine this evidence.

We then may need to:

- ask further questions to clarify our understanding or verify the robustness of the evidence; or
- request further evidence to ensure the above requirements are met.

Why is there sometimes a delay between the fieldwork ending and draft report being issue ?

Our fieldwork must be clearly documented to evidence our work. This, along with drafting reports, can take time.

Additionally, all audit work and reports are reviewed by a senior member of our team to ensure our quality standards are met.

Planning stage



Fieldwork stage



Reporting stage



Action tracking & implementation



Follow-up audits

What we do for each audit:

- Meet with management to identify and agree the audit scope—this is set out in the audit brief.
- Understand the risks relating to the area under review and the systems in place, e.g., through review of policies and procedures, understanding relevant laws, regulations and good practice, considering similar audits done at other Welsh health bodies, etc.
- Identify mechanisms in place (a.k.a., controls) that mitigate identified risks and develop a plan to test these.

What we do for each audit:

- Meet with management and operational staff (a.k.a., the kick-off meeting) to verify our understanding and gain further detail on the system under review.
- Consider whether the system is adequately designed to mitigate identified risks.
- Request and critically examine audit evidence to test whether the identified controls are being operated in practice; depending on the audit, this may include reports, meeting agendas and minutes, evidence of approvals, patient or staff records, etc.
- Address queries arising from our examination of the audit evidence through discussions with management / operational staff and / or requesting and examining further audit evidence.
- Discuss our initial findings with management before writing our draft report.

What we do for each audit:

- Issue our draft report and hold a meeting (a.k.a., the debrief meeting) with directors, management and / or operational staff to formally discuss our findings.
- Confirm the accuracy of our report.
- Agree management actions to address our recommendations (a.k.a., the management response), including responsible individuals and deadlines.
- Issue our final report to management and present this at the next Audit Committee meeting.

What the organisation must do for all actions:

- Add our recommendations and agreed management actions to the organisation's Recommendation (or Action) Tracker.
- Implement the agreed actions and provide regular progress updates on implementation status to the Audit Committee via the Recommendation Tracker.

What we do annually:

- Examine evidence to verify the implementation status of agreed actions and benefits realised for a defined sample of previous reports and / or recommendations.
- Report our follow-up findings to the Audit Committee.

What governs our work?

The new Global Internal Audit Standards (GIAS).

Internal Audit Charter—approved annually by the Audit Committee

Quality Manual and Consulting Protocol—our internal procedures setting out how we carry our work and comply with the GIAS.

Quality assurance

All audit work and reports are internally reviewed by a senior team member to ensure:

- work has been undertaken to an appropriate standard; and
- the opinion provided is consistent with the audit evidence.

Reports are also reviewed by the Head of Internal Audit to ensure alignment with our understanding of the wider organisation.

Additionally, we have:

- an Annual Quality Assurance and Improvement Programme undertaken by the Director of Audit & Assurance to confirm compliance with the GIAS and identify improvements;
- an annual assessment by Audit Wales; and
- a five-yearly External Quality Assessment (EQA) providing independent assurance over GIAS compliance.

What up can expect: we will:

- agree clear communication lines / methods;
- be clear in our requests to you;
- agree clear timeframes and deadlines for our work;
- be available to answer any queries or concerns you may have at any point in the audit;
- keep you up to date on our progress and findings throughout the audit; and
- be understanding of your workload, service pressures, team absences, etc.

What to expect and what's expected

What's expected of you as an auditee: we need you to:

- cooperate and be open and honest with the audit team;
- clearly explain the process and / or system being audited;
- provide audit evidence requested and respond to auditor queries throughout the audit in a timely manner; and
- communicate challenges in providing information and / or pressures within your team.

What's expected of you as a senior manager (director, head of service, etc) of an area being audited: we need you to:

- ensure all relevant individuals (including any not in your team) are aware the audit is taking place, including sharing the brief with them;
- provide us with the contact details for everyone involved in the system / process being audited, even if from a different team or division
- support and empower your team to provide all requested audit evidence in a timely manner; and
- communicate any issues to us which may impact on the audit, e.g., service pressures, known leave, availability of staff, difficulties around availability of /access to information, etc.

Timelines and key performance indicators (agreed via the Internal Audit Charter)

Audit Committee reporting: the Audit Committee we intend to report the audit to is agreed during the audit planning phase and is set out in the Audit Brief.

The timeframe for the audit will revolve around the Audit Committee papers deadline, which is usually **two weeks** before the date of the Audit Committee.

We need to have issued our final report by the Audit Committee papers deadline, considering the three key performance indicators identified to the right.

If necessary, we can agree shorter report turnaround periods with management.

Draft report: we aim to issue our draft report within **10 working days** of completing the fieldwork.

Management response: we ask that management responses to audit recommendations in the draft report are provided within **15 working days** of the draft report being issued.

Final report: we aim to issue our final report within **10 working days** of receipt of the management responses.

Annex 4: Audit Assurance Ratings

Internal Audit 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.
	Unsatisfactory 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.

Annex 5: Prioritisation of Recommendations

In order to assist management in using internal audit reports, they are categorised according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*

*Unless a more appropriate timescale is identified/agreed at the assignment

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2025

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

2. Progress against 2024/25 and 2025/26 Internal Audit Plans

3. Summary of Findings for Recently Completed Work

4. Audit for Deferral

5. Summary of Audit Briefs Recently issued

6. Recommendation

Appendix A: Progress against 2025/26 Internal Audit Plan

Appendix B: Audit Assurance Ratings

Appendix C: Audit / Review Briefs Issued

3

3

4

6

7

7

8

9

10

1. Introduction

The purpose of this report is to:

- confirm the status of the remaining audit work for the 2024/25 and 2025/26 Internal Audit Plans for Aneurin Bevan University Health Board (the 'Health Board') to the September 2025 Audit, Risk and Assurance Committee (the 'Committee');
- seek approval to defer the Falls Management audit to quarter four to allow the revised policy to be ratified, adopted and embedded; and
- provide details (with attached copies) of audit briefs for information purposes to the Committee.

2. Progress against 2024/25 and 2025/26 Internal Audit Plans

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 24th June 2025, which now concludes the remaining reports agreed from the 2024/25 Internal Audit Plan:

AUDIT ASSIGNMENT	ASSURANCE RATING
Health & Safety Management	Limited
Medical Equipment & Devices	Reasonable
Newport East Health & Wellbeing Centre	Reasonable
Electronic Document and Records Management Solution	Reasonable
Waiting List Management (b/fwd from 2024/25)	Reasonable
Financial Sustainability (b/fwd from 2024/25)	Reasonable

Further information over the assurance rating detailed above is included within Appendix B.

The current position of the 2025/26 Internal Audit Plan is summarised below, with further detail within Appendix A.

Audit Status	Number
Final reports	2
Draft reports	0
Work in Progress	9
Planning	2
Not started	17
Total number of audits planned	30

3. Summary of Findings for Recently Completed Work

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main conclusions from the reports issued since the last meeting on 24th June 2025.

Health & Safety Management (limited assurance)

The audit sought to gain assurance that key health and safety risks were managed in accordance with the Health Board's policies and procedures.

The audit identified several areas of progress, including an increase in inspections, more risks being identified and reported, greater utilisation of the Audit Management and Tracking Tool (AMaT) for monitoring actions, and improved compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements.

However, gaps remain, indicating that some systems and processes are not yet fully embedded. Issues for management consideration include:

- Ratification of the comprehensive Health and Safety Policy, which has been in draft since September 2024 and is undergoing further review.
- Review and approval of 13 health and safety policies, six of which have recently been submitted for ratification.
- Updating the internal register of legislative and statutory requirements.
- Closing overdue health and safety risks and actions in a timely manner within Datix and the AMaT tool.
- Ensuring reporting aligns with RIDDOR requirements.
- While regular updates were observed at operational forums, committees, and Board level, there was no evidence of further escalation or accountability for ongoing issues.

Medical Equipment & Devices (reasonable assurance)

The audit assessed the controls in place for the management of a sample of medical equipment and devices within the Health Board. Generally, good arrangements were observed, however a small number of issues require management attention:

- from a sample of 20 equipment items, four patient monitoring units could not be located and physically verified;
- the centralised equipment inventory system (MEDUSA) did not have a record of equipment service/ maintenance contracts where they are owner held;
- current owner held service contract documentation could not be traced for this cohort of equipment in the audit sample; and

- valuable oversight work provided by the Health Board's Medical Devices Committee ceased before the beginning of 2024/25, pending re-definition of its scope.

Newport East Health & Wellbeing Centre (reasonable assurance)

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

The audit identified strong arrangements in each objective area tested, with particularly comprehensive arrangements in respect of the equipping of the facility and preparation of the final account. The main points requiring management attention were:

- **Benefits Realisation:** Key to post project review is assessment of benefits realisation. At the time of approval of the business case the benefits realisation model remained to be fully developed, notably in respect of baseline definition and measurements. Accordingly, the Health Board will need to review the completeness of the benefits realisation model at the business case prior to undertaking the post-completion project evaluation.
- **Contracts & Service Level Agreements:** The Health Board interests should be safeguarded by formal contracts and Service Level Agreements to assure costs and benefits. At the time of the audit, there was a need to conclude and confirm lease and SLA arrangements at all three surgeries.
- **Disposals:** three of four premises identified for demolition/ disposal at the business case remained in situ at the time of the audit – accordingly associated savings had not been accrued; and
- **Revenue funding:** to confirm occupancy, revenue costs and their ongoing affordability, given the anticipated increase in both at the time of commissioning.

Waiting List Management (reasonable assurance)

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

The assurance assessment does not evaluate performance against targets, as these can be affected by factors like policy or resource prioritisation. Expectations were clearly documented and reporting was robust, management should therefore focus on enhancing performance management, especially in the following areas:

- **Incremental targets:** Whilst overall targets have been set, incremental targets should be agreed to assist staged achievement.
- **Action tracking:** A formal rolling action plan should be fully maintained with SMART actions.

- **Recorded actions:** To ensure the action plan is comprehensive, it should be updated to record the recent initiatives/ actions to date and their impact. This will then act as a single log of activities.

Electronic Document and Records Management Solution (reasonable assurance)

The review focused on the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services within the Health Board. The key matters for management to consider were:

- **Digital forms:** The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.
- **Updates:** The Health Board is using an outdated, unsupported version of cCube due to a lack of upgrades, which prevents modern functionality and interoperability with other clinical systems. This limits the system's evolution and its compatibility with current digital infrastructure.
- **Patching:** The host server is now unsupported and exposed to known security vulnerabilities.

Financial Sustainability (reasonable assurance)

The review focussed on the framework for managing recovery plans to assist with achieving a sustainable financial position, including the impact of any associated reduction in non-recurrent funding.

In 2024/25, the Health Board used a multi-stage budget approach, allocating funds to divisions and supplementing them based on savings and cost pressures. Key efficiencies were achieved through workforce optimisation, medicines management, service redesign, and data tools. The Value and Sustainability Board regularly monitored savings across categories and ensured targets were met. Welsh Government provided £40.5m in extra funding, reducing the deficit to £7.356m. Financial monitoring was continuous, with divisional and executive oversight, active risk management, and regular reporting to the Welsh Government.

The matters requiring management attention include:

- Gaps in the highlight reporting by the Value and Sustainability Board category leads to the Executive Team meetings; and
- Outstanding actions logged to address issues contributing to the underperformance of savings schemes.

4. Audit for Deferral

During discussion to agree the Falls Management draft audit brief, management outlined that a revised falls policy was in the process of being ratified and

subsequently requested that the audit is deferred into quarter 4 to allow the document to be published and embedded with ward staff. From our perspective we can accommodate the change, however we request that the Committee **consider** this position and if agreed provide **approval** to defer the audit into quarter 4.

5. Summary of Audit Briefs Recently issued

A summary of the briefs issued is provided within Appendix C, with copies of the final audit briefs included for information.

6. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and **approve** the deferral of the Falls Management audit to quarter 4.

Appendix A: Progress against 2025/26 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Planning for Q3
2. Standing Orders Compliance		Planning Complete
3. Strategic Risk and Assurance		Planning for Q4
4. Subject Access Requests		Work in Progress
5. Benefits Realisation (excluding digital)		Planning for Q3
6. Business Continuity Plan		Work in Progress
7. Capital Projects: Service Readiness		Planning for Q2
8. Falls Management		Deferment to Q4
9. Directorate Review - CAMHS		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		Work in Progress
14. Six Goals Programme		Planning for Q3
15. Discharge Planning		Planning for Q4
16. Safeguarding		Work in Progress
17. Cancer Referral Rates		Planning for Q4
18. Occupational Health		Planning for Q4
19. Overseas Recruitment		Planning for Q4
20. Speaking up Safely		Work in Progress
21. Follow-up of High Priority Recommendations		Planning for Q4
22. Cyber Security (Including cyber incident response)		Work in Progress
23. Shadow IT		Planning for Q2
24. Welsh Intensive Care Information System		Planning for Q2
25. RGH Central Decontamination Unit (capital systems from 2024/25)		Work in Progress
26. Estates Assurance – Space Utilisation		Planning Complete
27. Financial Sustainability (b/fwd from 2024/25)	Reasonable	Final Report
28. Waiting List Management (b/fwd from 2024/25)	Reasonable	Final Report
29. The Grange Emergency Department		Work in Progress
30. NHH Regional Satellite Centre (deferred from 2024/25)		Work in Progress

Appendix B: Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Appendix C: Audit / Review Briefs Issued

Audit Title	Status	Outline Scope
GUH – Emergency Dept Extension	Brief agreed	The audit will review the arrangements in place to progress the extension of the Grange University Hospital Emergency Department.
NHH Regional Satellite Centre	Brief agreed	The audit will focus on the delivery and management arrangements established by the Health Board and Velindre University NHS Trust to progress the development of the Radiotherapy Satellite Centre at Nevill Hall Hospital.
Cyber Security	Brief agreed	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
Shadow IT	Brief agreed	A review of the arrangements to manage shadow IT i.e. the use of IT assets (hardware, software, applications, services, and data) within an organisation without the explicit knowledge or approval of the central IT department.
WICIS	Brief agreed	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	Brief agreed	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	Brief agreed	To ensure key policies and procedures are embedded and adhere to safeguarding regulations.
Subject Access Requests	Brief agreed	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.
Business Continuity	Brief agreed	The audit will examine and assess the adequacy and completeness of business continuity plans and response protocols in a sample of the services of the health board's divisions as a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004).
Public Health	Draft brief issued	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.
Speaking-up Safely	Draft brief issued	The audit will provide an updated position on the prior audit completed issued in April 2025 that provided Limited assurance – recognising that a revised process was introduced in December 2024.
Falls Management	Draft brief issued and deferment requested	To review the arrangements in place for the prevention of falls, and effective management of patients following a fall.

Health and Safety

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Limited Assurance

Contents

Executive Summary	1
At a Glance	3
Findings & Agreed Action Plan	4
Appendix A	17

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2425-12b

April - May 2025

August 2025

September 2025

Peter Carr, Executive Director of Allied Health Professions (AHPs) & Health Science

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

To review how key health and safety risks were managed in accordance with the Health Board’s policies and procedures, including RIDDOR reporting.

Overview

This audit follows a pre-audit conducted in December 2024, which provided a high-level review of health and safety arrangements within Aneurin Bevan University Health Board (the ‘Health Board’). The initial assessment involved a walkthrough of processes, policy and document reviews, enquiries, and limited sample testing. The pre-audit identified concerns including unratified health and safety policies, unresolved overdue risks, inconsistent RIDDOR reporting in terms of timescales, and inadequate escalation of long-standing risks.

This audit revisited those areas and found some improvements, notably more inspections were undertaken, more risks were identified/ reported, increased use of Audit Management and tracking Tool (AMaT) to track actions and improved compliance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) requirements – see ‘At a Glance’ for further details.

Despite these improvements, significant gaps remained, reflective of systems and processes not being fully embedded; similarly, compliance for completing risk assessments, implementing agreed actions and RIDDOR reporting required further attention and focus. Accordingly, we have concluded **limited** assurance on this area. The matters requiring management attention include:

- The ratification of the comprehensive Health and Safety Policy, which has been in draft since September 2024 and has undergone multiple levels of review and scrutiny.
- 13 health and safety policies required review and ratification (six of these policies had recently been submitted for ratification).
- The internal register for legislative and statutory requirements needing a review and update.
- Overdue health and safety risks and actions were not closed off in a timely manner on Datix or the (AMaT) tool.
- Issues were not being reported in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- Whilst regular health and safety updates were observed to operational forums, committees and Board level, further escalation and accountability for long-standing issues were not observed.

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

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	The Health Board has an up-to-date health and safety policy that sets out clear direction, statutory requirements and key responsibilities	1,2	Reasonable
2	Mechanisms were in place to ensure compliance with health and safety legislation, including workplace risk assessments, routine workplace inspections and other relevant requirements	3,4,5	Limited
3	There was a process for Reporting of injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and were regularly monitored, and any associated management actions were implemented	6	Limited
4	Health and safety risks were monitored at Committee level and significant issues escalated and reported to Board when necessary	7	Reasonable

Management Actions

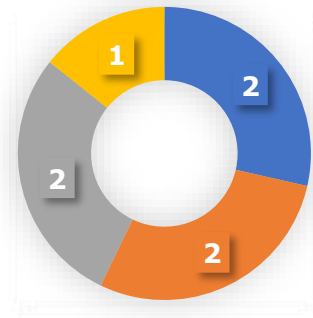


High Priority



Medium Priority

Themes



- Policies & Procedures
- Quality, Safety & Patient Experience
- Governance
- Reporting

Risk Types

Financial Loss
Legal & Regulatory Non-Compliance
Quality or Safety Issues
Public Perception & Reputational Risk

At a Glance

Risk Assessments

Health & Safety Risk Assessments are a requirement of the Management of Health and Safety at Work Regulations 1999 and are a systematic process of identifying potential hazards and risks in the workplace and developing strategies to minimize or eliminate them. To improve quality and compliance, the Health and Safety team had developed risk assessment guidance, a workbook and training available to help staff carry out risk assessments.

The quantum/ proportion of risk assessment outstanding or requiring re-assessment were not reported internally or provided during the audit; although it was reported that 256 risk assessments were conducted in 2024/25.

Workplace Inspections

Workplace inspections are undertaken to prevent work related accidents and ill health by identifying new hazards and checking preventative measures are implemented and effective. Inspection forms had been developed to standardise the approach and to maintain quality.

A rolling plan for inspections had been introduced looking at three key risk areas:

Financial Year	Focus	Total Areas Inspected	Area Inspections by Hospital					
			GUH	YAB	YYF	Royal Gwent	Nevill Hall	Other
2023/24	Acute Inpatient Areas	56	16	0	9	21	10	-
2024/25	Community and Mental Health Inpatient Areas	64	9	7	5	12	7	24
2025/26	Health Centres and Clinics	TBD	-	-	-	-	-	-

These inspections were then uploaded onto the Audit Management and Tracking (AMaT) tool. This tool captured compliance levels, RAG-rated actions, and associated action plans.

Consideration is currently being given to the frequency of re-inspection, which may be based on risk score. Further improvements are also being considered for the inspection approach, which may be widened to cover wider health and safety management arrangements.

From the 64 inspections undertaken in 2024/25 overall compliance was noted at 89.6%.

RIDDOR

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) is a UK health and safety law that requires employers and those in control of work premises to report certain workplace incidents. Specifically, it mandates reporting of work-related deaths, specified serious injuries, certain occupational diseases, and dangerous occurrences.

In 2022/23, compliance against RIDDOR requirements stood at 49.9%. The updating of the standard operating procedure, the introduction of RIDDOR awareness training and the establishment of a RIDDOR compliance dashboard has seen compliance increase to 67.7% for 2023/24 and 86.4% in January 2025. Future internal reporting of RIDDOR will also include detail the timelines where incident reporting requirements are missed.

Training and Development

Health and safety awareness training had improved from 82% in 2022/23 to 87% in 2023/24, exceeding the Welsh Government target of 85% for mandatory training.

Findings & Agreed Action Plan

Objective 1: Health and Safety Policy sets out clear direction and outlines statutory requirements and key responsibilities

Reasonable

Overview / Summary of Observations

The overarching Health and Safety Policy (the 'Policy') was under review and progressing through the Health Board ratification process (having been due for review in March 2022).

This refreshed version complied with the Health and Safety Act, statutory requirements, and clearly outlined key responsibilities. It had been benchmarked against policies from other NHS organisations to ensure alignment with best practices. It had also undergone scrutiny, and staff were already working in accordance with its principles.

Of the 19 health and safety policies available on SharePoint, 13 were overdue for review, and three were no longer required. Six out of the 13 policies were recently presented to the Health and Safety Committee and were awaiting a final approval.

Key Findings		Risk & Impact	Agreed Management Action
1	Overarching Health and Safety Policy The overarching Health and Safety Policy was still in draft and waiting for approval, having originally been drafted in September 2024. The Policy had gone through multiple reviews and scrutiny but has not yet been approved and ratified.	Health Board staff not adhering to the correct overarching Health and Safety Policy resulting in patient / staff harm.	Agreed Action: The Health and Safety Policy has been reviewed and shared with Executive Directors and key stakeholders for comment. Feedback received was constructive and has been used to strengthen the current iteration of the Policy. The policy is scheduled for formal ratification at the Health and Safety Committee on 23 rd September 2025. It is scheduled to be presented to the Workforce and Organisational Development (OD) Policy Group in September 2025 to ensure staff engagement.
			Expected Evidence of Implementation: - Health and Safety Policy - Health and Safety Committee Notes of formal ratification - Published to the staff intranet AB Pulse and Health Board website
		Medium Priority	Officer: Executive Director of Allied Health Professions & Health Science Implemented by: Head of Health, Safety & Fire Target Implementation Date: 30 September 2025
Theme: Policies & Procedures		Control Design	

2	Health and Safety Policies Out of 19 applicable policies: 13 policies were overdue for review. - Three policies were no longer needed. - The remaining three policies had recently been reviewed. Six out of the 13 policies were waiting for final sign-off having been through the Health and Safety Committee.	Policies not being up to date resulting in staff not being aware of the correct procedures resulting in patient / staff harm	Agreed Action: A plan has been developed to review and update all organisational health and safety policies by end of December 2025. Compliance with health and safety policies will be monitored via the Health and Safety Committee to ensure they are reviewed and have timely assessment.
		Medium Priority	Expected Evidence of Implementation: - Health and Safety Policies Register - Minutes from Health and Safety Committee formally ratifying policies - Policies on AB Pulse being current and in date
	Theme: Policies & Procedures	Control Design	Officer: Executive Director of Allied Health Professions & Health Science Implemented by: Head of Health, Safety & Fire Target Implementation Date: 31 December 2025

Overview / Summary of Observations

There was a register in place for all legislative and statutory requirements pertinent to the Health Board. This was outdated and required a review to ensure all applicable requirements were captured. Without this, there is a risk that key obligations may be missed, unrecorded, or not properly communicated to staff. It was noted that this action (H&S WP 25-26 079) was detailed on the Health and Safety Work Plan for 25-26 which was presented to the Health and Safety Committee and Executive Committee. At the time of this audit, work on this high priority action had not yet commenced, despite a target date of completion for the end of May 2025.

Risk assessment guidance, a workbook and training had been developed by the available Health and Safety team to support staff in carrying out risk assessments. Health Board staff were expected to take ownership of risk assessments and complete them as they arose within their respective wards or areas. Details on the number of risk assessments outstanding or requiring re-assessment were not provided and/or reported internally.

According to the Health and Safety Committee papers from April 2025, the number of risks recorded on DatixWeb increased from 1,697 in September 2024 to 1,878 in April 2025. Of those risks identified, 807 or 43% remain outstanding / not closed off as at April 2025.

From a sample of 15 risk assessments from the Risk Register on DatixWeb, it was found that risks were not always fully documented, particularly regarding the target risk score. Additionally, many risks remained not closed off and subsequently passed their scheduled "Next Review" dates. There was also a medium-rated action on the workplan (H&S WP 25-26 031) related to reviewing risk assessors across the Health Board and conducting a gap analysis, with a target completion date of June 2025.

Workplace inspections are undertaken to prevent work related accidents and ill health by identifying new hazards and ensuring preventative measures are implemented and effective. A proforma had been developed to standardise the approach to inspections and the results are uploaded onto the Audit Management and Tracking (AMaT) tool. This tool captured compliance levels, RAG-rated actions, and associated action plans.

In 2024/25, a total of 64 inspections were completed. Evidence showed follow-up discussions were held between health and safety advisors and the responsible managers regarding overdue actions. A review of 15 inspections revealed 213 actions raised, of which 124 were overdue including some from late 2024 and early 2025. Although the Health and Safety team has clear guidance on action deadlines (red = 1 week, amber = 4 weeks, green = 8 weeks), these timeframes were not consistently followed. We were informed that AMaT provides a weekly reminder to responsible officers, when risks are overdue. However, these still remain overdue.

It was evident overdue risks and actions were not always closed off appropriately, focus is required here and escalation to relevant divisional triumvirates to ensure progress is made.

Key Findings		Risk & Impact	Agreed Management Action
3	Record of Legislative and Statutory Requirements There was an electronic Health and Safety Legislative & Statutory Register for all relevant requirements, but this was out of date and should be reviewed.	Updated legislative and statutory requirements are	Agreed Action: The Health and Safety Legislative & Statutory Register has been reviewed and updated. The revised register will be presented at the next Health and Safety Committee in September 2025.

	The Health and Safety and Fire Work Plan 25-26 (H&S WP 25-26 -079) included a corresponding high priority action (with a target date of 31 May 2025) to address this, but work had not commenced at the time of the audit.	not communicated effectively.	The Health and Safety Legislative & Statutory Register will be reviewed annually via the Health and Safety Committee to ensure it is appropriately maintained. Health and safety performance has been and will continue to be regularly reported to the Executive Committee.
		Medium Priority	Expected Evidence of Implementation: • Health and Safety Legislative & Statutory Register • Health and Safety Committee Notes of September 2025 meeting
	Theme: Governance	Control Design	Officer: Executive Director of Allied Health Professions & Health Science Implemented by: Head of Health, Safety & Fire Target Implementation Date: 30 September 2025
4	Risk Assessments Of the 1,878 reported risks, the areas where the highest risks were overdue were: • 142 in Corporate Services. • 123 in Estates. A sample of 15 risks (relating to COSHH - 9, Sharps - 4 and Health & Safety – 2) was taken from the Datix Report from the Risk Register and the following was observed: • 13 risks were not completed fully (e.g. target risk scores and target risk levels were not completed). • Seven risks were outstanding and past their "Next review date" and two risks were close to their "Next review date" (end of May 2025) and outstanding. • One high risk was identified in July 2023 and now passed its "Next review date" of April 2025 and is still outstanding. • Two low risks were given the status of "new risk" but were raised in March 2024, so should have the status of "current risk" and both have passed their "Next review date" of September 2024 and are outstanding. Eight risks raised between 2010 and 2023 were still classed as "current risks". These should have been closed or more detail added to explain the current position,	Identified risks are not addressed in a timely manner.	Agreed Action: A comprehensive review of all health and safety risks recorded within the DatixWeb system will be undertaken by the Corporate Health and Safety Team during Quarter 2 of 2025/26. The findings will be presented to the Health and Safety Committee in September 2025 to inform ongoing assurance and improvement activity. To ensure divisional accountability, each division is responsible for actively managing its health and safety risks, including timely review and appropriate mitigation. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure health and safety compliance remains a key objective and focus: • Health and safety risk management forms part of Divisional Directors' annual appraisals; • It is discussed during regular 1:1 meetings' with Executive Directors;

including mitigating actions that have taken place in the meantime.	High Priority	• Relevant expectations are reflected in divisional performance objectives and monitored through existing governance mechanisms. The Corporate Health and Safety Team will monitor compliance by: • Reviewing risk entries for accuracy, consistency, and review status; • Identifying overdue or unmanaged risks and escalating these as required; • Providing targeted support or intervention where performance concerns are identified. Health and safety risk performance is reported regularly through: • Divisional Quality & Patient Safety Meetings (as a standing agenda item); • Divisional Assurance Reviews; • The Health and Safety Operational Group, which monitors divisional performance and escalates concerns to the Health and Safety Committee. Additionally, the Executive Director for Allied Health Professions and Health Science will engage monthly with Divisional Directors to review and communicate health and safety performance, reinforcing accountability and promoting continuous improvement. In addition, compliance with risk assessments is captured in the Quality Outcomes Framework (QOF) metrics. Expected Evidence of Implementation: • Review of Health and Safety Risks Report • Health and Safety Committee Notes of September 2025 meeting • Health and Safety Operational Group Notes of September 2025 meeting • Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings Officer: Executive Director of Allied Health Professions & Health Science

	Theme: Quality, Safety & Patient Experience	Control Operation	Implemented by: Head of Health, Safety & Fire Target Implementation Date: 31 October 2025
5	Workplace Inspections A sample of 15 inspections conducted in 2024/25 were reviewed from the Health and Safety Dashboard. From the 213 actions raised: 70 were fully complete. 19 partially complete (overdue). 124 overdue actions (57 RAG rated amber and two RAG rated red). Of the 15 inspections, eight were completed between October and December 2024 and included 76 of the actions highlighted above. Whilst three of the inspections tested detailed compliance below 90%, AMaT did not include corresponding actions (for example, one of the inspections included an action that was RAG rated red). Discrepancies on the Dashboard could result in actions being missed resulting in significant patient or staff harm. Having been informed of this issue, management advised they were in the process of reviewing and actively addressing this matter. Further consideration should be given to reporting to an appropriate forum those areas that are not planned to be routinely covered by inspections – and the associated rationale/risks.	Key risk issues are not tracked to ensure timely/appropriate remedial action.	Agreed Action: To ensure divisional accountability, all divisions are responsible for ensuring that actions arising from workplace health and safety inspections are managed appropriately, including timely review and closure. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure health and safety compliance remains a key objective and focus: - Health and safety risk management forms part of Divisional Directors' annual appraisals; - It is discussed during regular 1:1 meetings' with Executive Directors; - Relevant expectations are reflected in divisional performance objectives and monitored through existing governance mechanisms. The Corporate Health and Safety Team will oversee compliance and support continuous improvement by: - Reviewing DatixWeb entries for completeness, accuracy, and timely updates; - Identifying risks that are overdue for review or inadequately managed; - Providing targeted feedback and guidance to divisions on improving risk quality and compliance; - Following up on areas of concern and escalating persistent non-compliance through the governance structure where required. Health and safety risk performance will be monitored through the Health and Safety Operational Group, with trends, themes, and areas of non-compliance escalated to the Health and Safety Committee for strategic oversight.

		Divisions will be held accountable for ensuring that actions. To support a consistent and transparent approach, the Corporate Health and Safety Department will develop a formal procedure for the management, recording, and reporting of workplace inspections in Quarter 2 of 2025/26. Additionally, workplace health and safety inspections will be embedded within the Ward Accreditation Programme starting in Quarter 3 of 2025/26. A plan will be developed to ensure regular inspections are conducted across all areas, including non-clinical environments such as administrative offices. Compliance with actions arising from workplace inspections will be monitored through the Quality Outcomes Framework (QOF) metrics to support performance tracking and continuous improvement.
		Expected Evidence of Implementation: • Health and Safety Operational Group Notes of September 2025 meeting • Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings
		Officer: Executive Director of Allied Health Professions & Health Science Implemented by: Head of Health, Safety & Fire Target Implementation Date: 31 October 2025
Theme: Quality, Safety & Patient Experience		Control Design

Overview / Summary of Observations

Clear RIDDOR guidance was available via a standard operating procedure (SOP) on the Health and Safety SharePoint page, along with a RIDDOR dashboard aligned with Datix Cymru to help divisions monitor compliance.

Compliance has significantly improved from 49.9% in 2022/23 to 86.4% in January 2025. However, it remains below the 100% compliance expected. Failure to meet RIDDOR reporting timelines exposes the Health Board to potential enforcement action from the Health and Safety Executive (HSE). Responsibility for reporting incidents lies with divisional managers, but delays in reporting continue to impact compliance. A notable portion of reported incidents involved slips, trips, and falls. Managerial responsibilities are delegated to the Director of Therapies and Allied Healthcare Professionals, with ultimate accountability resting with its Chief Executive and Board.

RIDDOR data was regularly shared at operational forums, including Divisional Quality Patient Safety QPS groups, assurance meetings, the Health and Safety Committee, and the Patient Quality Safety Outcomes Committee (PQSOC). However, there was limited evidence of follow-up discussions focused on improving compliance.

Key Findings		Risk & Impact	Agreed Management Action
6	RIDDOR Reporting From the RIDDOR report for 2024/25 there were 73 incidents reported, of which 32 were categorised as 'slip, trip or fall'. The status of these was summarised as: 70 were closed. - Two were under management review / 'make it safe plus'. - One was awaiting closure. From the 11 incidents sample tested, seven were categorised as a 'slip, trip or fall' and the status of these were summarised as: - seven of the incidents were reported to the HSE within the RIDDOR timescale; but - four of the incidents were not reported to the HSE within the RIDDOR timescale. The main reason for non-adherence to the timeframe was because of late notification to the Corporate Health and Safety department.	Failure to comply with health and safety legislation resulting in financial penalties and reputational damage	Agreed Action: To ensure divisional accountability, all divisions will be held accountable for ensuring that all workplace incidents are reported and investigated promptly in line with legal requirements under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Timely reporting and investigation are critical to maintaining compliance and protecting staff and service users. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure RIDDOR reporting remains a key objective and focus: - RIDDOR compliance forms part of Divisional Directors' annual appraisals; - It is discussed during regular 1:1 meetings' with Executive Directors;

		• Relevant expectations are reflected in divisional performance objectives and monitored through existing governance mechanisms. To ensure accountability, the Corporate Health and Safety Team will: • Regularly audit incident reports for accuracy, timeliness, and compliance with RIDDOR criteria; • Identify and follow up on late, incomplete, or inaccurate reports; • Provide targeted feedback and support to divisions where issues are identified; • Escalate persistent non-compliance to the Health and Safety Operational Group and, if required, to the Health and Safety Committee. RIDDOR compliance is a standing agenda item at Divisional Quality & Patient Safety Meetings and is also reviewed as part of Divisional Assurance Reviews. Performance is monitored via the Health and Safety Operational Group, with significant issues escalated to the Health and Safety Committee for further action. The Corporate Health and Safety Department continues to deliver RIDDOR Awareness Training to relevant managers. To strengthen compliance, a proposal will be submitted to the Core Learning Committee recommending that RIDDOR training be made mandatory for all managers across the organisation. Compliance with RIDDOR requirements is tracked through the Quality Outcomes Framework (QOF), providing visibility of divisional performance and supporting continuous improvement. Expected Evidence of Implementation: • Health and Safety Operational Group Notes of September 2025 meeting • Health and Safety Committee Notes of the September 2025 meeting • Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings • RIDDOR Awareness Training data

		High Priority	Officer: Executive Director of Allied Health Professions & Health Science Implemented by: Head of Health, Safety & Fire Target Implementation Date: 30 November 2025
	Theme: Reporting	Control Operation	

Overview / Summary of Observations

A review of operational forums (Divisional QPS groups and assurance meetings), Committees (Health and Safety, Patient Quality Safety Outcomes), and Board papers was conducted to assess how health and safety risks were monitored at Committee and Board levels. It was evident detailed discussions took place in the form of updates but limited evidence of overdue risks and actions being resolved in a timely manner.

The Strategic Risk SRR010, which addresses the Health Board’s failure to protect staff, patients, and visitors in line with the Health and Safety at Work Act 1974, was recently reduced from a risk score of 16 to 12 following the implementation of improvement plans. However, this risk still exceeds the target score of eight and remains outside the acceptable threshold.

A deep-dive analysis would help identify the longest overdue risks and allow further investigations into key areas where risks remain unaddressed to understand the underlying issues.

Key Findings		Risk & Impact	Agreed Management Action
7	Monitoring Health and Safety Risks at Committee and Board level Regular reporting was observed at many different forums including Board, Committees and operational forums in the form of QPS groups and divisional assurance meetings. Discussion was observed regarding outstanding risks and their levels in operational forums but limited escalation of risks which have been outstanding for an extended period. In addition, the Strategic Risk SRR010 has been reduced from a risk score of 16 to 12. Whilst the current risk score exceeds the appetite level, the overall risk should be reviewed in light of the internal audit outcomes reported. In addition, a deep-dive analysis would help provide greater insights on overdue risks and underlying issues.	Outstanding risks and actions not escalated appropriately resulting in potential patient / staff harm.	Agreed Action: A full review of all health and safety risks recorded in the DatixWeb system will be undertaken by the Corporate Health and Safety Department in Quarter 2 of 2025/26. The outcomes of this review will be presented to the Health and Safety Committee in September 2025 to inform assurance and improvement activity. To ensure divisional accountability, all divisions are responsible for actively managing their health and safety risks — including ensuring timely review, accurate risk grading, and appropriate mitigation. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure health and safety compliance remains a key objective and focus: • Health and safety risk management forms part of Divisional Directors’ annual appraisals;

		• It is discussed during regular 1:1 meetings' with Executive Directors; • Relevant expectations are reflected in divisional performance objectives and monitored through existing governance mechanisms. The Corporate Health and Safety Team will oversee compliance and support continuous improvement by: • Reviewing DatixWeb entries for completeness, accuracy, and timely updates; • Identifying risks that are overdue for review or inadequately managed; • Providing targeted feedback and guidance to divisions on improving risk quality and compliance; • Following up on areas of concern and escalating persistent non-compliance through the governance structure where required. Health and safety risk performance will be monitored through the Health and Safety Operational Group, with trends, themes, and areas of non-compliance escalated to the Health and Safety Committee for strategic oversight. In addition, performance is routinely reviewed through Divisional Quality & Patient Safety Meetings and Divisional Assurance Reviews, where health and safety risk management is a standard reporting item. This integrated approach supports a consistent, transparent, and accountable framework for health and safety risk management, ensuring managers are both empowered and held responsible for maintaining safe environments across the organisation. In addition to the existing strategic risk (SRR 010), a corporate-level risk has been established and is owned by the Executive Committee. This risk is supported by a suite of risk assessments aligned to the Health and Safety at Work Act 1974, including Fire Safety and Workplace Inspections, Violence and Aggression, RIDDOR Reporting etc. These assessments will be reviewed through the appropriate governance structures reporting to the Health and Safety Committee.

			This structured approach ensures that individual risks are discussed in the correct forums, enabling consistent and targeted mitigation across all areas of the Health Board. It also supports sustained compliance and promotes a culture of safety for staff and service users. The corporate risk will contribute to the overall assessment of strategic risk SRR 010, providing a greater level of assurance and reinforcing that there is a Health Board-wide response and commitment to ensuring safe working environments.
			Expected Evidence of Implementation: • Review of Health and Safety Risks Report • Health and Safety Committee Notes of September 2025 meeting • Health and Safety Operational Group Notes of September 2025 meeting • Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings • Corporate Risk Register and risk assessments
		Medium Priority	Officer: Executive Director of Allied Health Professions & Health Science
Theme: Governance	Control Design		Implemented by: Head of Health, Safety & Fire Target Implementation Date: 31 December 2025

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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.



Medical Equipment & Devices

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	10

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2425-15

April - June 2025

30th July 2025

18th September 2025

Peter Carr, Director of Allied Health Professions (AHPs) & Health Science

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Chris Scott, Audit Manager

Executive Summary

Purpose

The review of Medical Equipment & Devices was completed in line with Aneurin Bevan University Health Board’s (the ‘Health Board’) 2024/2025 Internal Audit Plan. This audit assessed the controls in place for the management of a sample of medical equipment and devices within the Health Board.

The term medical device includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability but the scope of this audit was limited to electronic patient connected medical equipment, excluding ultrasound devices, which were the subject of a similar audit during 2023/24.

Overview

We have concluded **reasonable assurance** on this area, but recognise that risks still exist over the management of some medical devices. The area is governed by legislation and the audit observed compliance with sample elements of the Medicines & Health Care products Regulatory Agency (MHRA) Guidance for health and social care organisations January 2021 (the ‘Guidance’), Section 2: Systems of Management, notwithstanding matter arising four.

The matters requiring management attention include:

- from a sample of 20 equipment items, four patient monitoring units could not be located and physically verified;
- the centralised equipment inventory system (MEDUSA) did not have a record of equipment service/ maintenance contracts where they are owner held;
- current owner held service contract documentation could not be traced for this cohort of equipment in the audit sample; and
- valuable oversight work provided by the Health Board’s Medical Devices Committee ceased before the beginning of 2024/25, pending re-definition of its scope.

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

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Appropriate policies and procedures were in place for the management of medical equipment and devices, either within other Health Board policies or separately.	-	Substantial
2	There was an up-to-date inventory listing of medical equipment and devices (for example, RFID tagging or manual records), with location details recorded.	1	Reasonable
3	There was an established process and schedule to ensure medical equipment and devices were maintained and kept in an appropriate state of repair including the reporting of equipment incidents via Datix.	2, 3, 4	Limited

Management Actions

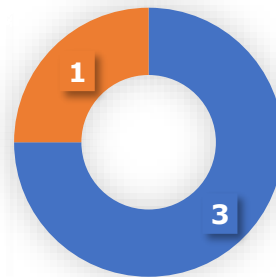


High Priority



Medium Priority

Themes



■ Quality, Safety & Patient Experience

■ Reporting

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: appropriate policies and procedures were in place for the management of medical equipment and devices, either within other Health Board policies or separately.

Substantial

Overview / Summary of Observations

We reviewed the Health Board's Medical Equipment & Devices (ME&D) Policy document against a generic checklist provided by the National Audit Office (NAO). Our finding was that the organisation has a comprehensive, compliant, in-date policy, procedure and process document (expires June 2025) for ME&D, which include the following elements (NAO good practice guidance, sections 1.3, 1.9):

- a. Aims and objectives.
- b. Applicability.
- c. Roles and responsibilities.
- d. Links to relevant organisational governing documents or policies where applicable, e.g., Standing Orders, Standing Financial Instructions, Scheme of Delegation, approval of orders above the Chief Executive's limit, etc. (NAO good practice 1.5).
- e. ME&D management approach, including:
 - o Use of ME&D inventories.
 - o ME&D service scheduling.
 - o ME&D item location.
- f. Resourcing.
- g. Training and development.
- h. Audit and review.

The ME&D policy was originally approved by the Clinical Standards and Policy Group in 2021 and was communicated to the organisation via designated intranet pages.

Overview / Summary of Observations

The Health Board observes the Medicines and Healthcare Products Regulatory Agency (MHRA) guideline on medical devices management and the audit tested compliance with its 'Managing Medical Devices' guidance document, in respect of systems for recording and managing the equipment it uses.

Medical devices were recorded and managed centrally in the 'MEDUSA' recording / management system. The Health Board's policy stated that records may also be maintained by the services/ sites using the equipment (e.g. local equipment registers).

The MEDUSA database records the location of equipment where it is first deployed. By design, this is not routinely updated to reflect physical location if items are moved over their lifespan.

A random sample of 20 equipment item records was taken from the MEDUSA database and assessed for accuracy, by physically locating the related equipment and confirming the accuracy of the item entries.

One of the items selected had been decommissioned but for the remaining 19, database details (e.g. description, serial number, RFID identification number) matched those of the physical equipment excepting four patient monitoring units that move with patients, but could not be located and physically verified (**Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	From a sample of 20 equipment items, four patient monitoring units which move around with patients could not be located and physically verified.	Equipment may not be easily tracked when required.	Agreed Action: A time limited working group will be established under the medical devices group to identify a solution for effective chain of custody monitoring. It must be recognised that there is no real time tracking solution established within the organisation and that RFID inert tracking system is currently utilised. An audit will be undertaken to establish baseline current state, including number of units within divisions, age of equipment and whether all units are RFID tagged and included on Medusa. This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation:

			- Written process for portable monitoring equipment chain of custody management - Audit outcomes - Documented monitoring and sign off within Medical Devices Group
		Medium Priority	Officer: Executive Director of Allied Health Professions (AHPs) & Health Science Chair of Medical Devices Group
	Theme: Quality, Safety & Patient Experience	Control Operation	Target Implementation Date: 31/03/26

Overview / Summary of Observations

(i) Equipment maintenance and repairs

Section 2.4 of the MHRA guideline for Managing Medical Devices provides an outline of good record keeping requirements for medical equipment and this includes references to a 'schedule and details of maintenance and repairs'. Three alternative approaches were observed by which service/ maintenance requirements were addressed:

1. EBME officers carry out service / maintenance/ repair work themselves (6 of 19 sample items);
2. EBME hold and manage service/ maintenance contracts with the equipment supplier or other provider (7 of 19 sample items); and
3. The clinical service who are the 'owners'/ users of the equipment arrange, are responsible for holding and managing service/ maintenance contracts with suppliers or other providers (6 of 19 sample items).

MEDUSA system modules (Work Orders, Planned Maintenance) were used to record the service/ maintenance work conducted under categories 1 and 2 above but where the clinical service managed this aspect, there were no records of service events generated or referenced within the central MEDUSA database (**Finding 2**). Rather, the clinical services are required to keep records and service/ maintenance schedules accordingly.

In the audit sample, EBME managed the service/ maintenance requirements of 13 of 19 items and appropriate records were provided to support all of these. For the remaining six, the service /maintenance of the equipment is under the control of the equipment user but we were unable to obtain records to evidence this was currently active in any of these cases (**Finding 3**).

(ii) Incidents involving medical equipment

We examined the management of incidents involving medical equipment by the Health Board and the role of the Medical Devices Committee (MDC). This committee provides structured oversight of incidents involving medical devices across the Health Board. A dedicated report, reviewed as a standing agenda item, supported this function by highlighting trends and outliers in incident data reported by staff through the DATIX system.

This retrospective review enabled the committee to monitor the effectiveness of risk control measures and identify emerging issues. When specific concerns were identified through trend analysis, they were escalated via divisional risk registers or through corporate and strategic risk management pathways, with expert input from the committee.

It is important to note that while DATIX incidents were addressed in the usual manner by designated incident owners, this operational response process was separate from the MDC's oversight role. The broader Health Board risk management process, which tracks and reports risk owner actions, operates independently and was outside the scope of this audit.

We noted, however, that MDC oversight activity lapsed some time ago pending a re-definition of its brief and the committee last met in October 2023. An annual report for the year 2023/24 was circulated in February 2025 containing information and statistics of a wide range of incident and safety related aspects but the committee has not been in operation during 2024/25 and as a result, during that period the Health Board has not benefitted from the valuable oversight it provides (**Finding 4**).

Accepting that addressing and closing these is not within the remit of the MDC, we obtained for the audit a report of moderate or greater harm rated incidents implicating medical equipment and devices across the Health Board for the year 2024/25 and noted that out of 60, eight of these remain open, the oldest of these dating from June 2024.

Key Findings	Risk & Impact	Agreed Management Action
2 MEDUSA system modules (Work Orders, Planned Maintenance) were used to record the service/ maintenance where arrangements were managed by EBME. However, where a clinical service user managed this aspect themselves, no records of service events appear in the MEDUSA database and therefore no oversight is operated by the centre.	Risk that items of equipment not covered by service or maintenance arrangements go undetected.	Agreed Action: Medusa maintenance tracking module or similar digital solution procurement will be explored by EBME and the estate & facilities division, to facilitate reconciliation of local electronic patient connected medical device management, with central oversight. Executive Director of Allied Health Professions and Health Science to communicate with divisions, highlighting divisional roles and responsibilities with respect to medical equipment management and adherence to organisational policies. Divisions should provide a mechanism for sharing access to this information to EBME for reconciliation audits to take place. Divisions will be expected to monitor progress through their divisional QPS meetings and provide assurance to the Medical Devices Group that inventory management processes are in place (this is also applicable to finding 3) This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation: - Implementation of digital solution that facilitates links between local and centrally held records - Divisions have mechanism in place to monitor asset management whether centrally held or through directorates - Small sample random equipment audit to ensure local and EBME records are accurately maintained - Documented monitoring and sign off within Medical Devices Group

		Medium Priority	Officer: Executive Director of Allied Health Professions (AHPs) & Health Science & Chair Medical Devices Group Target Implementation Date: 31/03/2026
	Theme: Quality, Safety & Patient Experience	Control Design	
3	From the sample, six cases identified that the equipment user was responsible for the service/ maintenance cover of the item, but we were unable to obtain any records to evidence this was currently active in any of these cases.	Risk that equipment is not maintained adequately and fails in use.	Agreed Action: Executive Director of Allied Health Professions and Health Science to communicate with divisions, highlighting divisional roles and responsibilities with respect to medical equipment management and adherence to organisational policies. Risk assessment to be undertaken with respect to equipment maintenance. This will be held on the medical devices group risk register with progress being monitored by the group through risk agenda item. Time limited multi-divisional working group to undertake work to establish: - Develop divisions of responsibility document – this will support understanding of who is responsible for what aspects of medical equipment management - Definitive list of patient-connected electronic medical devices that are in-scope - Current state baseline audit of in-scope equipment where equipment maintenance is service responsibility - Seek divisional assurance that identified equipment has adequate maintenance arrangements This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation: - Patient connected electronic medical devices division of responsibility document - Small sample random equipment audit to ensure maintenance management documentation is in place - Documented monitoring and sign off within Medical Devices Group - Reduction in equipment maintenance risk score from baseline

		High Priority	Officer: Executive Director of Allied Health Professions (AHPs) & Health Science & Chair Medical Devices Group Target Implementation Date: 31/03/2026
	Theme: Quality, Safety & Patient Experience	Control Operation	
4	Oversight monitoring of incidents that occur in the Health Board, involving the use of medical equipment or devices, ceased operating in 2023/24 pending re-definition of the remit of the Medical Devices Committee (which had previously fulfilled this control function).	Risk of reduced oversight of incidents involving the use of medical equipment or devices and non-adherence to section 2.2 of the Guidance.	Agreed Action: The Medical Devices Committee has been re-established under the new Quality Management System and is now referred to as the Medical Devices Group. Since the audit, the group has met twice and will continue to meet every two months. The group reports to the Executive-led Quality Management Group (QMG) for assurance purposes and will provide an annual activity report. The standard agenda for each meeting includes: • Review of incidents reported during the period • Trend analysis of medical device issues Updates on the procurement and decommissioning of medical devices Expected Evidence of Implementation: - Medical Devices Group Terms of Reference, Agenda and minutes/actions from meetings - Annual Activity Report
		Medium Priority	Officer: Executive Director of Allied Health Professions (AHPs) & Health Science & Chair Medical Devices Group Target Implementation Date: Implemented/Completed
	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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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 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 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.



Newport East Health & Wellbeing Centre

Final Internal Audit Report 2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	6
Appendix A	20

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

ABU-SSU-2425-28

March - May 2025

26 August 2025

18 September 2025

Executive Director of Public Health and
Strategic Partnerships

Executive Summary

Purpose

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

Overview

Reasonable assurance has been determined at this review.

The general aims of the project were to expand and coordinate local health and wellbeing provision within an approved capital funding envelope of £28.2m with an August 2024 targeted completion date. New, fit for purpose facilities have been delivered within 1.2% - 1.5% of its original cost parameters providing an expanded and integrated range of services. At the time of reporting, the new facility was planned to be fully operational as from 9th May 2025.

Approval of the business case was some 4 – 8 weeks later than anticipated. Construction originally targeted for completion in August 2024 was contractually extended to 13th January 2025 (at the time of prior audit). Partial occupancy by Ringland Surgery (one of the two GP practices) was achieved in January 2025. At the time of audit fieldwork (March – April 2025) full occupancy remained to be achieved and lease negotiations remained to be concluded with both Ringland Dental Surgery and Park Surgery. The Health Board advised that it was anticipated that these parties would occupy the building by the end of May 2025 with signed leases and agreed Service Level Agreements (SLAs) in place.

Matters requiring management attention included the need to confirm:

- baseline provision, appropriate occupancy, the intended range of services and associated benefits (compared to the original business case assumptions);
- appropriate contractual arrangements are fully applied;
- associated demolitions and sale of legacy premises; and
- the adequacy of revenue funding.

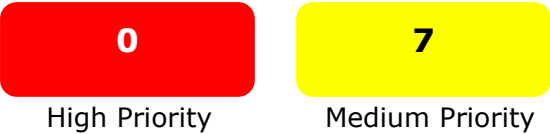
Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

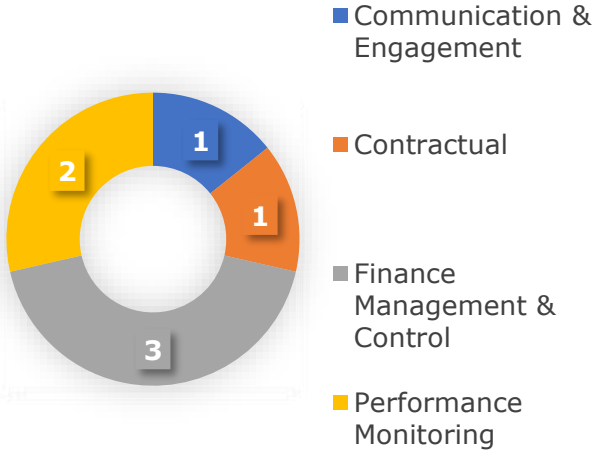
Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
2	Project Performance - Consideration of performance against project objectives (e.g., time, cost, quality, etc.) including assurance that both capital and revenue costs were appropriately funded.		1 - 3	Reasonable
2	Validation of Management Action - That previously agreed actions had been appropriately actioned by management (Appendix A).		-	Reasonable
3	Preparation of the final account - Assurance on the progressive agreement of the costs incurred to date (in accordance with the NEC Option C contract) in readiness for the agreement of the final account on completion.		-	Substantial
4	Equipping - Assurance that equipment requirements had been appropriately identified. The equipment budget was adequate and appropriately controlled. That a suitable programme was in place to afford time for procurement, delivery and installation. Procurement arrangements were managed in accordance with local and national requirements. Warranties / guarantees were appropriately obtained.		-	Substantial

5	Stakeholder engagement: - Assurance of appropriate stakeholder occupancy agreements and satisfaction with the delivered project as compared to agreed objectives and defined benefit measures.	4	Reasonable
6	Commissioning and Handover - To obtain assurance that an appropriate commissioning programme and schedule of activities had been applied in accordance with both contractual and UHB requirements; that the scheme was delivered in accordance with defined quality standards; arrangements were appropriately defined to manage testing, post completion, handover, and operational requirements.	5 - 7	Reasonable

Management Actions



Themes



Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance
- Quality or Safety Issues
- Public Perception & Reputational Risk

Newport East Health & Wellbeing Centre – At a Glance

The project aimed to deliver the co-location and increased collaboration of Ringland Medical Practice and Park Surgery, and to improve the integration of wider health and wellbeing services within the Newport East Neighbourhood Care Network. The new Health & Wellbeing Centre was therefore built alongside the existing Ringland Neighbourhood Hub to facilitate integration with social service provision. The project involved the demolition of the Ringland medical practice and re-provision of a multi-use games area on the site (£514k of the total cost). Three further legacy health premises were to be sold and services transferred (including a dentistry).

Cost

Welsh Government approved an overall funding envelope of £28.2m. Utilising financial reporting of 17th January 2025 the audit was able to confirm the following position (forecast to project conclusion):

Table 1

Item	Welsh Government Approval £	Forecast Expenditure £	Variance £	Notes
Design Fees	1,504,026	1,630,588	126,562	Design costs to full business case
Works	19,056,293	19,190,627	134,334	Contracted at a greater sum than budget
Works Compensation Events	-	831,151	831,151	Contract variations (additionally instructed works) Key variations have included: • £63k – delayed meter readings • £210k – inflationary uplifts • £141k – removal of asbestos from the existing health clinic & • £220k – road crossing (value potentially less - to be confirmed)
Health Board Internal Fees	802,584	922,545	119,961	Circa £88k of the increase relates to prolongation / administering Compensation Events, the remainder being due to accuracy of budget estimation.
Non-works cost	1,269,755	1,164,511	-105,244	Largely attributable to under-spends on surveys, art, and highway works
Equipment	542,134	542,134	0	
Contingency	601,986	17,777	-584,209	Remaining contingency
Remaining forecast	0	65,000	65,000	
VAT	4,422,852	4,169,426	-253,426	
Total	28,199,63	28,533,75	334,129	1.2% - Forecast over-spend based on known events
Remaining risk			74,423	Excess of remaining risk above remaining contingency

Potential liability (over-spend)			408,552	1.5% Possible overspend including remaining risk events

Management planned to finance the over-spend from discretionary capital allocations.

Time

As of January 2025, progress was reported as follows:

Table 2

Milestone	Business Case / Original target	Initially contracted date	Forecast/ Actual	Notes	Delay to contract (months)	Forecast / Actual delay to original target (months)
Welsh Government business case approval	31/03/22		03/05/2022			1 - 2
Start on site	30/04/22		20/06/2022			2.5
Construction completion	30/08/24	25/11/2024	28/02/2025	Ringland Surgery occupancy from 13/01/2025	3	6
Fully operational (including only NHS dentistry)	30/09/24		03/03/2025			5
Fully operational (incl. private dentistry) (as advised by the Health Board on 22 nd April 2025)	30/09/24		09/05/2025			8

Contract completion was extended agreed to 13th January 2025. Excepting two weeks non-working time (for extension of works over the Christmas period), thereafter the contactor was culpable for the remaining delay in construction (i.e., 6 weeks and 5 days).

Contract extensions were agreed as follows:

Table 3

Extensions of Time	Granted	Original / revised contract completion date
Original construction completion date	-	25 th November 2024
Additional asbestos works (from existing clinic)	3 weeks	16 th December 2024
Meter installation delays	4 weeks	13 th January 2025

Key inclusions planned for the development included:

- Park Surgery
- Ringland Surgery
- Ringland Dental Practice (separately both private and NHS provision)
- Health Board provided support health services / areas;
- a base for community health services;
- a community Hub Café supporting healthy eating; and
- integration with social support services in the adjacent Hub.

A community cafe was not provided and confirmation of social service integration remained to be assured. However, the remainder of these key provisions were provided / in process of confirmation at the time of concluding the audit.

Funding had also included:

- demolition of the Ringland health centre;
- re-provision of a multi-use games facility; and
- a carbon / heat efficient new build.

Supervisor's reports confirmed that, at the time of the audit, work was substantially complete. Minor works were concluding to enable full occupancy of parking areas. The Health Board had a full timetable for occupancy in the support areas, outlined at the business case, and the facility therefore fulfilled the broad aspiration of providing additional services in the community.

Findings & Agreed Action Plan

Objective 1: Project Performance

Reasonable

Overview / Summary of Observations

Cost

The project was forecast to deliver marginally outside its original cost parameters with a forecast over-spend (of £334k - £408k) to be financed from discretionary capital. While revenue and staffing costs remain to be fully confirmed, they have been estimated at £145k additional to budget, and circa £400k greater than the base (original) – “do nothing” position.

Of four premises identified for closure, excepting demolition of the Ringland practice (on the current site), the other three remain (impacting sale proceeds of circa £486k and associated reductions in backlog maintenance). The Health Board have advised that an on-going review of occupancy across the Health Board is now focussed on a reduction in leased premises and did not advise of any current plans to dispose of these buildings.

Time

The project was delivered eight months later than planned with 1 – 2 months being due to delayed funding approval, and two months contractually agreed for additional / unforeseen events. Circa 6 weeks and five days of the total was attributable to contractor delay. To expedite delivery, a phased opening was adopted with the Ringland practice and associated services operational from 13th January 2025. At the time of reporting, while Park Surgery were in process of relocation, lease negotiations remained on-going.

Quality

At the time of the audit fieldwork, the Supervisor’s reports confirmed effective delivery of the works.

As noted, (see *At a Glance*), the range of service provision had varied since the business case, notably associated integration with social services remained to be confirmed. Management have commented that this has been impacted by reduction in planned services by Newport City Council.

Key to the existing position was insufficient GP provision. In turn this impacts access to support services, where the need to improve referral rates featured in targeted benefits. Accordingly, there is a need for the Health Board to review the benefits realisation model to maximise intended benefits including quantification of both baseline provision and actual delivery.

However, noting fully scheduled occupancy, it was evident that the facility would facilitate the general aims both of enhancing services in the community and support care closer to home.

Noting the above, reasonable assurance has therefore been determined in respect of project performance and the achievement of the project’s key delivery objectives (time, cost, and quality).

Key Findings		Risk & Impact	Agreed Management Action																																								
1	Revenue costs Health Board ongoing annual revenue costs have been estimated to increase as follows: Table 4 <table><tr><th>Revenue costs</th><th>Financial Case 'Do nothing' (£ '000)</th><th>Financial Case - Business Case Yr 4 (£ '000)</th><th>Current estimate (25/26 costs) (£ '000)</th><th>Difference (£ '000)</th></tr><tr><td>Estates costs</td><td>153</td><td>360</td><td>524</td><td>164</td></tr><tr><td>Workforce</td><td>0</td><td>58</td><td>93</td><td>35</td></tr><tr><td>Dental</td><td>286</td><td>321</td><td>306</td><td>(15)</td></tr><tr><td>IT / other</td><td>23</td><td>55</td><td>48</td><td>(7)</td></tr><tr><td>Total</td><td>462</td><td>794</td><td>971</td><td>177</td></tr><tr><td>Contractor income</td><td>(8)</td><td>(69)</td><td>(101)</td><td>(32)</td></tr><tr><td>Net Revenue costs</td><td>454</td><td>725</td><td>870</td><td>145</td></tr></table> While utilisation by Park Surgery remained uncertain, their non-occupation would add circa 20k to the net costs above. However, this may present further opportunity for services and estates rationalisation across the Newport estate. The total increase in annual revenue costs is currently estimated at £416k p.a. (£870k - £454k). The above does not account for associated costs or efficiencies in reductions or ongoing occupancy in the owned & rented estate e.g., Clytha Clinic. There was therefore a need for the Health Board to confirm occupancy, revenue costs and their ongoing affordability, together with a review and confirmation of the wider services and estate occupancies in the Newport locality.	Revenue costs	Financial Case 'Do nothing' (£ '000)	Financial Case - Business Case Yr 4 (£ '000)	Current estimate (25/26 costs) (£ '000)	Difference (£ '000)	Estates costs	153	360	524	164	Workforce	0	58	93	35	Dental	286	321	306	(15)	IT / other	23	55	48	(7)	Total	462	794	971	177	Contractor income	(8)	(69)	(101)	(32)	Net Revenue costs	454	725	870	145	Revenue costs are unaffordable impacting other budgets	Agreed Action: Whilst it is acknowledged that revenue costs have increased to the original business case, these costs have been factored into the IMTP and therefore form part of the Health Board’s financial plan. This is recognised within the Full Business Case (FBC). Expected Evidence of Implementation: Included within approved IMTP
Revenue costs	Financial Case 'Do nothing' (£ '000)	Financial Case - Business Case Yr 4 (£ '000)	Current estimate (25/26 costs) (£ '000)	Difference (£ '000)																																							
Estates costs	153	360	524	164																																							
Workforce	0	58	93	35																																							
Dental	286	321	306	(15)																																							
IT / other	23	55	48	(7)																																							
Total	462	794	971	177																																							
Contractor income	(8)	(69)	(101)	(32)																																							
Net Revenue costs	454	725	870	145																																							
Theme: Finance Management & Control		Medium Priority Control Operation	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Clinical Futures Finance Manager Date: Complete																																								

Delivery

Target workforce & GPs

The business case identified insufficiency of both workforce and GP provision. This conclusion was reinforced by feedback from a survey of patients at Park Surgery.

The business case also targeted increased referrals to the new support services (for which access to GPs and practice nurses etc would be a key facilitator).

The benefits realisation appendix to the business case stated:

Practice	Total GP sessions provided	Required GP sessions
Park Surgery	24.0	39.0
Ringland Medical Practice	19.0	47.7

and that *"the benefits realisation plan will be analysed and used in order to facilitate non-cash releasing benefits and provide efficiencies using a value-based healthcare approach where possible to mitigate the costs indicated above."*

Accordingly, the Health Board have commented that the new estate should theoretically improve this risk, with the assumption that GP sessions can also be undertaken through other staffing where appropriate.

Noting on-going lease / occupancy negotiations with Park Surgery, there is a need to review the benefits realisation model to maximise intended benefits based on actual delivery.

Services

The approved business case anticipated a number of inclusions within the build including a community café within the adjoining Hub, which it stated would:

- promote healthy eating;
- promote social cohesion in a safe environment;
- create a vibrant space; and
- be a catalyst for positive action and building life skills;

A range of intended provisions within the Hub, such as the café were not provided and some planned services within the Centre have varied over time.

Insufficient GP and practice workforce impede target benefits.

Targeted services are not provided meaning that planned benefits are not realised

Agreed Action:

The Health Board acknowledges the business case's conclusion regarding GP workforce.

It is important to note that the GP practices operate under an independent contractor model, commissioned through a nationally determined General Medical Services (GMS) contract in accordance with The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023.

As such, while the Health Board does not directly manage GP workforce within the practices, it is anticipated that the new estate will provide a more conducive environment for collaborative working and enhanced service delivery.

In the absence of a contractually binding national position, the Health Board has a local benchmark expectation of practices delivering one GP equivalent session per week, per 200 registered patients. Based on current list size this equates to;

Park Surgery – 31 sessions (6,1560 registered patients)

Ringland Medical Practice – 45 sessions (8,923 registered patients)

Usual contractual performance management processes are in place for both practices. Both practices are compliant with the Access Standards.

Expected Evidence of Implementation:

Routine GMS contract management processes, including but not limited to;

- All practices are required to report quarterly in respect of their achievement against the Access Standards, and submit evidence on an annual basis.
- Escalation reporting
- GP Data activity
- Contract Assurance Framework
- Child health
- QI projects
- IG Toolkit and CGPSAT
- WNWRS reporting

	However, a full statement of pre-existing services within the area (notably Ringland & Park Surgeries) was not included within the business case). The business case confirmed that the Alway Clinic was intended for disposal. However, this is now planned for retention, and continues to provide local services, together with two local Pharmacies (in the Ringland Centre and Chepstow Road). Management have commented that integration with Hub services has been impacted by: • change in Newport City Council plans; and • closure of the link corridor due to anti-social behaviour. (Both matters being outside Health Board control). They also noted that while the building was complete, service provision has yet to reach the end project stage. Recognising the above, as a part of the planned post implementation review, the Health Board will need to review the intended model and provisions against those actually provided highlighting any variances against the business case and original baseline assumptions. Any output should be reported to an appropriate forum for scrutiny and approval.	Medium Priority	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Head of Primary Care Date: Complete
3	Disposals Four premises were identified for closure at the business case: • Ringland Surgery; • Park Surgery; • Always clinic; and • Clytha clinic & dental surgery. The sale of the Health Board premises of Alway and Clytha were estimated at £285k & £102k respectively (subject to re-valuation confirmation), with an associated reduction in backlog maintenance (stated to be £174k for Park Surgery). Of these while Ringland was demolished on the Health & Wellbeing Centre site, the other three remained in-situ at the time of the review (Park surgery being GP owned). The Health Board have advised that this is due to a targeted reduction in the number of rented premises.	Planned capital and revenue savings are not realised impacting other budgets	Agreed Action: At the time of submission, the assumption in relation to the closure of identified buildings was correct. However, further work has progressed in relation to the Health Boards wider Estate rationalisation strategy, which has identified changes to the follows - • Ringland Surgery – demolished as part of new development. Complete • Park Surgery – as confirmed with audit, Park is not included within any financial benefit to the HB as it is privately owned • Alway Clinic – This has now become the base for the Newport Locality Team due to the Health Board relinquishing the lease for Victoria House as part of the wider estates, rationalisation for the HB. • Clytha Clinic – this still houses some Health Board services which weren't included within the 19 Hills development. There are plans however for this to be

They also advised that review remained ongoing and that this may not represent the final position. It is additionally recognised that excepting agreement to the contrary, sales proceeds would accrue to the Welsh Government. There was a need therefore to confirm the position in relation to these premises, associated costs and revenues, and any retention of sales proceeds as part of an end project evaluation.		disposed of as part of the wider St Woolos rationalisation work.
		Expected Evidence of Implementation: Disposal of Clytha to be included within the St Woolos Business Case.
	Medium Priority	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Assistant Director of Strategic Capital Planning & Divisional Director Estates & Facilities Date: 30 September 2026
Theme: Finance Management & Control	Control Operation	

Overview / Summary of Observations

The prior audit focused on management of the build phase. The audit raised recommendations relating several aspects of project control. Excluding three “low” (advisory) recommendations, all remaining recommendations were rated “medium priority. The follow-up position may be summarised as:

Table 5

Recommendations	Number of Recommendations	Implemented	Outstanding	Closed	Comments
Review of Project Board governance arrangements, information and approval mechanisms.	1	-	-	1	Management confirmed that they have reviewed governance arrangements for this project. They have also recognised that project governance should form part of a wider organisation review. Approval of the key “go-live” dates closely control by the Project Board, and accordingly, no issues arising from governance were noted in the duration of this audit. Noting these matters, and the conclusion of the audit, while certain aspects remained under on-going review, this matter is deemed closed at this audit.
Ensure the effective functioning of the Communication and Engagement forum (including attendance).	1	1	-	-	
Monitor Gateway actions	1	-	-	1	The Project Boards of September 2024 & October 2024 Board meeting received updates of Gateway report actions. While certain of these remained outstanding, these will now appropriately inform future projects.
Monitor of project contingency and associated need for discretionary finance.	2	2	-	-	
Completion of project control forms, including:	2	2	-	-	The most recent three Change Control Forms were selected from the Change Control Register for inspection. Referencing and descriptions accorded with the Change Control Register. All three were

• appropriate authorisation / signature; and • adequate description to inform scrutiny and approval.					appropriately signed in accordance with procedures described at the Project Execution Plan and contained appropriate descriptions and information to inform scrutiny and approval / value for money decisions.
Total	7	5	0	2	

Accordingly reasonable assurance was determined in relation to the actions to address previously agreed management actions.

Overview / Summary of Observations

The audit tested the January 2025 application for payment by the Supply Chain Partner (SCP). Audit testing confirmed the correct calculation of overhead and profit mark-ups and overall compilation of the valuation. People and advisers charged by the Supply Chain Partner (SCP) were correctly charged, with supporting time sheets and rates reconciling to the contract.

Only the sub-contract accounts were found to contain discrepancies to supporting invoices (of £123,407). Of these £82,766 related to applications made in advance of substantiation (awaiting invoice evidence) and a further £36,282 related to claiming payment from the Health Board where retention was still being withheld from the sub-contractor i.e., the sums had yet to be incurred by the SCP.

The final account had yet to be presented, and accordingly, the latest claim (dated January 2025) was reviewed. This claim exceeded the uplifted contract sum by £1.4m. As a result, the claim was capped (£1.4m being deducted from the claim). The Cost Adviser commented that as a result detailed checks on further increases to sub-contract charges were no longer undertaken as they were not being paid (permitting the discrepancies found).

While a further increase in contract price was being confirmed, this was specific to a road crossing. Accordingly, while noting the above discrepancies, these had no impact to the sum paid due to the contractual cap. Applications for payment were therefore found to be appropriately assessed and certified.

Delay damages were applicable at £1 a day (net of VAT) for the first four weeks of delay and £473 per day thereafter. These were subject to ongoing correspondence between the Cost Adviser and the Health Board prior to implementation and were therefore found to be appropriately considered.

Overview / Summary of Observations

As per **Table 1**, a budget of £542k was allocated for equipment procurement, with anticipated expenditure expected to be finalised within this sum.

Equipment transfers formed part of the procurement process to minimise expenditure on new items.

Six items were sampled, forming 38% of the total budget to test compliance with procurement regulations and Standing Financial Instructions. All six procurement exercises were found to be fully compliant with regulations to assure best value (i.e., with requisite number of tenders / quotations / or framework selection).

Accordingly, substantial assurance is determined in relation to equipment procurement.

Overview / Summary of Observations

A Communications and Engagement forum was established at a formative stage of the project including relevant parties. In September 2018 this agreed appropriate communication arrangements with potential stakeholders. The Stakeholder Engagement Plan continued to be refined throughout the project.

The key stakeholders included the Ringland and Park Surgeries, with on-going engagement with the respective practice managers, with information issued both locally and direct to the practices. A formal consultation was required for Park Surgery patients in view of the change of location. Resultant feedback from a Park Surgery questionnaire was reported by the Head of Service Planning to the Executive and approved by the Executive Director of the Community Health Council in December 2022. Key issues raised within this feedback were accessibility to GP services, additional travel for those closer to the existing Park surgery than the new Centre (e.g. two buses being cited), and query of what new services were proposed. Proposed mitigations within the analysis paper included subsidised / free travel and additional bus services.

Noting revision to the final services, as compared to the business case, notably the withdrawal of Park Surgery, the post project review should include the effectiveness of engagement for planned services not provided (see **Appendix A**) (i.e., appropriate consultation / engagement for services planned but subsequently omitted). Additionally, as new services for Park Surgery patients may nevertheless be provided from the new Centre, specific review of communication, mitigations and associated approvals relating to Park Surgery could also usefully form a distinct part of the analysis.

Key Findings	Risk & Impact	Agreed Management Action
4 Post project evaluation - communications A post project review should include the effectiveness of engagement of planned inclusions not provided (see Finding 2). Additionally, in the event that Park Surgery does move, certain support services for Park Surgery patients may nevertheless be provided from the new centre, potentially necessitating greater travel for certain services. An additional key matter raised in feedback was access to GPs, which in turn impacted referral to secondary services (see Finding 2). Review of communication, approvals and mitigations relating to such matters could also usefully form part of the planned post project review.	Communication is not tailored to final delivery impacting benefits realisation	Agreed Action: During the Communication and engagement period a risk was flagged, at which point the communications and engagement strategy and working group was refreshed. Governance of the group was re-established with it reporting directly into the project board to ensure flow of communication, messaging and activities happened correctly. A series of engagement activities was carried out which can be found the engagement flow chart, and communication activity is captured in the embedded word document along with analytics of the 19 Hills ABUHB web page which hosted all communication throughout. In addition to this, the patients who will have been affected by moves, etc will have been appropriately communicated to in relation to appointments, etc and the dates from which they will be moved across to the new facility. As part of the wider Prost Project Evaluation and Lessons Learnt, communications will be subject area that will be assessed in order for us to take learning from. Expected Evidence of Implementation: Lessons learnt findings

			Comms and Engagement Plan
		Medium Priority	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Assistant Director of Strategic Capital Planning & Head of Strategic Communications, Public Health. Date: 30 March 2026
	Theme: Communication & Engagement	Control Operation	

Overview / Summary of Observations

At the time of audit, the building was in process of a staged hand-over, a building control certificate had been issued, and landscaping and planting remained on-going as satisfaction of the final planning conditions. However, an environmental (BREEAM required grade “Excellent”) certificate remained outstanding. Highway works also remained ongoing in respect of a pedestrian crossing, and fencing was being completed. The Supervisor report of 28th February 2025 confirmed witness testing of mechanical and electrical installations were complete but noted 16 outstanding building defects (snagging issues) still in the process of being resolved (including completion of the car park, damaged ceiling tiles and Welsh signage etc). Ringland Surgery and associated services moved in on 13th January, with remaining services and Park Surgery to follow by 31st March.

As of early March 2025, occupancy remained partial with services and equipment still being moved into the building – notably the private dental service (a fieldwork visit on 3rd March 2025 noted only 3 of 12 clinical services, plus the Ringland Surgery in operation – with Park Surgery and dental services not in residence). The business case had also detailed linkage to wellbeing / social support services. Management was advised that while referenced within the business case for the Health & Wellbeing Centre, these were services that would be provided via the adjacent Community Hub (originally planned to be physically linked, with an adjoining door now locked due to security concerns). Information relating to these aspects was not available.

A signed lease and agreed SLA were in place for Ringland Surgery who were in occupancy as from January 2025. To April 2025 Park Surgery had delayed occupancy in favour of their current premises due to a dispute over the associated rental price. At the time of concluding the audit fieldwork, lease negotiations remained to be finalised with both Park Surgery and Ringland Dental Practice, though it was anticipated that both parties would be in occupancy with these agreements in place as at the end of May 2025. It is also noted that occupancy of office areas such as Community Nursing desks may only be partially occupied at any point in time and would benefit from an assessment of post completion utilisation.

The planned Benefits Realisation report should therefore confirm outputs as against intended provision (including contracted occupancy, SLA / lease arrangements, decarbonisation, mechanical, electrical and IT inclusions and associated manuals). While the focus of this would be the agreed provision as specified in the business case, noting flexibility of occupancy, end user (patient) feedback could usefully inform this report.

Key Findings		Risk & Impact	Agreed Management Action						
5	Contracts and Service Level Agreements	Health Board interests are not contractually safeguarded risking financial or reputational impacts.	Agreed Action:						
	The Health Board interests should be safeguarded by formal contracts and Service Level Agreements to assure costs and benefits. At the time of concluding the audit the Health Board had advised:		The Health Board acknowledges that future project leases and SLA negotiations will require negotiations to start earlier and to be concluded prior to the estate opening to the public. This will be taken forward with future capital projects.						
	<table><tr><th>Service Provider</th><th>Lease</th><th>SLA</th><th>Occupancy</th></tr><tr><td>Ringland Surgery</td><td>Signed</td><td>In negotiation</td><td>Yes, but being amended for revised agreement (to separate utility charges).</td></tr></table>		Service Provider	Lease	SLA	Occupancy	Ringland Surgery	Signed	In negotiation
Service Provider	Lease	SLA	Occupancy						
Ringland Surgery	Signed	In negotiation	Yes, but being amended for revised agreement (to separate utility charges).						

	<table><tr><td>Park Surgery</td><td>In negotiation</td><td>In negotiation – costs agreed</td><td>Planned May</td><td>9th</td></tr><tr><td>Ringland Dental Surgery</td><td>In negotiation</td><td>In negotiation – costs agreed</td><td>Planned May</td><td>31st</td></tr></table> It was noted at the audit visit held on 3rd March 2025, that a range of dental staff were in occupancy stocking the storeroom / completing handover. Noting the well documented lease issues with Park Surgery, the audit did not conclude that any similar issues pertained in relation to dental services. However, there was a need to conclude and confirm lease and SLA arrangements.	Park Surgery	In negotiation	In negotiation – costs agreed	Planned May	9 th	Ringland Dental Surgery	In negotiation	In negotiation – costs agreed	Planned May	31 st		- Evidence of early engagement meetings document through diary invites - Comprehensive project scope and confirmed timescales with detailed milestone tracking - Dated Heads of Terms and SLA documentation
Park Surgery	In negotiation	In negotiation – costs agreed	Planned May	9 th									
Ringland Dental Surgery	In negotiation	In negotiation – costs agreed	Planned May	31 st									
	Theme: Contractual	Medium Priority	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Divisional Director Estates & Facilities / Community Estates Manager Date: Complete										
		Control Operation											
6	Decarbonisation The WG approval letter (Schedule 1) stated that "<i>The funding includes £0.638m funding support for decarbonisation measures listed below: -</i> <i>Utilisation of rooftop photo-voltaic (PV) cells;</i> <i>Passivhaus design principles (thermal breaks to building fabric/structure: more insulation; airtightness);</i> <i>Triple glazing to external windows;</i> <i>AHU heat recovery efficiency; and</i> <i>Electronic Vehicle (EV) charging points."</i> The Supply Chain Partner have confirmed the inclusion of the above elements within the build, though not the value. The Health Board have clarified that the building was not designed to Passivhaus standards but adopted some of its design principles (such as those described above). A BREEAM (Building Research Establishment Environmental Assessment Method) sign-off also remained to be provided. Recognising the decarbonisation requirements, achievement for the delivery of the same could usefully form part of the planned	Failure to deliver decarbonisation requirements	Agreed Action: Future projects will include (where necessary) a separate report for decarbonisation to demonstrate value for money.										
			Expected Evidence of Implementation: A document has been shared with Internal Audit that had been prepared by the Trust Cost Accountant for 19 Hills (Newport East). The information set out the carbon reduction measures included within the design and specification for Newport East HWBC. It also included information extracted from payment assessments, final accounts and specifications. Some of the information included values, to demonstrate the value enhancement. For example, the extra over cost for the third pane of glass, the additional thickness of wall and roof insulation and the cost differential for this thickness is, what the extra over cost of structural supports would be as we do not have the design. A Separate report for decarbonisation to demonstrate value for money will be included in all future capital projects, where necessary.										

	Post Project Evaluation to inform future projects (e.g., the achievement of Passivhaus principles).		
	Theme: Finance Management & Control	Control Operation	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Assistant Director of Strategic Capital Planning & Divisional Director Estates & Facilities. Date: Complete
7	Benefits Realisation Key to post project review is assessment of benefits realisation. Including receipt of intended outputs (provisions). At the time of approval of the business case the benefits realisation model remained to be fully developed, notably in respect of baseline definition and measurements (e.g., a statement of existing services delivered locally, and target reductions in dental waiting times etc) e.g., original and target services as listed at Appendix A . Similarly, the Business Case targeted improved space utilisation within Primary Care (specifically GP premises). Noting the more general aspiration, the measure could usefully be extended to support areas. The business case also contained aspirations not included in the benefits grid, such as increased referrals via the common ailments scheme. As part of the scheduled review of benefits realisation, there was additionally therefore a need to for the Health Board to review the benefits realisation model alongside the business case for completeness Such review could also usefully include benchmarking against similar provisions.	Benefits are not realised due to insufficient quantification to facilitate monitoring	Agreed Action: Full review of Benefits Realisation will be assessed a year after opening as part of the Project Evaluation. Interim monitoring will also be taking place, but there may also be a need to change/ update the intended benefits realisation matrix in order to align to any changes within the service strategy due to the time which elapses from concept to operational delivery of the projects. The BRM will also be linked to the performance dashboard to capture the data and in order to capture the wellbeing information, a ripple map has been created.
	Theme: Performance Monitoring	Control Operation	Expected Evidence of Implementation: Both an Interim review of Benefits Realisation Matrix and Full review at Post Project Evaluation have been shared with auditors. For future projects both an interim review and post project evaluation will be undertaken.
		Medium Priority	Officer: Director of Public Health and Strategic Partnerships Implementation Officer: Head of Service, Newport - Interim review & Assistant Director of Strategic Capital Planning PPE Date: 30 June 2026

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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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.



Waiting List Management

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
At a Glance – Adult Weight Management Services	3
Appendix A	10

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2425-13

April-June 2025

Leanne Watkins, Chief Operating Officer

September 2025

Leanne Watkins, Chief Operating Officer

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



Executive Summary

Purpose

The review of Waiting List Management was completed in line with the 2024/25 Internal Audit Plan for Aneurin Bevan University Health Board (the 'Health Board'). The review focused on adult weight management, which has Health Board derived targets in the absence of national targets.

Overview

The audit provides **reasonable** assurance over the various aspects relating to data collection, analysis and reporting arrangements.

The assurance assessment does not consider performance against the targets, as these may be impacted by other factors such as local/ national policy and/or prioritisation of resourcing.

Recognising that the expectations were well documented and that robust reporting arrangements were in place, management focus should be on strengthening the performance management aspects, in particular:

- Whilst overall targets have been set, incremental targets should be agreed to assist staged achievement.
- A formal rolling action plan should be fully maintained with SMART actions.
- To ensure the action plan is comprehensive, it should be updated to record the recent initiatives/ actions to date and their impact. This will then act as a single log of activities.

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	Robust and SMART targets were established for improving/ maintaining waiting lists within the weight management / dietetics service areas.		1	Reasonable
2	A waiting list that is up-to-date and maintained, including links and connections between different lists.			Substantial
3	Effective action plans and related monitoring to reduce the size of current waiting lists, including any associated reporting.		2, 3	Reasonable
4	Effective arrangements for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation).			Substantial
5	Adequate arrangements to communicate with patients waiting for health care services, including the offer of additional support if required.			Substantial

Management Actions

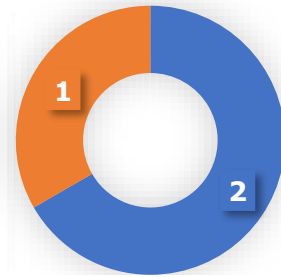


High Priority



Medium Priority

Themes



■ Performance Monitoring

■ Reporting

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Financial Loss

At a Glance – Adult Weight Management Services

Adult Weight Management Services are provided based on the following tiers:

- Tier 1: Public Health/ Community based early intervention
- Tier 2: Focus on Lifestyle interventions (e.g. voucher schemes)
- Tier 3: Multi-disciplinary team approach with potential for weight loss medication/ weight loss surgery.

The latter two are managed by the Health Board via a self-referral service – there was an average of 284 referrals per month in 2024/25 – the waiting list having increased from 3,332 to 4,488 in the financial year.

Patients are advised that the current anticipated wait is 5 years for Tier 3 and 6-9 months for tier 2 referrals. Subsequent to the audit, patients are now being advised of potential further delays of up to 8 years for Tier 3.

There are no Welsh Government targets for Adult Weight Management Services, however the service has adopted the same targets as required by WG for other services within dietetics.

Below is a summary of performance against some of those key performance criteria:

	Total Waiting	Waiting <14 Weeks	% Referral to Treatment Compliance	Longest Wait	Longest Urgent Wait	Overall 'Did Not Attend'	Virtual Rate New	Virtual Rate Follow up
Agreed Target	-	-	100%	<14 weeks	-	5%	35%	50%
Adult Weight Management	4488	787	17.5%	141 weeks	86 weeks	15.9%	83%	78%

Whilst many metrics were missed, there were examples of good practice, for example the virtual rate for both new and follow-ups is significantly above the set targets.

Findings & Agreed Action Plan

Objective 1: Robust and SMART targets were established for improving/ maintaining waiting lists within the weight management / dietetics service areas.

Reasonable

Overview / Summary of Observations

In the absence of Welsh Government (WG) targets for Adult Weight Management Services, internal targets and reporting was in keeping with other Therapy Services for example, a 14-week Referral to Treatment (RTT) target.

Whilst not formally approved by the Board or other committees, these had been widely accepted and adopted for many years.

Whilst recognising that the targets aligned with WG requirements in other areas, it may be beneficial to set interim targets that contribute incrementally to the overall achievement of the targets – particularly reflecting on the current significant variation between actual performance and the targets (see *At a Glance* page).

These would need to be agreed/ signed off by an appropriate forum.

Key Findings		Risk & Impact	Agreed Management Action
1	Interim Targets Whilst the overall aspirational targets align with those expected by Welsh Government for similar services, there may be benefit in developing interim targets, to assist in incremental achievement of the overall targets. Particularly noting the current significant variation between targeted and actual waiting list performance. Any targets would need to be appropriately signed off.	Overall targets may be deemed unachievable.	Agreed Action: Further internal targets have been considered by the Service and in discussion with the Dietetics and Weight Management Head of Service and Therapies Clinical Director. Internal targets will be closely monitored, in line with the Therapies Performance and Governance Framework, reviewed within service and reported monthly at Accountability and Assurance Meetings. In addition, the service will ensure it stays appraised of any formal National developments in line with national data standards and data assurance process (previously considered in December 2023).
			Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.
	Theme: Performance Monitoring	Medium Priority Control Operation	Officer: Directorate Manager for Therapy Services Target Implementation Date: 30 th September 2025

Overview / Summary of Observations

Initial data entry into the Welsh Patient Administration System (WPAS) - including referrals, appointments, and clinic outcomes - was performed by booking administrators and overseen by the Therapies Booking Centre Team Lead.

Data was extracted and maintained on the key performance indicators (KPI) report for onward reporting at both service-level and broader directorate-level. The data collected and reported aligns with that produced for services that fall under Welsh Government reportable targets.

The data is RAG scored against the pre-determined targets, including 46 metrics covering:

- Outpatient New Waiting List;
- Outpatient Follow Up waiting List;
- Referrals; and
- Outpatient Activity.

For information, some of the key metrics are provided within the *At a Glance* page.

Objective 3: Effective action plans and related monitoring to reduce the size of current waiting lists, including any associated reporting.

Reasonable

Overview / Summary of Observations

Oversight of waiting list performance was via the following:

- WMS performance meetings held monthly.
- Therapies Senior Management Teams monthly Assurance and Accountability Meetings.
- Family and Therapies Division Divisional Management Team (DMT) meeting approximately every 6 weeks.
- Monthly Divisional Assurance Meetings.

Whilst data on Adult Weight Management was produced/ presented regularly, and there was evidence of adequate reporting, focus within dietetics was on the Welsh Government target areas.

Various actions and progress were captured within the KPI Dashboard, the concern is that as the overall targets are extremely ambitious, much of the responses to address the gaps may not be achievable.

Locally, an additional monthly record was maintained of initiatives/ actions, however this record was not fully complete, and the actions were not always SMART.

Key Findings		Risk & Impact	Agreed Management Action
2	Tracking Improvement Plans Performance was monitored against the overall targets, identifying any gaps as necessary and remedial action. Given that overall targets were extremely ambitious, the resulting observations/ actions were reflective of the gap in performance. Separately, monthly action plans were produced to capture any local initiatives. This document was not fully complete, and the actions documented were not always SMART, making it difficult to quantify the impact of the action. The action plan would also be better maintained as a rolling record, rather than separately produced each month, demonstrating whether items were addressed in a timely manner.	Actions are not tracked impacting the achievement of the overall objectives.	Agreed Action: Develop SMART Actions for all improvement initiatives - rolling record. Develop a live and shared tracker to capture progress of all initiatives including objectives, SMART target, Key Actions, Owner, Deadline and Success Measures. Agree maintenance /responsibilities of tracker updates including escalation progress Agree forum/s to review tracker progress Demonstrate impact and outcomes of Actions
			Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.
		Medium Priority	
Theme: Performance Monitoring		Control Operation	Officer: Head of Dietetics and Weight Management Services Target Implementation Date: 30 th September 2025

Key Findings		Risk & Impact	Agreed Management Action
3	Investigation of Issues As part of the audit, key data was interrogated. For example, we queried: - The longest wait KPI reported seemed to relate to the same patient as it increased from 94 to 141 in the period. Management explained that this individual's referral had now been changed to urgent. - The DNA % for the cohort was 15.9% against a target of 5%. Management demonstrated how a number of initiatives had been implemented, with examples of improved rates from a move to self-led groups. Whilst it was reassuring that the above had been investigated/ challenged, this was not captured/ documented within the existing performance management reporting.	Management efforts/ initiatives are not tracked to include the resulting impact.	Agreed Action: Ensure all key data sets that are investigated, captured and documented using existing performance management reporting. Develop investigative issues log Agree maintenance and responsibilities of log updates including escalation process
		Medium Priority	Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.
	Theme: Reporting	Control Operation	Officer: Head of Dietetics and Weight Management Services Target Implementation Date: 30 th September 2025

Overview / Summary of Observations

Patients are primarily required to self-refer for the Adult Weight Management service. Accordingly, patients were initially prioritised in date order based on referral date.

Certain patients can be fast-tracked if they meet the following agreed criteria:

- Infertility – primarily age 35+;
- IIH and severe symptoms such as vision loss; and
- Requires weight loss for life threatening illness or lifesaving operation.

The process was well defined and there was no evidence within the sample that this was not working effectively.

Overview / Summary of Observations

As previously noted, the Adult Weight Management service is largely a self-referral service that utilises an online referral form. This form clearly outlines to patients that current waiting times are:

- Tier 2 – 6 to 9 months
- Tier 3 – At least 5 years

The self-referral form also outlines the limitations on weight loss medication with only 50 patients able to be treated at a time, and that the use of Mounjaro is pending Welsh Government guidance on implementation.

Upon completion of the form, patient contact details were retained allowing text communication to be targeted or globally issued to the entire cohort. For example, upon completion of the form an automated message was sent outlining potential timescales. A cohort wide update was also issued in April 2025. During this period, patients can also call the WMS number to get an update on the current waiting times.

When available, patients on the waiting list are offered other support, e.g. vouchers via Public Health Wales initiatives, without impacting on their position on the waiting list, but these are subject to availability.

Note that post completion of the audit fieldwork, this referral form has been updated to highlight potential delays of up to 8 years for Tier 3 and also refers patients to the new alternative options such as the GRO app. An SBAR paper regarding Level 3 Adult Weight Management Services was presented to ABUHB Executives in June 2025. The immediate actions including stakeholder engagement and a communication plan is currently being progressed.

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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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.



EDRMS

Final Internal Audit Report

2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	2
Findings & Agreed Action Plan	4
Appendix A	10

Review Reference

ABUHB 2425-24

Fieldwork

February 2025

Executive Sign Off

September 2025

Audit Committee

October 202025

Executive Lead

Paul Solloway Director of Digital

Head of Internal Audit

Stephen Chaney

Executive Summary

Purpose

To review the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services within Aneurin Bevan University Health Board (the 'Health Board').

Overview

We have concluded reasonable assurance on this area. Overall, we raised two high priority matters arising. However, for matter arising three, this was one exception against a background of significant positive testing conclusions. Therefore, the risk impact level is offset and balanced by the overall position, where we found the remaining controls to be operating effectively towards the achievement of this objective.

The matters requiring management attention include:

- The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.
- A lack of upgrades has meant that the Health Board is on an old, unsupported version of cCube, which is not able to provide modern functionality and interoperability with other clinical systems. A lack of upgrades limits the system's ability to evolve in line with organisational needs and restricts interoperability with modern digital infrastructure.
- cCube is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Consideration should be given to encrypting the data at rest within the cCube system.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	The EDRMS in use meets the needs of the organisation and enables effective document and record management.	1	Reasonable
2	The EDRMS is appropriate for the organisational needs in the future, and enables integration with other digital solutions.	2	Limited
3	The EDRMS provides a secure and resilient document and record storage solution.	3	Reasonable

Management Actions

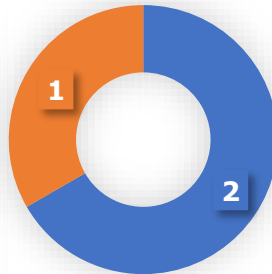


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Cyber Security

Risk Types

Quality or Safety Issues
Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The EDRMS in use meets the needs of the organisation and enables effective document and record management.	Reasonable

The EDRMS meets the organisation’s needs by providing an integrated, accessible, and up-to-date health record system. The transition from paper to electronic records has been essential for improving patient care, reducing inefficiencies, and mitigating risks associated with missing or inaccessible information. The system was implemented based on a business case demonstrating that it aligned with organisational requirements by supporting an integrated and accessible health records system.

The Health Board’s Electronic Document and Records Management System (EDRMS), which uses cCube, was implemented in 2012. At that time, there were approximately 885,000 current or active acute health records distributed across various locations, including Nevill Hall Hospital, Caerphilly District Miners Hospital, the Royal Gwent Hospital, St Woolos Hospital, County Hospital, and Chepstow Hospital. Of these, 400,000 records were centralised in Online House, with the remainder stored at Nevill Hall Hospital and St Woolos Hospital.

Currently, 180,000 acute health records are stored in Online House, while 40,000 remain at Nevill Hall Hospital, either undergoing active scanning or awaiting destruction in accordance with applicable retention schedules (e.g., for deceased patient records).

Scanning has played a central role in modernising health records management. During a recent site visit to Online House, it was confirmed that scanners are in frequent and extensive use.

Although the EDRMS was originally intended for acute records, as outlined in the business case, it is now widely used across multiple departments. These include Dietetics, Physiotherapy, Podiatry, Lymphoedema, and Community Paediatrics have been incorporated into the programme of work. Progress in these areas is dependent on the respective services funding scanning activities during weekends, with Health Records staff working additional hours via the staff bank to complete the work. These extended services also rely on departmental funding for work outside standard operating hours. Additionally, scanners such as Kodak and XDS are used for Dental and Ophthalmology services, where paper referrals are scanned using Kodak scanners into the EDRMS within Online House.

The EDRMS continues to meet organisational needs by providing a process driven document and records management system. It supports the full document lifecycle, from creation and storage to retrieval and archiving. Clinicians and medical secretaries benefit from timely access to records, particularly through the digitisation of patient information ahead of scheduled appointments. The system enables simultaneous access across multiple hospital sites, eliminating delays associated with transporting physical records. New or updated documents are scanned and made available immediately, supporting a paper-light approach and significantly reducing the risk of information loss. There is currently no functionality available for the digital archiving of record.

Performance monitoring is embedded within a governance framework that includes quality assurance through key performance indicators, throughput monitoring, and staff training. Compliance with data protection and information governance standards is mandated in the supplier contract, helping to maintain system integrity and efficiency while ensuring effective document and records management.

There are additional functionalities that are offered by cCube, however the significance of these is diminished due to the way cCube integrates with Clinical Workstation (CWS) and their use would displace workflows that are currently managed through CWS. Additionally, there is a notable lack of eForms in use, which further limits the system’s functionality, and leads to the Health Board operating a paper transformation approach rather than a paper replacement digital approach.

Key Findings		Risk & Impact	Agreed Management Action
1	E forms The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.	Underutilised system potential	Agreed Action: Limited development of eForms took place prior to 2019, after which responsibility for development transferred to the informatics budget, and the Health Board’s software development team. Since 2018/19, linear eForms have been available within Clinical Workstation, the Health Board’s clinical portal, and are in regular use. However, this functionality is outdated and poses a risk to the organisation. To address this, a business case is being developed to procure a replacement eForms and workflow solution. This will enable form and workflow development in both inpatient and outpatient settings supporting clinical safety, productivity and efficiency benefits. This will also release DHR capacity to focus on digitising historical paper records for mental health and learning disabilities services as they transition to the new EPR in 2026. With the roll out to primary & community care services, in the future Further reductions in paper usage will also be achieved through the implementation of national applications, such as Welsh Nursing Care Record (WNCR) Badgernet for Maternity services, subject to their respective implementation roadmaps.
			Expected Evidence of Implementation: • Reduction in use of inpatient and outpatient supplementary scanning in acute care settings. • Reduction in the use of paper forms • Increase in the use of eForms
	Theme: Information, Data Quality & Data Accuracy	Medium Priority Control Operation	Officer: Director of Digital Implementation Officer: Head of Digitised Health Records Service

Objective 2: The EDRMS is appropriate for the organisational needs in the future and enables integration with other digital solutions.

Limited

The Health Board uses version 4.1 of cCube, which does not integrate with the Clinical Workstation but does support demographic updates through integration with the Welsh Patient Administration System (WPAS). For the Clinical Workstation (CWS), it relies on an iFrame and HL7 messaging from WPAS to update demographic data.

However, the system's inability to fully support free text clinical input, due to the risk of overwriting existing data, has resulted in the disabling of some functionalities and hinders integration into clinical workflows. This limitation raises concerns about the system's suitability for clinical environments where unstructured data is essential. Although technically compliant with NHS Wales interoperability standards, the integration is superficial and does not reflect a deep system interoperability.

As departmental demand for scanning and digital record management increases, the reliance on the current version of cCube is showing signs of weakness due to limiting functionality. The system's implementation has yet to be fully tested across areas such as Mental Health, Learning Disabilities, Payroll, and HR, where integration requirements are often more complex. In addition, emerging compatibility issues with newer platforms, lack of cloud support and lack of AI support also indicates that cCube is approaching obsolescence.

The original contract for cCube did not present a formal vendor roadmap but demonstrated a commitment to ongoing system enhancement through a planned upgrade path to version 4.3 of the cCube EDRMS, with provisions for future updates and regular maintenance, including two upgrade cycles annually. This structured approach indicated an incremental improvement strategy rather than a transformational roadmap. However, the Health Board has not implemented the regular provided updates, due to a perceived lack of enhanced functionality provided, as such the current position is that there is significant technological debt and a gap between the current and new versions of cCube.

Version 4.1 is no longer supported by cCube, however moving to the latest version (4.4) requires a server upgrade, as such a business case has been submitted to support the necessary infrastructure upgrades. This new version will offer a more intuitive user interface and improvements to the web interface, database, backend server. It will also introduce improved integration capabilities through APIs (Application Programming Interfaces, which allow different software systems to communicate) and eForms (electronic forms designed to capture and submit data digitally) and is both FHIR and cloud compatible. Implementation is anticipated by the end of the year, subject to amendment and successful testing of the APIs and eForms by Health Board developers.

Key Findings		Risk & Impact	Agreed Management Action
2	Current suitability A lack of upgrades has meant that the Health Board is on an old, unsupported version of cCube which is not able to provide modern functionality and interoperability with other clinical systems. Consequently, the system has not evolved with organisational requirements.	Underutilised system potential	Agreed Action: The Health Board acknowledges that remaining on an unsupported version of cCube limits functionality and interoperability with other clinical systems and no longer meets organisational requirements. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to

		progress with the upgrade will not be completed prior to September 2025. Further development planning sessions are scheduled for September 2025 to agree a timeline for completion of the upgrade. However, completion is dependent on approval of the CWS Risk Business Case and the reorganisation of the service to establish a core support team to undertake the required API amendment. Subject to these dependencies, completion is estimated for early 2026/27. A risk has been raised relating to cCube on the directorate risk register: • 1829 – cCube out of support (Score 6) Support is provided by the supplier for issues although no development requests can be submitted.
		Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capture scanning software to the latest version 4.4.
	High Priority	Officer: Director of Digital Implementation Officer: Head of Digitised Health Records Service
Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: The EDRMS provides a secure and resilient document and record storage solution.

Reasonable

The system’s architecture is highly resilient, using virtualisation across two Health Board data centres. Backups are appropriately managed, with assurance on data validity. The retention policy allows restores to any day within the past 30 days, with monthly backups retained for two years. Granular restoration of individual files is also supported. This is further strengthened by the use of virtual environment snapshots, which enable rapid data recovery.

However, the current cCube EDRMS environment presents operational and strategic risks due to its reliance on outdated infrastructure and software. It is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities, highlighting an urgent need for an upgrade to a modern platform such as Windows Server 2019 or 2022. However, due to the lack of progressive upgrades, the version of cCube currently in use (4.1) is incompatible with these newer platforms, and its reliance on outdated Microsoft components further limits options for a seamless transition.

Following implementation, a benefits analysis undertaken in 2019 confirmed improved security through digitisation and electronic access controls, which have reduced physical storage risks. Further improvements are anticipated with the transition to cCube version 4.4, incorporating upgrades across web, database, and backend services. Despite current technical limitations, the move from paper to digital records has significantly enhanced accessibility, reduced the risk of document loss or physical damage, and improved compliance by mitigating risks associated with insecure storage and limited access controls.

The system supports data protection and information governance standards through access restrictions, audit trails, and secure entry points—and plans are in place to implement immutable backups for enhanced malware protection. However, the stored data is not currently encrypted, which remains a vulnerability.

Access to records is managed via the national Active Directory (AD) and is role-based, with users assigned to specific AD groups according to their job roles. These groups define permissions within the cCube system, including the ability to view scanned documents, access the portal, and carry out administrative functions. The majority of staff, including clinicians, nurses, allied health professionals, medical examiners, and other authorised personnel, have read-only access to scanned documents through the integrated Clinical Workstation. Access to sensitive records follows the same controlled process. General access also includes records from departments such as Physiotherapy, Lymphoedema, Podiatry, and Orthotics.

Group creation and management are handled by system administrators, with requests submitted through the ABUHB Service Desk. As part of our review, we examined a sample of groups with elevated access and found that permissions were appropriate.

Logging is in operation with the system logging all access interactions, allowing identification of who last edited or viewed a record, the logs are managed by automated deletion of short-term storage after six weeks, managed through robotic process automation (RPA) which ensures compliance with retention policies while reducing storage burdens.

Key Findings		Risk & Impact	Agreed Management Action
3	Servers		Agreed Action:

cCube is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities.	Potential loss of service and inappropriate access to data	The Health Board acknowledges that cCube is currently hosted on Windows Server 2012 R2, which is unsupported and presents known security vulnerabilities. To mitigate this risk in the short term, Extended Security Update (ESU) support has been applied to the web and importer servers for a 12-month period, as confirmed by the Business Systems Unit. This provides continued security patching and reduces the immediate exposure. For the long term, a business case and upgrade plan are in place to move to cCube version 4.4, which will run on a supported operating system. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Subject to this dependency, migration to the supported version and operating platform is expected thereafter. A risk has been raised relating to cCube on the directorate risk register: • 1739 – cCube Cyber Security Vulnerability (Score 12) Standard mitigations have been put in place by our Cyber Security Team to ensure the system is protected from cyber security threats and support is provided by the supplier for issues although no development requests can be submitted.
Theme: Cyber Security	High Priority Control Operation	Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capture scanning software to the latest version 4.4. Officer: Director of Digital Implementation Officer: Head of Digitised Health Records Service

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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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.



Financial Sustainability

Final Internal Audit Report 2024/25

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	8

Review Reference

ABU-2425-01

Fieldwork

June-August 2025

Executive Sign Off

Rob Holcombe, Executive Director of Finance,
Procurement & Value

Audit Committee

September 2025

Executive Lead

Rob Holcombe, Executive Director of Finance,
Procurement & Value

Audit Team

Stephen Chaney, Head of Internal Audit
Chris Scott, Internal Audit Manager

Executive Summary

Purpose

To determine if appropriate recovery plans were in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent funding. Therefore, we have provided assurance over the establishment, implementation and tracking of financial savings targets, in relation to the recovery plans.

Overview

To achieve financial sustainability for the 2024/25 financial year, Aneurin Bevan University Health Board (ABUHB) implemented a multi-faceted strategy in response to significant financial pressures as follows:

1. Multiple Stage 2024/25 Budget Setting Process

The Health Board adopted a two-part budget setting approach. This included an initial budget allocation made to divisions and directorates followed by further allocations, incorporating detailed financial savings and cost pressure plans.

2. Savings and Efficiency Programmes

The Health Board focused on delivering sustainable cost savings through:

- Workforce optimisation (e.g., reducing agency spend, improving rostering).
- Medicines management (e.g., reducing waste, optimising prescribing).
- Service redesign to improve efficiency and reduce duplication.
- Use of data interrogation tools (e.g. CHKS, VAULT, and GiRFT) to identify savings opportunities.

Divisions delivered savings in these and other areas by devising and pursuing a range of individual savings schemes.

3. Value and Sustainability Board (VSB)

A dedicated VSB met fortnightly to monitor progress across savings categories (CHC £8.443m, Medicines Management £3.518m, Procurement & Non-pay £15.115m, Service redesign £3.624m, Workforce £9.808m) to identify further savings opportunities and ensure accountability and timely delivery of savings targets.

4. Welsh Government Support and Revised Control Total

The Health Board received £40.5 million in additional recurrent funding from the Welsh Government in December 2024 (£9.5m for operational pressures and £31m conditional on meeting specific objectives).

This resulted in a revised control total deficit target of £7.356 million, which the Board aimed to meet or improve upon.

5. Monitoring and Reporting

Regular financial monitoring was conducted internally with oversight from Divisions, Executive Team, Finance & Performance Committee and Board - with returns submitted to the Welsh Government. Identified risks such as drug cost inflation, workforce pressures, and pay awards were actively managed throughout the year to prevent overspend.

By the end of 2024/25, ABUHB reported a £7.185 million deficit, slightly under the revised control total, indicating progress toward financial sustainability.

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- Gaps in the highlight reporting by the Value and Sustainability Board category leads to the Executive Team meetings; and
- Outstanding actions logged to address issues contributing to the underperformance of savings schemes.

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Appropriate oversight, approval and the scrutiny of recovery plans were in place, in accordance with core themes set out by the Value and Sustainability Board.	1	Reasonable
2	Progress toward achievement of each recovery plan was regularly monitored and where necessary, changes were made to the operating models of divisions, services and departments to address any underperformance against plans.	2	Reasonable
3	There was an escalation process to the Finance and Performance Committee where savings were not achieved, alongside suitable remediation and regular progress reporting.	-	Substantial

Management Actions



High Priority



Medium Priority

Themes



■ Governance

Risk Types

Financial Loss
Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Appropriate oversight, approval and the scrutiny of recovery plans was in place, in accordance with core themes set out by the Value and Sustainability Board.

Reasonable

Overview / Summary of Observations

The Health Board operated a multi-faceted monitoring, reporting, oversight and approval model for its savings schemes to support their delivery. The end-to-end process was as follows:

Identifying savings

As part of the annual IMTP process, Divisions working with their Finance Business Partners reviewed their planned activities for the next year and submitted into the centre a list of savings schemes they expected to be able to achieve. These were then examined centrally, and the Division’s review was repeated. When all avenues for savings opportunities were believed to have been exhausted, Divisions savings scheme final lists were incorporated into the Health Board’s Annual Plan and allocated to the appropriate Value and Savings Board (VSB) category. Divisions and the VSB continued to seek savings opportunities as the year progressed, during which further schemes may be added.

Monitoring savings scheme delivery

The savings monitoring model was structured and operated as follows:

- 1. Scheme owners reported scheme progress to their Divisional management team meeting;
- 2. Divisions submitted updated proforma reports of savings scheme progress to the monthly Divisional meeting of the VSB;
- 3. The VSB lead reported progress to the Executive committee in the monthly Executive Committee VSB meeting; and
- 4. The VSB lead reported progress to the Finance & Performance committee in the quarterly VSB Assurance report.

We noted that across the months of the 2024/25 financial year, there were several gaps in the meeting regimes of both Divisional and Executive Team VSB meetings (**Key Finding 1**). Further, we noted that for meetings that did take place, there were typically gaps in the highlight reporting by the VSB category leads to the Executive Team meetings (**Key Finding 1**).

Key Findings		Risk & Impact	Agreed Management Action
1	Governance - Savings monitoring meetings We noted that across the 12 months of the 2024/25 financial year, there were several gaps in the monthly meeting regime of VSB meetings: eight Divisional and seven Executive Team meetings took place. We also noted that the VSB lead of the Medicines Management category did not submit a report of savings scheme progress to the meeting of the Executive Team in May 2024.	Decision making of the oversight groups are impacted by frequency of reporting, impacting opportunities to secure existing or further savings	Agreed Action: V&SB meetings will be held as per the established timetable, there may be circumstances where operational pressures or savings delivery planning may replace these meetings – amendments to meetings are subject to CEO approval. Executive leads will be reminded of their responsibility to provide updated reports.

			Expected Evidence of Implementation: Correspondence & Minutes of meetings for verification
		Medium Priority	Officer: CEO/ DoF Date: September 2025
	Theme: Governance	Control Operation	

Objective 2: Progress toward achievement of each recovery plan was regularly monitored and where necessary, changes were made to the operating models of divisions, services and departments to address any underperformance against plans.

Reasonable

Overview / Summary of Observations

Progress toward achieving savings schemes was continuously monitored by the Divisions and reported to the VSB monthly - as outlined in the previous section of this report. During the audit, we examined the progress of a small sample of these savings schemes across the 2024/25 financial year, using the evidence of monitoring activity that takes place to assess the level of scrutiny being applied through the collective oversight bodies.

Division	Savings Scheme Number	VSB category	Scheme / Opportunity	Full year forecast savings at M10 (£000's)	Full year actual savings (£000's)	Action taken/ event from which the savings have been obtained
Mental Health and Learning Disabilities	OPPS2-10	CHC	West Sussex - patient funding reimbursement	1,033	1,033	Reimbursement of the costs of complex care of a patient treated by the Health Board from West Sussex authority.
Primary Care and Community	PCC-57	Medicines Management	Rivaroxaban LOE - Price reduction	1,060	1,141	Price reductions in the supply of these drugs to the NHS by the supplier.
Corporate	CORP-07	Procurement & Non-pay	Health Protection - Newport Debenhams lease	220	220	Termination of a leased premises previously used for vaccinations.
Corporate	CORP-04	Service redesign	Inter-site transport	966	966	Revisions to an SLA with WAST reducing the number of chargeable inter-site transport movements.
Estates and Facilities	EF-07	Workforce	NHH Ward Closure 4:3	69	69	Closure of a ward and associated costs, these in particular relating to patient meals and cleaning costs.

All savings schemes (215 in number summing to £40.508m in total for 2024/25) were included in the tables incorporated into the monthly finance reports that appeared in the Finance & Performance Committee and Board meeting materials - where current savings achievement and RAG status are recorded for each.

We examined VSB materials for the sample schemes and found the following:

West Sussex – patient funding reimbursement

This savings scheme featured in the Divisions update reports to the VSB across the year. The scheme, originally estimated as an opportunity to save £1m, was RAG rated red throughout the earlier part of the year, raised to amber in the Q4 report to Finance & Performance Committee and ultimately realised an actual saving of £1.033m after re-imburement of patient care costs were agreed with the West Sussex authorities.

Rivaroxaban – price reduction

This saving was derived from a price reduction for a specific drug, featured in the Division’s update report to the VSB in December 2024 where it was given a RAG rating of green. Analysis / evidence was provided by the Health Board’s Finance team to support savings of £1.14m across the full year.

Newport Debenhams Lease - expiry

Corporate scheme updates were not reported to the Divisional VSB but this scheme was included within the scope of the Procurement & Non-Pay VSB’s monthly report to the Executive Team (although not individually highlighted), and included again within the scope of the key update of the Procurement & Non-Pay VSB category lead in the quarterly reports of the VSB to Finance & Performance Committee. This was the cessation of a service with no replacement and therefore the values declared as savings in 2024/25 merely reflect the monthly costs no longer being incurred.

Inter-site transport – amendments to SLA

As stated above, corporate schemes were not included in update reports to the Divisional VSB but this scheme was included within the scope of the VSB’s Service re-design category monthly report to the Executive Team (although not individually highlighted), and individually referenced in the update of key scheme progress by the Service Re-design VSB category lead in the quarterly reports of the VSB to Finance & Performance Committee. We verified financial analysis to support £786,647 of the £966,000 savings values posted for this savings scheme.

NHH Ward Closure 4:3

Ward 4:3 at Nevill Hall Hospital was officially closed in December 2024 as part of a broader reconfiguration by the Health Board. Savings for this scheme, made up the costs of rota staffing, patient feeding and ward cleaning that ceased on closure were first reported as achieved in December 2024 in the month 10 Finance Performance report included in the Board and Finance & Performance Committee meeting materials. The scheme sits within the Workforce VSB category and analysis was provided by the Health Board’s Finance team to support savings of £69k declared across the full year.

We noted that the VSB operated an action log as a means of capturing and addressing issues that arise which require corrective action but that there was a backlog in the delivery of these (**Finding 2.**).

Key Findings		Risk & Impact	Agreed Management Action
2	We noted that there was a backlog in the delivery of remedial actions in the VSB action log to address issues threatening savings scheme delivery and that there were a total of six open actions with an average age of seven months, two of which were of 15 months age (September 2023).	Failure to action corrective measures mean issues identified that impact savings opportunities remain unaddressed	Agreed Action: Actions need to be delivered or revised within agreed timescales
			Expected Evidence of Implementation: Minutes/Action logs reported
		Medium Priority	Officer: Action owner
Theme: Governance		Control Operation	Date: September 2025.

Overview / Summary of Observations

The Finance & Performance Committee (the 'Committee') plays a critical oversight role in the delivery of the Health Board's annual savings schemes. The committee's oversight functions are as follows:

Monitoring Financial Performance

The Committee regularly reviewed financial reports to ensure the Health Board was operating within its allocated budget and meeting statutory financial duties.

Scrutinising Savings Plans

- It evaluated the planning and delivery of savings schemes, including whether targets were realistic and achievable.
- The Committee identifies areas where savings were off-track and pushed for corrective actions.

Risk Management

- It assessed financial risks associated with underperformance or delays in savings delivery.
- The Committee encouraged earlier intervention to manage risks before they escalate.

Supporting Strategic Planning

It contributed to the development and review of the Integrated Medium Term Plan (IMTP), which outlined financial and operational goals over a three-year period.

Ensuring Accountability

The Committee held executive teams accountable for delivering agreed savings and maintaining financial balance.

Escalation

The Committee also provided a means of delivering Board level scrutiny/ oversight to the Health Board's savings scheme activities.

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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



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.



Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital

Final Internal Audit Brief

Aneurin Bevan University Health Board

Introduction

The audit will focus on the delivery and management arrangements established by Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) to progress the development of the Radiotherapy Satellite Centre at Nevill Hall Hospital. This audit has been commissioned in accordance with the agreed audit plan and (and associated fee) provided within the approved Full Business Case for the project.

The Welsh Government originally requested that Commissioners and Velindre University NHS Trust (VUNHST) develop a Transforming Cancer Services (TCS) Programme Business Case (PBC) for South-East Wales. After significant stakeholder and patient engagement, the clinical model within the PBC required the development of a regional centre to serve the North of the South-East Wales catchment population.

An independently led option appraisal was undertaken, and Nevill Hall Hospital in Abergavenny was identified as the preferred location for the new unit. The unit will support the existing, and in due course, the new Velindre Cancer Centre in its provision of Radiotherapy services for the population of South-East Wales.

At the latest available Project Manager’s report (February 2025), it was reported that the contract completion date had been extended from 12/11/2024 to 01/05/2025 (approx. 28 weeks). with the project being managed within the approved budget, as follows:

	£	£
WG Total Funding - FBC Approval Letter Aneurin Bevan University Health Board dated 16/12/22		37,185,000
WG Total Funding - FBC Approval Letter Velindre University NHS Trust dated 16/12/22		11,412,000
Total - FBC Funding Envelope		48,597,000
Less - Exceptional Market Volatility Risk [Category 3 - Held by the Welsh Government]		(1,356,000)
Additional Funding provided by WG for RAAC Removal		401,000
Overall Revised Funding Position		47,642,000
Forecast Works Cost Outturn position (ABU)	36,138,570	
Forecast Equipment Procurement Outturn (VNHST)	11,412,000	
Total forecast Outturn		47,550,570
Variance (i.e. forecast underspend)		91,430

The project is unique in that both Aneurin Bevan UHB and Velindre UNHST have a key role as follows:

- ABUHB will build and provide the landlord services and facilities for the building.
- VUNHST will provide the clinical services and own the associated clinical equipment within the unit.

Project specific governance arrangements were established to accommodate the requirements of both key stakeholders.

This will be the third audit undertaken of the project with the previous audit determining reasonable assurance.

Scope, Risks & Approach

Scope	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. Accordingly, the scope and remit of the current audit will include: • Validation of Management Action: Previously agreed actions have been appropriately actioned by management (Appendix A). • Project Performance: An assessment of performance against key project objectives (e.g. time, cost, benefits, critical success factors etc.). • Project Governance: Assurance that appropriate governance arrangements are in place for the current project phase. Particular consideration will be given to the stakeholder engagement and effectiveness of the collaborative working arrangements established between ABU and VNHST, recognising the joint delivery objectives for this project. • Project Financial Management: Adequate cost control and reporting systems are operated, both internally and by the External Cost Adviser. Validation of costs to date as contributing to the final account including assessment of contract changes and the calculation of pain/gain as appropriate. • User/ Technical Commissioning: Assurance that appropriate arrangements are in place to co-ordinate the technical commissioning by the contractor and the user commissioning by the Health Board/Trust. • Equipping: To ensure that the equipping process is aligned with the key construction delivery timetable, and that there are appropriate management and reporting arrangements in place to ensure its satisfactory co-ordination. • Other issues: that may impact the assurance provided, including performance against project objectives (e.g., time, cost, quality, benefit, critical success factors).
Associated risks	• Projects are not effectively managed; • Project over-runs on time and/ or cost; and • Failure to achieve the required quality or anticipated benefits.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government, or any other parties pertinent to the review. Assurance opinions and action plan risk ratings

Contacts & Timings

Client contacts	Hannah Evans	Executive Director Strategy, Planning and Partnership (ABU) (Joint SRO)
	Carl James	Executive Director of Strategic Transformation, Planning and Digital, and Deputy Chief Executive Officer (VUNHST) (Joint SRO)
	Hannah Capel	Assistant Director of Strategic Capital (ABU)
	Rachel Hennessy	Interim Director for Cancer Services (VUNHST)
	Lorraine Morgan	Programme Manager, Strategic Capital & Estates (ABU)
	Stephanie Tynan	TCS Project Manager (VUNHST)
	Kelly Jones	Head of Capital Finance (ABU)
	Danielle Jackson	Risk & Assurance Officer (ABU)
	Vimal Upadhyay	Finance Manager, Capital (ABU)
	Rani Dash	Director of Corporate Governance (ABU)
	Non Gwilym	Director of Corporate Governance (Interim) (VUNHST)
Audit & Assurance contacts	Huw Richards	Deputy Director, Specialist Services Unit
	Paul Stocker	Audit Manager
Indicative timings	Fieldwork	July 2025
	Debrief meeting	August 2025
	Audit Committee	September 2025
Brief agreement	Management is formally requested to agree this brief. The associated fee was paid (during 2024/25) in accordance with the integrated audit plan provisions included within the Full Business Case. This is the third (and final) audit to be progressed from the approved Full Business Case integrated audit plan.	

Appendix A – Validation of Management Action

Recommendations agreed at the 2023/24 audit

Ref	Recommendation	Priority Rating	Responsibility & Timescale
3.1	The UHB should ensure appropriate signed authorisation for every invoice submitted in accordance with the UHB’s Standing Orders Reservation and Delegation.	Medium	Project Director – August 2024
4.1	Performance management information regarding the prompt rectification of snags, defects, etc., should be consistently provided, highlighting trends (monthly). This reporting should include details on completed items, outstanding issues, and other relevant updates etc.	Medium	Project Director – February 2025
6.1	A thorough reassessment of remaining project risks should be undertaken to update the risk register and confirm the remaining contingency requirements.	Medium	Project Director – October 2024
6.2	The Project Board should demonstrate ongoing scrutiny and management of the project risks (and available contingency funds) through to completion.	Medium	Project Director – October 2024 Actioned

Ref	Recommendation	Priority Rating	Responsibility & Timescale
6.3	The Project Board should be appraised of any discrepancies, inefficiencies, or risks associated with the project's cash flow. This highlighting of key project financial metrics to the Project Board would allow for an informed understanding of the financial health of the project and any potential issues that need to be addressed and ensure appropriate challenge and scrutiny.	Medium	Head of Capital Finance – September 2024

Recommendations agreed at the 2022/23 audit

Ref	Recommendation	Priority Rating	Responsibility & Timescale
7.1	The UHB should seek to obtain the necessary collateral warranties at the earliest opportunity	Medium	Project Director – February 2025



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

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit 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.

Business Continuity Plan

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

The review of Business Continuity Plan will be completed in line with Aneurin Bevan University Health Board’s (the ‘Health Board’) 2025/2026 Internal Audit Plan.

As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response.

The audit will examine and assess the adequacy and completeness of business continuity plans and response protocols in a sample of the services of the health board’s divisions.

Scope, Risks & Approach

Scope	The overall objective of the audit is to 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). Objectives of the area under review: 1. There is an effective business continuity management system in place that includes the identification of governance arrangements, roles and responsibilities, business impact analysis, risk and threat assessment, mitigations, activation and response and command; and control and co-ordination. 2. There are robust business continuity plans in place, which have adequately been tested, so that core business functions can continue to be delivered in the event of a disruptive incident. 3. Business continuity plans are easily accessible within each service delivery group and for appropriate staff; and that there is access to the guidance and framework for business continuity management. 4. Processes are in place to warn, inform and advise relevant stakeholders on a timely basis in the event of a business continuity incident.
Associated risks	The main risk considered in this review is that the Health Board is unable to maintain critical services during a business continuity event, leading to significant disruption and potential risk to patients.
Limitations to scope	We will not test disaster recovery or major incident arrangements, but instead focus on local business continuity planning throughout the Health Board.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:

	Quality Domains	Quality Enablers
	Quality Domains – Safe, Timely	Quality Enablers – Information, whole systems approach

Contacts & Timings

Client contacts	Hannah Evans Wendy Warren Andrew Goodenough	Director of Strategy, Planning and Partnerships Head of Planning – Civil Contingencies Emergency Planning Manager
Audit Assurance & contacts	Stephen Chaney Eifion Jones Chris Scott	Head of Internal Audit Deputy Head of Internal Audit Internal Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	August / September 2025 September 2025 TBC
Brief agreement	Hannah Evans, Director of Strategy, Planning and Partnerships 6 th August 2025	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Grange University Hospital Emergency Department Extension

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

This audit has been commissioned in accordance with the Integrated Audit Plan provided within the Business Justification Case (BJC). The audit will review the arrangements in place to progress the extension of the Grange University Hospital Emergency Department.

At the latest project reports, completion was forecast as follows:

- Phase 1 (new extension): Forecast completion 18th July 2025, compared with original contract completion date of 13th December 2024 (7 months delay); and
- Phase 2 (reconfiguration of the existing ED Wait): Forecast completion 10th October 2025, compared with original contract completion date of 7th March 2025 (7 months delay).

The project reported a forecast overspend of £0.184m (against the approved funding envelope of £14.36m), which was being supported from the Discretionary Capital Programme.

This will be the second (and final) audit of the project and will cover project activity from September 2024 onwards (i.e. following the period covered in the 2024/25 audit).

Scope, Risks & Approach

Scope	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. Accordingly, the scope and remit of the current audit will include: • Validation of Management Action: Assurance that previously agreed actions have been appropriately actioned by management. • Project Performance: Consideration of performance against key project objectives (e.g., time, cost, quality, etc.) and an assessment of any variances to the achievement of the same. • Governance: Assurance that appropriate governance arrangements are in place, including effectiveness of project forums, operation of effective reporting and accountability lines, risk management and compliance with defined approval processes. That appropriate arrangements are in place to ensure service readiness for the upgraded facility. • Financial and Technical Assurance: To obtain assurance of both the financial and technical aspects of scheme delivery. The assessment may include e.g. compliance with framework and contract requirements, additional approvals/ change control, adequacy of cost monitoring, control and reporting systems operated internally and by the external Cost Adviser. Validation of costs to date (inc. main contract, advisers, other costs etc.), risk management and associated management of contingency funds. Appropriate monitoring and management of the CRL. • Equipping: Assurance that equipment requirements have been appropriately identified. That a suitable programme is in place to afford time for procurement, delivery, installation and commissioning. Procurement arrangements have been managed in accordance with local and national requirements. • Quality Assurance: Arrangements are in place to monitor achievement of investment objectives and benefits. Appropriate controls are applied in the management of contractor performance, in line with framework and contractual

	requirements. Assurance that the role of the Supervisor is appropriately executed to support effective management of the quality of construction activities. • Other: Consideration of any other issues arising from the review relevant to the objectives of the audit.
Associated risks	• Potential failure to achieve key project objectives (e.g., delivery to time, cost, and quality). • Poor performance is not identified and addressed. • Potential failure to achieve value for money. • Agreed contractual conditions may not be appropriately applied. • Insufficient readiness for handover.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Hannah Evans	Executive Director Strategy, Planning and Partnership (Lead Executive)
	Richard Morgan-Evans	Deputy Chief Operating Officer (Senior Responsible Officer)
	Hannah Capel	Associate Director of Strategic Capital (Project Director)
	Robert Holcombe	Director of Finance and Procurement
	Darren Cann	Project Manager
	Kelly Jones	Head of Capital Finance
	Rani Dash	Director of Corporate Governance

Audit Assurance contacts	Huw Richards Melanie Goodman	Deputy Director, Specialist Services Unit Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	Quarter 2 2025 August 2025 September 2025
Brief agreement	Management agreement to this brief was provided on 17 th June 2025. The associated fee of £15,529 is in accordance with the integrated plan provided within the project’s approved Business Justification Case. This is the second (and final) audit to be progressed from the integrated audit plan provided at the approved Business Justification Case.	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan 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.

Space Utilisation

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

Optimising space utilisation within NHS Wales is crucial to support improved efficiency, cost reductions and to benefit patient care. This audit aims to evaluate the effectiveness of the management and control of space utilisation within the University Health Board.

This audit originates from the 2025/26 audit plan, agreed with management, and approved by the Audit Committee.

Scope, Risks & Approach

Scope	The audit will be undertaken to determine the adequacy of, and operational compliance with, established systems for the management, control and utilisation of space within the UHB, and will also take account of other supporting regulatory and procedural requirements, as appropriate. Accordingly, the focus of the current audit will be directed (but not limited) to the following areas: • Strategy and Governance: ○ To obtain assurance that the UHB's strategy for space utilisation across its estate is adequately defined and approved. Assurance that measurable targets and objectives have been established for the short, medium and long term. ○ That there are supporting policies and procedures in place. ○ To ensure that appropriate governance arrangements have been defined and are operating effectively. • Data Capture and Monitoring: ○ To ensure that a robust baseline for space occupancy and associated costs has been established, together with robust ongoing monitoring mechanisms. ○ Processes are in place for the ongoing monitoring of space utilisation, to provide up to date data to enable monitoring against performance targets, inform decisions, e.g. via surveys, audits, monitoring software etc. ○ Demonstration that evaluation data is collated from post-completion project reviews to confirm whether new build spaces are being utilised in accordance with the agreed business case objectives. ○ Assess the utilisation of monitoring tools to track space utilisation. • Management and Compliance: ○ Review processes and technological tools for managing space utilisation, including compliance with policies and procedures for space allocation, changes in use, surplus space management, and decision-making around leasing/SLAs to enable optimisation of space. ○ Evaluate the integration of cost considerations in decisions and the assessment of available space in project planning stages. • Performance Evaluation and Reporting: ○ Assess how space utilisation data is used to monitor performance against established targets. ○ Assess how data informs strategic planning for the estate. ○ Evaluate the effectiveness of reporting mechanisms, including actions taken to address under-utilisation.

	• Other: Consideration of any other issues relevant to the scope of this review.
Associated risks	• Failure to make the most efficient use of available estate to benefit patient care; • Failure to achieve cost savings; • Absence of accurate data with which to make informed decisions; • Resistance to change.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Leanne Watkins Hannah Evans Jamie Marchant Liza Methuen	Chief Operating Officer Executive Director of Planning Director Estates and Facilities Assistant Head of Estate, Capital & Property Management
Audit & Assurance contacts	Huw Richards	Deputy Director Specialist Service Unit (SSu)
Indicative timings	Fieldwork	July/August 2025
	Debrief meeting	September 2025
	Audit Committee	21 st October 2025
Brief agreement	The audit brief was agreed by the Chief Operating Officer on the 7 th July 2025 and confirmed by email.	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Subject Access Requests

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Introduction

A Subject Access Request (SAR) is a record made by or on behalf of an individual for the information that they are entitled to ask for under applicable Data Protection legislation (GDPR and the Data Protection Act 2018).

Complying with legal and regulatory obligations requires implementing effective processes that ensure timely, accurate, and transparent handling of personal data. A robust system for managing Subject Access Requests is essential, as it safeguards individuals’ rights by securely processing requests while maintaining data integrity and confidentiality. Efficiency in this system not only supports compliance but also enhances trust by delivering clear, comprehensive responses within mandated timeframes.

Scope, Risks & Approach

Scope	To ensure the Health Board is complying with legal and regulatory obligations with effective processes and that the system for managing subject access requests (SARs) is robust, secure, and efficient. Objectives of the area under review: 1. Review current SAR policies and procedures to ensure alignment with applicable data protection laws. 2. Evaluate the SAR handling process to determine if requests are acknowledged within statutory timeframes and that sufficient records are retained of the request. 3. Appropriate checks are in place to verify identity, clarify the request and review the information prior to release. 4. A record is maintained/ updated at the points of closure and the response is delivered in a secure manner (mindful of GDPR and Data Protections requirements). 5. Assess staff awareness and training on SAR procedures and legal responsibilities. 6. Appropriate arrangements are in place for complaints/ appeals.
Associated risks	• Poor SAR processes may lead to accidental data breaches or unauthorised disclosures. • Non-compliance in SAR handling could result in financial penalties from Data Protection authorities. • Higher likelihood of lawsuits from individuals whose data rights are violated resulting in litigation. • Failure to properly handle SARs could cause reputational damage.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings

Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards: Quality Domains: Person Centred, Timely and Efficient Quality Enablers: Information and Whole Systems approach

Contacts & Timings

Client contacts	Paul Solloway Michele Morgan	Director of Digital Information Governance & Access to Healthcare Records Manager
Audit Assurance & contacts	Stephen Chaney Eifion Jones Rhian Gard	Head of Internal Audit Deputy Head of Internal Audit Internal Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	July/August 2025 August 2025 September 2025
Brief agreement	Paul Solloway, Director of Digital 08.07.2025	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Welsh Intensive Care Information System

Final Internal Audit Brief

Aneurin Bevan University Health Board



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

The review of the Welsh Intensive Care Information System (WICIS) will be completed in line with the 2025/26 Internal Audit Plan for Aneurin Bevan University Health Board (the 'health board').

The WICIS is to be a full digital solution to be capable of replacing all existing charts. It will collect real-time information automatically from the monitoring devices, pumps and respiratory equipment used for each patient's care, providing easy access to vital data and insights and providing frontline staff a quick and clear overview of the status of patients and devices across the ward.

However delays to implementation, due to funding issues, as well as concerns raised by clinical staff have meant that at present it has not been implemented.

Scope, Risks & Approach

Scope	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. The objectives of the audit are as follows: 1. An exercise has been undertaken to identify learning and actions within the health board from work to date on the WICIS. 2. The health board has plans in place to mitigate any risks associated with delays in delivery of the WICIS.	
Associated risks	• SRR 006 There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery. • Loss of services and/or inappropriate access to information.	
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings	
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards: [List the relevant HC&Q Standards in the table below - HCQS - overview]	
	Quality Domains	Quality Enablers
	Safe Timely Effective Efficient	Workforce Information Learning, improvement and research Whole systems approach Leadership

Contacts & Timings

Client contacts	Paul Solloway Janice Jenkins	Director of Digital Assistant Director of Digital Programmes
Audit & Assurance contacts	Stephen Chaney Martyn Lewis	Head of Internal Audit IT Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	September / October 2025 October 2025
Brief agreement	P Solloway – 24/6	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Cyber Security

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

The review of cyber security will be completed in line with the 2025/26 Internal Audit Plan for Aneurin Bevan University Health Board (the 'health board').

Cyber security and resilience are the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

A core piece of legislation relating to Cyber Security is the Network and Information Systems Regulations of 2018 (NIS Regulations), transposed into UK law in May 2018 from the EU Security of Networks & Information Systems (NIS) Directive, with the intention to raise levels of cyber security and resilience of key systems across the EU.

Scope, Risks & Approach

Scope	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans. The objectives of the audit are as follows: 1) The risks associated with cyber security are appropriately stated, recorded, understood and managed within the organisations risk appetite. 2) An appropriate governance process for cyber security across the organisation is in place which enables monitoring, reporting and effective management. 3) Identified actions to improve cyber security are progressed appropriately. 4) An appropriate cyber incident response plan is in place.	
Associated risks	- SRR 006 There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery. - Loss of services and/or inappropriate access to information.	
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings	
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards: [List the relevant HC&Q Standards in the table below - HCQS - overview]	
Quality Domains		Quality Enablers
Safe		Workforce
Timely		Information
Effective		Learning, improvement and research
Efficient		Whole systems approach
		Leadership

Contacts & Timings

Client contacts	Paul Solloway Mark Llewellyn Mark Goodwin	Director of Digital Network, Voice and Cyber Security Manager ICT Cyber Security Manager
Audit & Assurance contacts	Stephen Chaney Martyn Lewis	Head of Internal Audit IT Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	August 2025 September 2025
Brief agreement	P Solloway – 23/6/25	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Safeguarding

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Introduction

Aneurin Bevan University Health Board (the 'health board') acknowledges its legal responsibility to safeguard both adults and children at risk, and to actively promote their well-being. In doing so, the Health Board must comply with the Duty of Candour, a legal obligation under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which requires all NHS organisations in Wales to be open and honest with individuals receiving care and treatment.

The Health Board fulfils its safeguarding duties through close collaboration with statutory partners, professionals, third-sector organisations, and the wider community. This collective approach is essential to protecting children and adults from harm. Every Health Board employee shares responsibility for ensuring that anyone—child or adult—who may be at risk of harm, whether through direct or indirect contact with the Health Board, is properly safeguarded and protected.

Scope, Risks & Approach

Scope	To ensure key policies and procedures are embedded and adhere to safeguarding regulations. Objectives of the area under review: 1. There are policies and procedures that conform to legislation and guidance – including Disclosure Barring Service (DBS) controls for staff and volunteers. 2. Confirmation of multi-agency cooperation in place and this is working in accordance with legislation. 3. Staff have received adequate training and support in relation to the protection of children and adults at risk, this to include the sharing of good practice. 4. Governance arrangements exist to manage safeguarding issues, allegations and concerns as well as there being a clear strategy in place.
Associated risks	• Non-compliance with applicable legislation, guidance and policy, resulting in patient harm. • Insufficient communication and cooperation with relevant multi agencies. • A lack of training and development of staff to ensure effective and safe working. • Safeguarding issues and concerns are not investigated and management appropriately leading to inappropriate / insufficient governance arrangements regarding safeguarding throughout the Health Board.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards: Quality Domains: Safe and Person Centred Quality Enablers: Workforce, Culture, Information and whole system approach

Contacts & Timings

Client contacts	Jenny Winslade Kelly Downes Howard Stanley Eleanor Edwards	Executive Director of Nursing Deputy Director of Nursing Head of Safeguarding Deputy Head of Safeguarding
Audit & Assurance contacts	Stephen Chaney Eifion Jones Rhian Gard	Head of Internal Audit Deputy Head of Internal Audit Rhian Gard
Indicative timings	Fieldwork Debrief meeting Audit Committee	July / August 2025 August 2025 September 2025
Brief agreement	Jenny Winslade, Executive Director of Nursing 08.07.2025	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Shadow IT

Final Internal Audit Brief

Aneurin Bevan University Health Board



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

The review of shadow IT will be completed in line with the 2025/26 Internal Audit Plan for Aneurin Bevan University Health Board (the 'health board').

Shadow IT refers to the use of IT assets (hardware, software, applications, services, and data) within an organisation without the explicit knowledge or approval of the central IT department. It often arises when employees seek quicker or more convenient solutions than those provided by the IT department, or when the tools IT provides are deemed insufficient.

The use of unauthorised hardware, software, or services introduces risks, particularly concerning security and compliance. These risks include data breaches, compliance violations, increased IT costs, and operational inefficiencies. Unauthorised applications and devices can introduce vulnerabilities, making systems susceptible to cyberattacks and data loss.

Scope, Risks & Approach

Scope	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. Objectives of the area under review: 1. IT systems and digital tools procured or managed outside the central IT function are required to comply with relevant digital policies, procedures and guidance and are included within the overall digital governance and oversight arrangements. 2. Procurement and contract management processes prevent unauthorised or duplicate IT systems from being acquired and supported outside of digital services oversight. 3. Controls are in place to prevent users from downloading and installing software without explicit approval. 4. Processes are in place to identify shadow IT and ensure risks are managed appropriately (cyber-security, compliance).
Associated risks	• SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery. • Loss of services and/or inappropriate access to information.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings

Contacts & Timings

Client contacts	Paul Solloway Sharif Biharie	Director of Digital Head of ICT
Audit Assurance contacts &	Stephen Chaney Martyn Lewis Kevin Bridgman	Head of Internal Audit IT Audit Manager IT Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	January 2026 February 2026 TBC
Brief agreement	Ps – 5/8	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Aneurin Bevan University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: September 2025

Document reference: 3997A2024

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

© Auditor General for Wales 2025. No liability is accepted by the Auditor General or staff of the Wales Audit Office in relation to any member, director, officer, or other employee in their individual capacity, or to any third party, in respect of this report.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit, Risk and Assurance Committee update

About this document	4
Accounts audit update	5
Performance audit update	6
Other relevant publications	10
Additional information	10

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.	Complete	Completed June 25
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
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).	Phase 1 Flow out of Hospital Part a – Final Part b - Final	April 2025
		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 2 Managing Urgent and Emergency care – Clearance with Health Board	This committee

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local Project Work 2024 - Eye Care Review	Chief Operating Officer	This work assesses the Health Board's eye care services including plans to meet current and future population needs, regional working and arrangements to improve service efficiency. The review also considers how the Health Board is supporting patients to minimise the risk of harm occurring as a result of delays in access.	Report in clearance with Health Board	October 2025
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork	December 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; Corporate planning arrangements; and Corporate financial planning and management arrangements.	Fieldwork	December 2025
Structured Assessment 2025 – Deep Drive Estates	Chief Executive Officer	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.	Scoping	March 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of cancer services	Chief Operating Officer	This work will follow on from the <u>review of national leadership arrangements for cancer services</u>. 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
Local project work 2025 – Follow up Outpatients	Chief Operating Officer	We were due to follow up previous Audit Wales recommendations. However, we have needed to reallocate audit resources to respond to correspondence regarding GP practice appointments and sustainability concerns (see below). As a result, the intended review on follow up outpatients is postponed with a view to moving this into next year's audit plan.	Postponed	TBC

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Local project work 2025 – GP Managed Contact Arrangements	Chief Executive Officer	We are reviewing the Health Board's arrangements for awarding the contracts to GPs who are members of the eHarley Street Group, as well as the on-going contract management arrangements relating to these practices. We will draw upon work already undertaken by Internal Audit to inform our work as appropriate.	Fieldwork	TBC

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
<u>Digital Health and Care Wales – Review of Stakeholder Engagement Arrangements</u>	July 2025
<u>Temporary Accommodation – Long term crisis?</u>	July 2025
<u>Cost Savings Arrangements – A checklist for NHS Board Members</u>	June 2025
<u>The Wales Infrastructure Investment Strategy</u>	May 2025
<u>No time to lose: Lessons from our work under the Well-being of Future Generations Act</u>	April 2025
<u>The Biodiversity and Resilience of Ecosystems Duty</u>	March 2025

Additional information

- 7 There have been no corporate documents published by Audit Wales since the last committee update.
- 8 Audit Wales is currently consulting on its fee scales for 2026-27. The deadline for responding to the consultation is 19 September 2025.



Audit Wales

1 Capital Quarter, Tyndall Street,
Cardiff CF10 4BZ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

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.

Urgent and Emergency Care: Arrangements for Managing Demand – Aneurin Bevan University Health Board

Date issued: May 2025

Document reference: 4916A2025

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

© Auditor General for Wales 2025. No liability is accepted by the Auditor General or staff of the Wales Audit Office in relation to any member, director, officer or other employee in their individual capacity, or to any third party, in respect of this report.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

About this report	4
Key facts	5
Key findings	7
Recommendations	9
Detailed report	
Planning arrangements	12
Accessing services	14
Scrutiny and monitoring arrangements	27
Appendices	
Appendix 1 – audit methods	32
Appendix 2 – audit criteria	34
Appendix 3 – management response	38

Summary report

About this report

- 1 This report sets out the findings from the Auditor General's 2024 review of the arrangements for managing demand for urgent and emergency care at Aneurin Bevan University Health Board (the Health Board). The work is the second phase of a programme of work focused on several elements of the urgent and emergency care system in Wales. The first phase, which examined discharge planning and the impact of patient flow on urgent and emergency care, is reported separately.
- 2 Our approach recognises that the urgent and emergency care system is complex, with many different organisations needing to work together to provide urgent and emergency care and to ensure the wider system operates effectively and efficiently. The Welsh Government's Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) launched in 2021, provides the context for our work. At the time of our work, the urgent and emergency care system in Wales continued to be under significant pressure. Under the Welsh Government's escalation and intervention framework, the Health Board is also in enhanced monitoring¹ for performance and outcomes related to urgent and emergency care at the Grange University Hospital.
- 3 Our work has examined the Health Board's arrangements for managing the demand for urgent and emergency care to reduce unnecessary pressure on the system. It has been undertaken to help discharge the Auditor General's statutory duties under Section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to ensure the efficient, effective and economic use of its resources.
- 4 We undertook our work between May and November 2024, with further data analysis in March 2025. The audit methods and criteria we used to deliver our work are summarised in **Appendices 1 and 2**.

¹ Under the Joint Escalation and Intervention Arrangements, Welsh Government officials meet Audit Wales and Healthcare Inspectorate Wales at least twice a year to discuss the performance of each health body. There are five escalation levels: routine arrangements, area of concern, enhanced monitoring, targeted intervention, and special measures.

Key facts and figures

Primary Care Services	
629	Number of GP urgent and acute appointments ² available per day per 100,000 head of GP population in September 2024 compared with the all-Wales average of 731. This is a decrease of 31.6% since April 2022.
1,015	Number of GP out-of-hours contacts per month per 100,000 head of GP population in June 2024 compared with an all-Wales average of 973.
266	Number of contacts at the Urgent Primary Care Centre per 100,000 head of GP population in November 2024 compared with an all-Wales average of 447.

Ambulance Services	
163%	Increase in Category A (red) ambulance calls between February 2019 and February 2025 compared with an all-Wales average of 178%.
53%	Category A (red) ambulance calls responded to within eight minutes in February 2025, compared with the all-Wales average of 51% and a national target of 65%. This is a reduction of 24% from February 2019.
12%	Patients handed over from ambulance crews to the emergency department within 15 minutes of arrival in February 2025, compared with the all-Wales average of 15% and a national target of 100%. This is a reduction of 16% from February 2019.

² Urgent and acute appointments are defined as appointments for urgent or acute conditions which have occurred over the short term.

Page 5 of 50 - Urgent and Emergency Care: Arrangements for Managing Demand – Aneurin Bevan University Health Board

Hospital Services

2%	Increase in the number of attendances at the Health Board's Emergency Departments between February 2019 and February 2025, compared with an all-Wales average increase of 1%.
1,109	Number of people waiting more than 12 hours in the Health Board's Emergency Departments in February 2025. This is an increase of 59% since September 2019.
04:32	Average time spent in the Health Board's Emergency Departments in February 2025, compared with the all-Wales average of 5 hours, 31 minutes. This is an increase of 39 minutes since February 2019.
226	Number of attendances to the Same Day Emergency Care units per 100,000 head of GP population in February 2025 compared with an all-Wales average of 233.

Funding

£77.2m	Additional monies allocated to the Health Board for the period 2022-2025 to recover planned and urgent and emergency care over and above the Health Board's core funding.
£5.7m	Additional in-year monies received by the Health Board in 2023-24, and 2024-25 to support delivery of the ambitions of the Six Goals Programme.

Key messages

Overall conclusion

- 5 Overall, we found **the Health Board is altering its urgent and emergency care services to better meet demand, supported by strong plans and oversight. Whilst changes are leading to improvements in some areas, there is a need to make better use of other alternatives to its Emergency Department and to undertake stronger engagement with patients and staff to inform plans.**

Key findings

Planning arrangements

- 6 We found that the Health Board has detailed and well-structured plans in place to manage the demand on urgent and emergency care services, including the development of new service models which provide alternative provision to the Emergency Department if appropriate for a patient's needs.
- 7 Plans demonstrate a good understanding of the key challenges affecting urgent and emergency care services, are informed by data and reflect the Welsh Government's ministerial priorities. However, more detail could be provided within plans regarding how it mitigates and monitors risks as well as the levels of resourcing and staffing required for the delivery of the Six Goals Programme.

Accessing services

- 8 We found that there is a range of activity to signpost urgent and emergency care services to the public. Despite this, feedback suggests there are further opportunities to strengthen public awareness of services, including ensuring GP and dental websites provide clear signposting to urgent services when required.
- 9 There are good examples of engagement with staff to raise awareness of services, supported by the flow navigation model. The Health Board is also developing its directory of services, and, as it progresses this work, it should ensure there are effective arrangements to ensure the directory remains up to date and is accessible to key staff, including staff working in care homes. We also heard that staff in secondary care find it difficult to communicate with GPs in a timely manner due to having to access the public phoneline.
- 10 Services have been developed to help manage demand, including some community pharmacies providing additional enhanced services. However, there remain opportunities to identify further referral mechanisms that could stream patients to their required service in a more efficient manner. The Health Board is making good use of its Minor Injuries Units, but there is more work to do to

maximise the use of Same Day Emergency Care units and Urgent Primary Care Centres, with the lowest rate of attendances in these provisions across Wales.

- 11 Despite some of the recent changes made by the Health Board, data indicates that it continues to struggle to meet demand. Ambulance handover delays continue to be at unacceptably high levels, and waiting times continue to be challenging. Performance against the 12 hours wait however is improving and the rate of discharge from the Emergency Department is comparatively high.

Scrutiny and monitoring arrangements

- 12 The Health Board utilises a range of data to monitor urgent and emergency care performance, but more work is needed to analyse this data to inform strategic planning, as well as ensure evaluative practices for monitoring project investments are consistent. However, whilst the Health Board is gathering patient feedback, it is unclear how it is using this intelligence to inform its strategic planning, and we found no evidence of how the Health Board hears from its staff about the running of urgent and emergency care services.
- 13 There is effective oversight and scrutiny of plans and performance at a corporate and operational level. The Six Goals for Urgent and Emergency Care Improvement Programme Board provides effective scrutiny and assurance on six goal workstreams as well as urgent and emergency care plans and associated expenditure. The Health Board could strengthen its reporting of the use of funding further by providing guidance for staff on how to evaluate projects funded through additional money for urgent and emergency care services.

Recommendations

14 **Exhibit 1** details the recommendations arising from our work. The Health Board's management response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations	
Risk Management within plans	
R1	The Health Board should ensure that in future Six Goals for Urgent and Emergency Care Plans, all identified risks have clear risk owners and that mitigating actions have clear target dates (Exhibit 2).
Six Goals Programme funding	
R2	To support the ongoing delivery of Six Goals related initiatives, the Health Board needs to clarify and confirm the funding arrangements for schemes beyond March 2025. Plans for future years should also identify any funding needs beyond their current annual allocation (Exhibit 2).
GP and dental public signposting via websites	
R3	To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance (Paragraph 28).
Communicating and engaging with patients and staff	
R4	To strengthen access and understanding of key services within the urgent and emergency care system, the Health Board should review the communication and referral process between secondary care and GPs to identify a more time-efficient channel to discuss patient cases (Paragraph 36).

Recommendations

Directory of services

- R5 To ensure health and care staff can adequately signpost and refer people to the right urgent and emergency services, the Health Board should:
- 5.1 Establish a mechanism to ensure the WAST Directory of Services remains up to date, which includes the identification of an officer with lead responsibility for this task.
 - 5.2 Establish a mechanism to share the Directory of Service with community and care home staff which should include referral routes to support their cohort of patients (**Paragraph 37**)

Referral pathways

- R6 To improve access and utilisation of referrals for appropriate alternative urgent and emergency care services, the Health Board should work with key staff, including WAST, to develop referral mechanisms that are clear, well-communicated and easily accessible (**Paragraph 39**).

Use of patient feedback

- R7 To ensure the Health Board is building on feedback from patients, plans for urgent and emergency care should demonstrate how they have considered patient feedback (**Exhibit 9**).

Staff feedback on service changes

- R8 To identify potential weaknesses or learning in relation to recent changes to its urgent and emergency care services, the Health Board should introduce regular mechanisms for staff feedback. This should include feedback from key partners including primary care and WAST (**Exhibit 9**).

Primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board

- R9 To ensure the Health Board has a broad understanding of demand pressures and the interaction of urgent and emergency care services, it should ensure there is primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board (**Exhibit 10**).

Recommendations

Evaluating project benefits

- R10 To strengthen its reporting of the benefits achieved from its Six Goals Programme work and associated use of funding, the Health Board should develop and communicate guidance for staff on how to evaluate the effectiveness of projects, initiatives and service changes relating to urgent and emergency care services (**Exhibit 10**).

Detailed report

Planning arrangements

- 15
- This section considers whether the Health Board has robust plans in place to manage the demand on urgent and emergency care services. We were specifically looking for evidence of plans:

 - being informed by relevant and up-to-date information;
 - identifying and seeking to address key risks associated with urgent and emergency care services;
 - aligning with requirements of the Six Goals Programme, and clearly setting out how alternative clinical pathways will work; and
 - identifying the current and required levels of resource and staffing to achieve the intended ambitions.
- 16
- We reviewed the Health Board’s Six Goals for Urgent and Emergency Care Health Board Delivery Plan (2024-25) and relevant sections of its Annual Plan: Three-year intent (2024-27).
- 17
- We found that **there are strong plans to manage demand, including the introduction of new service models, however, it is unclear how new models will be funded in the medium to longer term.**
- 18
- The findings that underpin our conclusion are summarised in **Exhibit 2**.

Exhibit 2: approach to planning urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Plans are informed by relevant and up-to-date information?	Yes	Health Board plans are well-structured and comprehensive with clear alignment between their ambitions. Plans are informed by relevant and up-to-date information, contain meaningful data such as baseline performance measures and reflect key Ministerial and local priorities.
Plans identify and seek to address key risks associated with urgent and emergency care services?	Partially	Key risks are identified in the plan, particularly risks that could affect the delivery of each workstream underpinning the Six Goals Programme. Risks include demand increasing beyond expectations, risks related to recruitment, and financial risks.

Audit question	Yes/ No/ Partially	Findings
		Whilst mitigating actions have been identified for some of the risks, others do not have identified actions, and, therefore, the plan does not provide adequate assurance that they will be resolved. Responsible officers have been assigned for each of the Six Goals, but there are no clear target dates for the mitigating actions (Recommendation 1).
Plans align with requirements of the <u>Six Goals for Urgent and Emergency Care Programme</u> , and clearly setting out how the alternative clinical pathways will work?	Yes	Plans set out details of existing and new initiatives/service models to support the delivery of the Six Goals Programme. Under each Goal, the Health Board has provided details regarding several workstreams, with single point of access development being the primary focus of Goal 2, and Same Day Emergency Care (SDEC) services, the implementation of a 24/7 Urgent Care Service and Accelerated Cluster Development being the areas of focus for Goal 3.
Plans identify the current and required levels of resource and staffing to achieve the intended ambitions?	Partially	The Health Board was allocated £2.96 million to support its delivery of the Six Goals Programme for Urgent and Emergency Care in 2024-25. Plans provide costings related to how these monies will be allocated between the three required areas. The predicted spending falls within the Welsh Government funding total, with £2.8 million of the monies being allocated to staffing, and a note states that any overspend in 2024-25 will be met by the Health Board. The Health Board's monthly monitoring return for month 12 of 2024-25 shows that spending was on track. The plan also contains some detail related to spending on other initiatives/programmes that would further enhance the delivery of the Six Goals Objectives, including e-triage development from the Six Goals Innovation Fund and regional Telecare and Acute Frailty Response from the Further Faster fund. However, more detail could be provided within the plan regarding the levels of

Audit question	Yes/ No/ Partially	Findings
		resourcing and staffing required for the delivery of the programme, in addition to where additional monies will be allocated from, if an overspend occurs. Plans do not set out any funding or staffing needs beyond March 2025 for the initiatives (Recommendation 2) .

Source: Audit Wales

Accessing services

- 19 This section considers whether the Health Board has robust arrangements in place to encourage and enable people to access the right care, in the right place, at the right time, and whether these are working. We were specifically looking for evidence of:
- effective signposting of patients to the urgent and emergency care services that best meets their needs;
 - staff having good knowledge of, and information on, the range of services available to patients, and being able to signpost/refer patients to alternative services, where appropriate; and
 - changes to service delivery resulting in improvements in access to urgent and emergency care services.
- 20 We found that **despite significant activity by the Health Board to engage patients and staff on how to access urgent and emergency care services, staff feedback and data suggest there is scope to further strengthen awareness and the utilisation of some services.**

Signposting of services to the public

- 21 We found that **there is a range of activity to signpost urgent and emergency care services to the public, however, feedback suggests there are further opportunities to strengthen public awareness of services.**

Communication plans

- 22 The Health Board has established a Communications and Engagement Strategy 2023-26 and is strengthening its arrangements to hear from patients, service users and staff. The strategy's aims have been aligned within the Health Board's IMTP

and one of the key external objectives within it is to communicate and engage the public, patients and stakeholders regarding 'Accessing Healthcare Services.' While a section of the strategy is focused on urgent and emergency care priorities, more detail could be included relating to the campaigns/activities to be employed to engage and inform members of the public regarding the services available, how these are to be accessed, as well as more information explaining alternative services to the Emergency Department.

- 23 The Health Board has employed a good range of methods to provide members of the public with information on its urgent and emergency care services including communication campaigns relating to winter pressures, 111 Press 2³, the 'Think 111 First' service and the national 'Help Us Help You' campaign. Other public communication methods include information provided on the Health Board's website and social media pages, including videos, leaflets, posters, flyers and through stakeholder channels.

Public information

- 24 The first point of call for most patients with an urgent need may be their GP, and our review of available data shows that between October 2023 and September 2024 the Health Board's GP practices provided a lower level of urgent and acute appointments (727 appointments per day) than the all-Wales average (809 appointments per day) per 100,000 head of GP population. The level has also been decreasing over time, dropping from 774 appointments per day in October 2023 to 629 in September 2024, which was the lowest in Wales. Furthermore, these are only available during the day, and in times of high demand and out of hours, patients need to be signposted to alternative services that may be better placed to meet their urgent care needs.
- 25 Our review of the Health Board's website and social media pages found that they offer a range of helpful information to the public on accessing services, including how to register and access primary care services and the roles of different healthcare professionals. Webpages also focus on the NHS 111 service, out of hours provision, common ailment scheme and the Gwent Health Guide which provides advice to patients regarding choosing the right service for their needs. The Health Board also provides information relating to its pharmacy services, including videos explaining the different job roles.
- 26 We also considered information available to the public via GP and dental practices, to assess whether there was clear signposting for patients if they have urgent or emergency care needs out of hours. **Exhibit 3** sets out the results of this work,

³ 111 Press 2 is an urgent service offering assessment and signposting advice for anyone experiencing a mental health crisis or requiring support to manage their symptoms.

which reviewed the websites and out of hours answer phone messages of 17 GP practices and 18 dental practices⁴.

Exhibit 3: results of the review of GP and dental practice information (October 2024)

Indicator	This Health Board	All-Wales position
% of GP practice websites with clear signposting	41.2	56.8
% of GP practice answerphone messages with clear signposting	94.1	89.5
% of dental practice websites with clear signposting	11.1	36.7
% of dental practice answerphone messages with clear signposting	100	86.7

Source: Audit Wales

- 27

Almost all GP and dental phonelines sampled across the Health Board provided clear signposting to urgent or emergency care services out of hours. This is better than the all-Wales position for both services. However, clear signposting on GP practice websites is less prevalent, and signposting from dental practice websites was poor, with only 11.1% of the sample providing clear information. Findings indicate that the Health Board has implemented some effective messaging via its GP and dental practice phonelines, but more work needs to be done to strengthen clear signposting on GP and dental websites (**Recommendation 3**).
- 28

Across Wales, between 450,000 and 500,000 people access the 111 website each month. The Health Board has a lower rate of 111 calls per 100,000 head of GP population, with 111 calls made by Health Board residents accounting for 14.9% of all calls in February 2024. The top five reasons for calls are set out in **Exhibit 4**.

Exhibit 4: top five reasons for calling 111 (February 2024)⁵

This Health Board	% of all calls	All-Wales position	% of all calls
Abdominal pain	2.7	Dental problems	4.1
Chest pain	1.9	Abdominal pain	2.4
Cough	1.5	Chest pain	1.6

⁴ The sample included a mix of NHS and private dental practices.
⁵ Due to ongoing issues with the new 111 system implemented in April 2024, there has been no data on the 111-service reported since February 2024.

This Health Board	% of all calls	All-Wales position	% of all calls
Rash	1.1	Cough	1.4
Fever	1.0	Rash	1.0

Source: Ambulance Services Indicators

- 29 Abdominal pain and chest pain are the top reasons for calling the 111 service in the Health Board area, accounting for 2.7% and 1.9% of calls respectively, which are both slightly higher than the all-Wales percentage for this symptom. Whilst the Health Board's website contains information about how to access the NHS 111 Wales service, advice on accidents and minor injuries and a hyperlink to a symptom checker, there is no clear information provided on the symptoms associated with the top two most frequent 111 calls across the Health Board.
- 30 Across Wales, the most common reason for calling the 111 service is dental problems. This does not feature as one of the top five reasons for calling 111 in the Aneurin Bevan area, accounting for 0.7% of calls between March 2023 and March 2024. This may be because the Health Board has a slightly higher number of dental contracts per 100,000 head of GP population compared to the all-Wales average (17.8 and 16.8 respectively). The Health Board also provides an urgent dental care service which is available during weekdays. One of the Health Board's key priorities within its urgent and emergency care services is to increase access to its dental services and plans to support this are evident within its Ministerial Priorities 2023-26 document, including the recruitment of more staff and increasing dental pathways.

Patient awareness

- 31 Despite the Health Board's Communications and Engagement Strategy and the various methods in place to communicate with the public, staff we spoke to indicated that the Health Board could do more to improve the public's awareness and understanding of urgent and emergency care services. We heard views that the system is complex and can be confusing for patients and some public service organisations (for example, care homes) to navigate within. Staff called for more work to be done to improve the public's understanding of the purpose of these services, explain how they are accessed, and keep the public up to date when there are service changes.
- 32 This perspective is supported by work from Llais⁶. In their Engagement Report in March 2023, Llais assessed patient's experiences within the Emergency Department at the Grange University Hospital and at the Health Board's four Minor

⁶ Llais is a national, independent body set up by the Welsh Government to collect and report the views and experiences of the public to influence decision-makers in the NHS and social care sector.

Injury Units. Several people surveyed stated that they had not contacted a health professional before attending the Emergency Department and Llais also reports that some patients were unaware of the option to contact 111. Following receipt of the report, the Health Board engaged with Llais to make improvements, including raising awareness with the public regarding its 'Choose Well' communications campaign through weekly information sent out to partners and stakeholders and by placing patient information screens in waiting areas. In February 2025, Llais published a national report⁷ on accessing urgent and emergency care, which captured mixed positive and negative patient experiences from within the Health Board as well as across Wales.

Staff awareness and ability to refer

- 33 We found that **there are some good examples of engagement with staff to raise awareness of services, supported by the flow navigation model, however, there is scope to further raise awareness of the availability and accessibility of some services, particularly those provided by third sector organisations.**

Promoting staff awareness of services

- 34 The Health Board uses a range of methods to raise staff awareness of urgent and emergency care services. These methods include staff bulletins, presentations and staff consultations. Flyers aimed at staff to explain the purpose of the Flow Centre navigation model⁸ can also be found on the Health Board's website, as well as a 'Care Navigation' training resource, which guides staff through the various urgent and emergency care services available to signpost patients to. The Health Board has also met with a number of volunteer groups to raise awareness of services available. The Health Board's Communication and Engagement Strategy (2023-2026) also emphasises the importance of working with Urgent and Emergency Care teams.
- 35 However, evidence from some interviewees suggests that some staff continue to find the urgent and emergency care system complex and confusing, with variable understanding of what services are available to patients.
- 36 Communication and engagement between the Health Board and primary care staff have been found to be variable. The development of an urgent primary care workstream within the Health Board's Six Goals programme has strengthened

⁷ Llais national report, '[Getting Urgent and Emergency Healthcare in Welsh Hospitals](#)' February 2025

⁸ The Flow Centre navigation model facilitates referrals for urgent and emergency care. Health professionals access this model via telephone. The Flow Centre is supported by a multidisciplinary team (MDT) and is aimed at improving patient flow, providing specialist advice regarding referral routes and reducing conveyance to the Emergency Department.

some relationships, with closer links forged between GP clusters and the Flow Centre and Minor Injury Units. Meetings with the Local Medical Council were also highlighted by interviewees as an effective forum for communication, as well as Professional Collaboratives and weekly updates from the Deputy Medical Director to primary care staff. However, interviews highlighted opportunities to improve the communication channel between secondary care and GPs, as secondary care staff stated they can only contact GPs via phone lines that are also being used by patients to book appointments (**Recommendation 3**).

- 37 In addition, information to capture pathways and guide staff can be inconsistent and information on how and where staff can refer patients to intermediary services run by the third sector and services within the community are not easily accessible. The Welsh Ambulance Services University NHS Trust (WAST) holds a directory of services for each Health Board area which contains details of referral pathways. It is the responsibility of the Health Board to ensure that this directory is kept up to date for accurate information. As of May 2025, the Health Board were working to further develop the directory of service to create a combined version which pulls together information into a single warehouse. In completing this work, the Health Board should consider how to ensure there is broad access to the information on this directory of service, including to community and care home staff (**Recommendation 4**).

Referring to services

- 38 The Health Board aims to strengthen referral processes for urgent and emergency care through its flow navigation model. This is supported by the implementation of a single telephone number, which health professionals can use to access three services: frailty, urgent primary care and the Flow Centre itself. Through this phone line, paramedics and GPs can seek advice when making referrals, including information on alternative pathways such as the Community Resource Team and SDEC services.
- 39 Ambulance staff interviewed and observed possessed a good awareness and knowledge of referral pathways. Several of the alternative pathways implemented in partnership with WAST have been described as successful, including the Physician Response Unit, a Falls pathway and the use of Consultant Connect. However, several WAST interviewees expressed the need for more direct referral routes into alternative services, rather than accessing these through the Flow Centre. As well as this, ambulance staff suggested the need for further alternative referral pathways to be developed, including for health conditions such as chest pain, breathing problems and abdominal pain, in addition to an early pregnancy pathway and more alternative pathways to support patients with mental health conditions (**Recommendation 6**).
- 40 The Health Board has a slightly lower rate of patients who call 999 who are dealt with through 'hear and treat' than the all-Wales average (14.1% compared with

15.1% in April 2024). Of those calls, the proportion directed to alternative services is broadly in line with the all-Wales average (73.1% compared with 73.9%).

- 41 The 111 service is also directing a higher proportion of patients from the region to alternative services. **Exhibit 5** sets out the extent to which the 111 service has been able to direct patients away from the Emergency Department.

Exhibit 5: referral to other services (February 2024)

Indicator	This Health Board	All-Wales position
% of 111 calls referred to GP out of hours	48.1	41.0
% of 111 calls referred to another health profession	2.0	2.4

Source: DHCW Urgent and Emergency Care Dashboard, Ambulance Services Indicators

- 42 During 2023-24, the rate at which 111 calls were referred to the Health Board’s GP Out of Hours service was higher than the all-Wales position, with the rate being considerably higher during the winter period. Referrals to another health profession were broadly consistent with the all-Wales average. However, it is difficult to know whether patients took up that advice, or whether those services ultimately still referred patients onto the Emergency Department.
- 43 In addition, 4.6% of calls to the 999 service were transferred to the 111 service, indicating they were less urgent. However, of those calls, 30.6% were transferred back to the 999 phoneline to be considered for an ambulance dispatch. This is higher than the all-Wales average, which was 27.6% for the same period. This higher rate suggests there is scope to increase the availability of appropriate pathways for calls which are urgent but not life-threatening across the Health Board.
- 44 The extent to which ambulance crews are able to ‘see and treat’ patients at scene within the Health Board area is just higher the all-Wales average (15.8% compared with 11.8% in February 2025). The percentage of these patients who are referred to alternative care services is lower than the all-Wales position (7.4% compared with the all-Wales average of 11.9% in February 2025).

Services to help manage demand

- 45 We found that **services have been developed to help manage demand, including some community pharmacies providing additional enhanced services. However, the utilisation of these services is lower when compared with other Health Boards, which suggests opportunities to strengthen access.**

Community pharmacy services

- 46 For 2023-24, the Health Board had a below average number of community pharmacies per 100,000 head of GP population in Wales, at 19.9 (compared to 20.9 at an all-Wales level). Each one of the Health Board’s community pharmacies signed up to provide the common ailment scheme in 2023-24. This scheme allows pharmacists to assess and treat a common list of minor ailments⁹. However, should antibiotics be required, then patients would need to be referred to their GP. The number of common ailment consultations per 100,000 head of GP population for 2023-24 was the lowest in Wales (8,556 compared with an all-Wales average of 10,471). The most common ailments reported were conjunctivitis, hay fever and dermatitis.
- 47 To supplement the scheme, some community pharmacies have also signed up to provide additional enhanced services, which further increase the ability of community pharmacists to respond to minor ailments. This includes providing the sore throat treat and test service, and the independent prescribing service. Both services enable the community pharmacist to prescribe antibiotics. In addition, community pharmacists can also provide the additional hours service, which allows them to extend their opening hours and provide bank holiday cover.
- 48 The uptake of these is set out in **Exhibit 6**.

Exhibit 6: uptake of enhanced services in community pharmacies (2023-24)

Indicator	This Health Board	All-Wales position
% of community pharmacies providing the sore throat treat and test service	63	79
% of community pharmacies providing the independent prescribing service	30	28
% of community pharmacies providing additional hours services	23	16

Source: StatsWales

- 49 While nearly two thirds of the Health Board’s community pharmacies provide the sore throat treat and test service, an increase from 53% in 2022-23, uptake is the lowest in Wales. Provision of the independent prescribing service has also increased since 2022-23, with uptake slightly higher than the all-Wales position. Although the percentage of community pharmacies providing the additional hours service is well above the all-Wales average, the rate has significantly reduced from 54% of practices in 2022-23.

⁹ [Common ailments scheme](#), 2021

Same Day Emergency Care and Urgent Primary Care Centres

- 50 In line with the ambitions of the Six Goals Programme, the Health Board has established Same Day Emergency Care (SDEC) units. The principle of the SDEC is to provide same day assessments and treatment for patients needing urgent medical or surgical attention, without the patient needing to be admitted into hospital overnight. The Health Board has both Surgical and Medical SDEC units which currently operate five days a week between 8 am and 8 pm, except for the Ysbyty Ystrad Fawr SDEC which closes at 4 pm on Fridays.
- 51 Between March 2024 and February 2025, the Health Board had the second lowest rate of attendances to its SDEC units per 100,000 head of GP population across Wales (191.9 compared to the all-Wales average of 246.3). Referrals to SDEC can be made through the flow navigation model or via the Consultant Connect system¹⁰. The Six Goals Plan 2024-25 outlined the ambition to ensure that patients are seen in the right place first time. This includes increasing the volume of acute medical patients who are seen within an SDEC unit, with a predicted forecast of 400 patients a week across SDEC/Ambulatory services (plus 240 more predicted via Medical Assessment Units). A Board paper in January 2025 reported that following an initial pilot of providing medical patients with an initial assessment in SDEC, as opposed to the Medical Assessment Unit, the Health Board has seen a substantial increase in patient throughput through the SDEC. This is supported by the data which shows that attendance levels have increased significantly since October 2024.
- 52 Good practice indicates that there should be high rates of discharge from SDEC units to ensure that they are being used effectively and appropriately. The number of patients that were discharged from the Health Board's SDECs was also lower than the all-Wales position in July 2024 (77.4% compared to the all-Wales average of 82.5%). These figures suggest there may be potential to ensure the patients being referred to SDEC have the appropriate needs for the service ie that they can receive diagnosis and treatment and be discharged the same day. This perspective was supported by focus groups held which indicated that there is more work to be done to improve the interface between SDEC and the Emergency Department.
- 53 The Health Board also has two Urgent Primary Care Centres (UPCC) which provide 24/7 services and are based at the Royal Gwent and Nevill Hall Hospitals. The rate of UPCC contacts per 100,000 head of GP population in the Health Board has fluctuated significantly since April 2022, ranging between a high of 351 and a low of 100. The average number of monthly UPCC contacts per 100,000 head of GP population during that period has been the lowest in Wales at 220, compared to an all-Wales average of 375. Referrals to the UPCC can be made from the GP Out of Hours service, Minor Injuries Units and the Emergency Department, as well as from NHS 111 Wales. The implementation of a 24/7 urgent care service is a key

¹⁰ Consultant Connect is a phone app which connects NHS clinicians, including GPs and paramedics, to a range of hospital consultants for advice and guidance.

workstream within the Health Board's Six Goals Plan. To support this, the Health Board launched an integrated nurse practitioner co-located model for a third UPCC and Minor Injuries Unit at Ysbyty Ystrad Fawr in November 2023. This service was identified as a case study by the Welsh Government, which stated the service had supported 866 patients avoid an Emergency Department attendance, therefore improving the utilisation of the UPCC and creating a more sustainable model of delivery. Despite this, there remains more to do to ensure the Health Board is maximising the value of UPCCs to bring the volume of public contacts in line with the all-Wales average.

Impact of service changes on urgent and emergency care performance

- 54 We found that **the Health Board is making good use of its Minor Injuries Units, but there is more work to do to maximise the use of SDECs. Waiting times within the Emergency Department are problematic and handover delays continue to be at unacceptably high levels.**

Ambulance performance

- 55 Since the pandemic, 999 calls to the ambulance service across the Health Board have continued to rise. The number of red calls received is now substantially higher than the level experienced by the service pre-pandemic with an average of 1,015 red calls per month between March 2024 and February 2025, compared to an average of 374 calls per month between March 2018 and February 2019. Whilst continuing to account for most 999 calls, the number of amber calls has decreased since the pandemic with an average of 4,523 calls per month between March 2024 and February 2025 (compared to 4,782 between March 2018 and February 2019).
- 56 Despite the overall increase in ambulance demand, the rate at which ambulance crews convey patients to hospital has reduced since pre-pandemic levels from 68.4% (March 2018 to February 2019), to 63.3% (March 2024 to February 2025). The rate is consistent with the all-Wales average (63.4%). **Exhibit 7** sets out the destination for all conveyances.

Exhibit 7: conveyance destination as a proportion of total conveyance (March 2024 to February 2025)

Indicator	This Health Board	Trend	All-Wales position
% of patients conveyed to major emergency departments	68.3		88.7
% of patients conveyed to minor injuries units	29.9		6.3
% of patients conveyed to major acute medical admissions unit	0.2		3.1
% of patients conveyed to other unit eg. mental health or maternity unit	1.6		1.8

Source: Ambulance Services Indicators, DHCW Urgent and Emergency Care Dashboard

- 57 Ambulance crews convey a lower proportion of patients to its major Emergency Department than the all-Wales average. This is likely due to the comparatively high rate of conveyance to minor injuries units, which is much higher than the all-Wales average and the highest across Wales. There are four minor injuries units within the Health Board, all situated within hospital sites and referrals are primarily made through the Flow Centre. Two of the units had previously been emergency departments prior to the opening of the Grange Hospital in 2020. After a period of public engagement between September and December 2023, the Health Board altered the opening hours of the different minor injuries units to better meet demand. As a result, three of the four units are open seven days a week, with the unit at the Royal Gwent Hospital open for 24 hours.
- 58 However, conveyance to major acute medical admissions units (which include SDECs) as well as conveyance to other units is low. This is because the primary referral source into these services is via the Flow Centre, including for those by WAST.
- 59 Conveyances to hospital following a 999 call from a care home were at an average rate of 53.8% per month between October 2023 and November 2024, lower than the all-Wales average of 60.5% and the lowest in Wales. This may reflect the work of the Health Board’s Frailty Response Team, as well as the new Falls Pathway that has been implemented. The Health Board is also planning on undertaking a programme of work co-produced with care homes to help further reduce conveyances to the Emergency Department, as well as supporting a ‘Luscii’¹¹ pilot led by WAST.

¹¹ The ‘Luscii’ pilot involves remote monitoring technology designed to communicate patient clinical information to WAST staff, in order to safely prioritise the appropriate response.

- 60 Two key aims within the Health Board's Six Goals Plan are to improve ambulance handover performance and reduce ambulance conveyance to the Emergency Department. Key actions put in place to support these aims are a collaborative programme between the Health Board and WAST and an Emergency Medicine action plan. However, data shows that ambulance handover delays across the Health Board continue to be at unacceptably high levels. The percentage of ambulance handovers completed within 15 minutes between March 2024 and February 2025 was just 15.9%, against a national target of 100%. This performance was in line with the all-Wales position of 15.8%. Most handover delays are experienced at the major Emergency Department at the Grange University Hospital, although handover delays can be problematic at Minor Injuries Units. This was evident between March 2024 and February 2025, as only 15.0% of handovers at the Health Board's Minor Injuries Units were completed within 15 minutes (against an all-Wales average of 31.4%).
- 61 During our observations, we saw some of the flow issues that result in handover delays at the Health Board's hospitals. At the Grange University Hospital, where we saw between eight and ten ambulances waiting on the hospital forecourt, Paramedics indicated that they sometimes spend an entire 12-hour shift waiting to hand over one patient. Concerns were also expressed from both nursing and WAST staff regarding the current dual pin handover system, which staff said was not always fully completed as expected. Whilst it was beyond the scope of our review to examine these technical issues, the Health Board and WAST may benefit from examining these issues further.
- 62 Handover performance has been steadily declining within the Health Board since September 2023 and is resulting in a high number of lost hours. The Health Board lost on average 3,214 hours every month between March 2024 and February 2025. This equates to 267 12-hour shifts where patients were waiting in an ambulance outside of hospital for treatment and paramedics were unable to respond to other calls.
- 63 In 2021, a clinical review developed by the Association of Ambulance Chief Executives¹² discovered that the rate at which harm occurs for patients increases when their handovers take over an hour to complete. This review indicated that the likelihood of a patient experiencing severe, or permanent, harm was 7% for handovers taking between an hour and an hour and a half, 10% for handovers taking between two and three hours and 27% for handovers taking over four hours to complete. Data from February 2025 showed that 40.5% (771) of handovers within the Health Board took over one hour to complete, and 20% (380) of handovers took over four hours to complete. By this methodology, there is a potential that 103 patients came to severe harm because of handover delays during February 2025.

¹² 'Delayed hospital handovers: Impact assessment of patient harm' Association of Ambulance Chief Executives, November 2021

64 Handover delays inhibit the ability of ambulance staff to respond to other urgent calls in the community. Ambulance response times continue to be challenging and below performance targets, although they are slightly better than or in line with the all-Wales average (**Exhibit 8**).

Exhibit 8: red and amber call response times (March 2024 to February 2025)

Indicator	This Health Board	Trend	All-Wales position
% of red calls responded to within eight minutes	51.1		48.6
Median response to amber calls (minutes)	112		111

Source: Ambulance Service Indicators

65 The percentage of red calls responded to within eight minutes is significantly below the target of 65%. On average, the response time to amber calls between March 2024 and February 2025 was 1 hour 52 minutes, rising to 9 hours 6 minutes for those who waited the longest. Performance has declined over the last 12 months.

Emergency department performance

- 66 Within the Health Board, the rate of attendances at an Emergency Department per 100,000 head of GP population has been consistently lower than the all-Wales position, with 1,174 average attendances a month between March 2024 and February 2025 (compared to an all-Wales average of 1,976). Conversely, attendances at the Health Board’s Minor Injuries Units have been significantly higher than the all-Wales average (1,262 and 756 respectively). Members of staff we interviewed suggested that some patients with needs that should not be treated at Minor Injuries Units are self-presenting due to long ambulance waits, inappropriate referrals from primary care or because the patient has not been able to access a GP appointment.
- 67 Waiting times in the Health Board’s emergency departments have been broadly consistent over recent months, and above the all-Wales average, ranging between 73% and 79% of patients waiting more than four hours. Performance, however, continues to be a challenge at the Emergency Department at the Grange University Hospital. Over the last 12 months, performance has been around 52% which is below the all-Wales average for a major emergency department. The percentage of patients spending less than 12 hours in the Emergency Department has, however, improved, at 82.2% but is still below the all-Wales average. Once assessed, the average rate of admission is higher than at an all-Wales level, at 25.6% compared to 22.3% between March 2024 and February 2025.

Scrutiny and monitoring arrangements

- 68 This section considers whether the Health Board is doing enough to monitor the performance of its urgent and emergency care services, and applying lessons learnt to improve services further. We were specifically looking for evidence of:
- arrangements for monitoring the impact of alternative clinical pathways; and
 - effective oversight and scrutiny of the delivery of plans for urgent and emergency care.
- 69 We found that **there is a range of urgent and emergency care performance data which is regularly monitored and scrutinised, however, there is scope to strengthen staff feedback, more clearly demonstrate the use of patient feedback to inform plans, and to consistently evaluate project investments.**

Monitoring impact

- 70 We found that **there is a range of available data on the use of urgent and emergency care services, including patient feedback, however, it is not clear how this intelligence is used to improve performance and inform plans, and staff feedback is limited. The Health Board also needs to expand its use of data when reporting on alternative pathways.**
- 71 The findings that have led us to this conclusion are summarised in **Exhibit 9**.

Exhibit 9: approach to monitoring impact on urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is the Health Board tracking and reporting data to show whether patients are accessing urgent and emergency care services appropriately?	Partially	The Health Board has a good range of system-wide data to show how services are being used, for example, emergency department and SDEC units, Flow Centre referrals and the new Falls pathway. The Health Board’s Six Goals Plan and programme updates are also data driven, and have been used to inform workstream planning, including changes within the Flow Centre model. However, data related to other alternative clinical pathways was less prevalent in reporting, for example, the impact of the Health Board’s UPCCs and its Physician Response Unit. Staff we spoke to suggested the Health Board could do more to regularly drill down into

Audit question	Yes/ No/ Partially	Findings
		data to analyse specific service performance, such as, patient acuity. Increased data analysis related to GP activity and community services was also a suggestion as to how demand management could be further enhanced, although this data is routinely available.
Is regular patient feedback being sought and used to inform and improve plans?	Partially	The Board receives regular updates regarding patient experience and engagement. The Health Board regularly seeks public feedback through the CIVICA system¹³, launched in 2023, as well as reports from Llais. In a March 2023 Llais survey, while 73% of the 399 patients surveyed rated their experience within the Health Board's Emergency Department or Minor Injuries Unit as either 'very good' or 'good', there were many negative responses regarding the length of waiting times. The survey report notes that, despite this more negative feedback, changes made since the previous survey have improved patient satisfaction. Evidence suggests that the Health Board has actively shared the survey findings with staff and WAST. The Health Board has also sought feedback relating to specific service changes, such as the opening hours of Minor Injuries Units and their experience of care received by an SDEC unit. However, it is unclear how the Health Board is using patient feedback to inform and improve plans (Recommendation 7).
Is there regular staff feedback on the impact of changes to services and pilots to identify and apply lessons?	No	There is no evidence of the Health Board proactively collecting feedback from staff related to urgent and emergency care services. Whilst the Health Board provided us with some good examples of how it communicates with staff to raise awareness of the range of

¹³ CIVICA is a software platform designed to measure patient feedback within healthcare organisations.

Audit question	Yes/ No/ Partially	Findings
		available services, we did not find evidence of the Health Board seeking staff feedback related to recent changes in services or urgent and emergency care services more generally (Recommendation 8).

Source: Audit Wales

Oversight and scrutiny

- 72 We found that **there is effective oversight and scrutiny of performance, but there is scope to evaluate projects more consistently.**
- 73 The findings that have led us to this conclusion are summarised in **Exhibit 10**.

Exhibit 10: approach to oversight and scrutiny of urgent and emergency care services

Audit question	Yes/ No/ Partially	Findings
Is there effective oversight of urgent and emergency care performance operationally, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Yes	The Six Goals for Urgent and Emergency Care Improvement Programme Board, provides scrutiny and assurance on key urgent and emergency care workstreams. The Executive Director of Nursing chairs the Programme Board. The Programme Board has clear representation from executive, operational and clinical leadership and includes attendance from WAST. However, minutes indicate that there are currently no representatives from primary care in attendance at these meetings, which could limit the Board's understanding of broader demand pressures and the interaction of urgent and emergency care services (Recommendation 9). Minutes from the Programme Board demonstrate updates and reporting on all key workstreams, as well as the analysis of Six Goals metrics. Scrutiny of planning and

Audit question	Yes/ No/ Partially	Findings
		actions is also evident in a range of performance reports. Urgent and emergency care operational performance is also scrutinised through Enhanced Monitoring Meetings¹⁴ and Safety Flow Meetings¹⁵, which provide very detailed information focused on a range of service areas, with some data analysis produced from the Lightfoot system¹⁶.
Is there effective oversight of urgent and emergency care performance at the committee and board level, including scrutiny and assurance on the effectiveness of plans and actions being taken to better meet demand?	Yes	Our review of papers found effective scrutiny and oversight of urgent and emergency care at Board and Committee level, including performance, priorities and plans. Reporting on urgent and emergency care milestones and ministerial targets occurs through the Health Board's quarterly Integrated Performance Reports and Dashboard. These reporting mechanisms provide an overview of performance as well as trends, but more detail could be provided regarding the actions taken to improve performance and their impact. Monitoring of progress against the Six Goals for Urgent and Emergency Care Plan occurs within the Six Goals Programme Board meetings, which are held monthly.
Are there arrangements in place for monitoring and oversight of economy, efficiency and	Partially	The Health Board is monitoring project investment within its Six Goals Programme and is on track according to recent Monthly Monitoring Returns. However, more work

¹⁴ Enhanced Monitoring Meetings were introduced by the Health Board to monitor and scrutinise service areas that have been placed under escalation status by the Welsh Government. Meetings monitor performance metrics, targets and actions.

¹⁵ Safety Flow Meetings have been set up by the Health Board to monitor flow through the urgent and emergency care system, with a particular focus upon improving ambulance handover performance.

¹⁶ Lightfoot is a data analytics platform designed to improve healthcare and operational efficiency. It provides Health Boards with real-time data which, for example, can be utilised to manage patient flow.

Audit question	Yes/ No/ Partially	Findings
effectiveness of project investment from the Welsh Government?		needs to be done to develop consistent evaluative practices across the organisation. We found that while the Health Board has internal processes in place to evaluate urgent and emergency care projects and initiatives for effectiveness and value for money, this is inconsistent across the organisation (Recommendation 10).

Source: Audit Wales

Appendix 1

Audit methods

Exhibit 11 sets out the audit methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 11: audit methods

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Six Goals for Urgent and Emergency Care Delivery Plan, 2024-25 • 2024-27 Annual Plan: Three-year intent • Integrated Medium Term Plan (2022-25) • Quarterly Outcome and Performance reports • Health Board Ministerial Priorities 2023-26 • Communications and Engagement Strategy 2023-2026 • Strategic Risk and Assurance Reports • Public Board Meeting papers • Finance and Performance Committee papers • Safety Flow Meeting papers • Enhanced Monitoring Meeting papers • Divisional Assurance Meeting papers • Six Goals for Urgent and Emergency Care Improvement Programme Board papers • Six Goals for Urgent and Emergency Care Programme Update • Care Navigation. Urgent and Emergency Care at Aneurin Bevan University Health Board (staff training resource) • CIVICA Once for Wales Patient Feedback presentation • Llais Gwent region briefing document
Interviews	We interviewed the following: • Chief Operating Officer • Programme Lead for Urgent and Emergency Care • Director of Primary and Community Services • General Manager for Urgent Care at the Grange University Hospital • WAST Head of Service Operations (South-East)

Element of audit approach	Description
Group discussions	We held group discussions with the following: • GP Cluster Leads and Out of Hours Leads • Leads for the Emergency Department, SDECs, UPCCs and Minor Injuries Units
Observations	We also observed the ambulance handover process at the Emergency Department in the Grange University Hospital. We spoke with the following staff: • Locality Manager • Paramedic x 2 • Senior Nurse • Triage Nurse • Emergency Unit Receptionist
Data analysis	We analysed data relating to urgent and emergency care services, using the following sources: • Ambulance Services Indicators; • DHCW Urgent and Emergency Care Dashboard; • StatsWales; • Data provided by the Welsh Government in relation to GP out-of-hours services; and • Monthly Monitoring Returns.
Website and practice reviews	We reviewed the Health Board's website and social media accounts relating to the provision of information to the public on accessing urgent and emergency care services. We also reviewed practice websites and phonelines for: • a sample of 17 GP practices; and • a sample of 18 dental practices.

All audit work has been delivered in accordance with the International Organisation of Supreme Audit Institutions (INTOSAI) audit standards.

Appendix 2

Audit criteria

Exhibit 12 sets out the audit criteria that we used to deliver this work.

Exhibit 12: audit criteria

Audit questions	Audit criteria
Does the Health Board have robust plans in place to manage the demand for urgent and emergency care services?	
Do plans seek to improve the management of demand through changes to service delivery in line with the Six Goals for Urgent and Emergency care?	- Strategies and/or plans relating to urgent and emergency care: - are based and grounded in rich and up-to-date information, informed by urgent and emergency care demand data (past and future), including peaks in activity at certain times/days and months, demographics, and conditions of patients; - identify and seek to address key risks associated with demand for urgent and emergency care services; - align with the requirements of the Welsh Government's Six Goals for Urgent and Emergency Care for better managing demand; and - include documented information on alternative clinical pathways, including how and when they should be accessed.
Do plans identify the current and required levels of resource and	- Strategies and/or plans detail the: - resource requirements and identified funding to support any changes to service delivery included within the strategy/plan.

Audit questions	Audit criteria
staffing to achieve the ambitions?	– workforce and skills required to meet demand, including for changes in models of delivery such as winter peaks. The plan is clear about the required resources of clinical and non-clinical skills/staff.
Are arrangements in place to encourage and enable people to access the right care, in the right place, first time, and are these working?	
Is the Health Board effectively signposting urgent and emergency care services to the public, so they know how to access services appropriately?	• The Health Board provides clear information on available services and alternatives to emergency departments to the public through various avenues – websites, call handlers, posters/leaflets, advertisements, GP/dentist websites and phone lines, social media, videos etc. • Strategies and/or plans on public communication align to requirements of goals 2 and 3 of the Welsh Government's Six Goals for Urgent and Emergency Care (Right care, right place, first time). • There is evidence to suggest patients have a good understanding of how to access urgent and emergency care services that are appropriate to their needs.
Do staff have good knowledge of, and access to, information regarding the range of other services available to their patients and at what times they are available?	• There is engagement between Health Boards and GP clusters/dentists/paramedics/pharmacists about alternative pathways in place and the future of urgent and emergency care services. Information on these pathways and services is accessible for staff. • Staff can refer directly/divert patients to more appropriate settings for their needs, including Urgent Primary Care Centres (UPCCs) and Same Day Emergency Centres (SDECs).

Audit questions	Audit criteria
Is there evidence that changes to service delivery are resulting in better demand management?	• Referrals into new service models are in line with the ambitions of the six goals for urgent and emergency care policy handbook. • WAST can refer at least 4% of cases to SDEC. • Calls to 111 are answered quickly and abandonment rates are low. • Emergency ambulance response times, ambulance handover delays and waits within Emergency Departments and Minor Injury Units are improving. • Data shows decreasing volumes of patients with low acuity/minor complaints presenting at Emergency Departments. • Data indicates a good range of GP appointment availability. • Data indicates that calls diverted between 999 and 111/NHS Direct Wales are appropriate, with low levels of calls diverted back and low numbers of re-contact rates.
Is the Health Board doing enough to monitor the performance of its urgent and emergency care services and apply lessons learnt to improve the services further?	
Is the Health Board monitoring the effectiveness of alternative clinical pathways, including by seeking feedback from staff and service users?	• The Health Board tracks and reports data to show whether patients are accessing urgent and emergency care services appropriately. • The Health Board can evidence that it seeks patient feedback regularly and uses it to inform and improve plans. • Regular feedback is sought from various staff on the impact of changes to services and pilots to identify and apply lessons.

Audit questions	Audit criteria
Is there effective scrutiny and assurance in relation to delivering plans for urgent and emergency care and alternative clinical pathways?	• There is effective oversight of urgent and emergency care performance operationally and at the committee and board level. This includes scrutiny and assurance on the effectiveness of the plans and actions being taken to better meet demand. Oversight and scrutiny are informed by comparative benchmarking and learning from other bodies where appropriate. • There are arrangements in place for monitoring and oversight of economy, efficiency, and effectiveness of project investment from the Welsh Government. This includes establishing value for money and what difference the project has made.

Appendix 3

Management response to audit recommendations

Exhibit 13 sets out the Health Board’s management response to the recommendations made because of this audit.

Exhibit 13: management response

Recommendation	Management response	Completion date	Responsible officer
Risk Management within plans R1 The Health Board should ensure that in future Six Goals for Urgent and Emergency Care Plans, all identified risks have clear risk owners and that mitigating actions have clear target dates (Exhibit 2).	The Six Goals Programme maintains a centralised risk register and action log; to strengthen our assurance process the register will be reviewed and updated regularly, with escalation routes clearly defined for significant risks. In addition, risk management will be strengthened across the Six Goals for Urgent and Emergency Care Programme, in the following ways: - all identified risks within the Programme will have named owners accountable for ongoing oversight, escalation, and resolution. This will be reflected consistently in the risk register and programme documentation. - each mitigating action will have clear target dates and associated leads. This will ensure timely intervention and provide a basis for tracking progress at Programme Board level.	September 2025	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	These improvements will be in place ahead of the September 2025 Programme Board meeting. Progress will be monitored by the Programme Team and reported to the Board quarterly to ensure sustained compliance.		
Six Goals Programme funding R2 To support the ongoing delivery of Six Goals related initiatives, the Health Board needs to clarify and confirm the funding arrangements for schemes beyond March 2025. Plans for future years should also identify any funding needs beyond their current annual allocation (Exhibit 2).	To ensure the continued delivery and sustainability of Six Goals-related initiatives, the Health Board is taking the following steps: • national programme funding has been secured and allocated to support the ABUHB Six Goals Programme through to March 2026. • a structured evaluation process will be undertaken for all projects funded up to March 2026. This will assess impact, outcomes, and alignment with strategic priorities to inform future funding decisions. • internal planning is underway to identify ongoing funding requirements for services expected to continue beyond 2025-26. This will include engaging with operational leads, finance colleagues, and strategic planning teams to ensure sustainability and alignment with health board priorities. • funding needs for continuing schemes will be incorporated into the Health Board's medium-term financial plan and business planning	December 2025	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	processes, ensuring early visibility of any investment gaps or reallocation needs.		
GP and dental public signposting via websites R3 To help address demand for urgent care, the Health Board should ensure GP and dental practices provide clear, accessible information about urgent and emergency care services on their websites and conduct a future audit to ensure compliance (Paragraph 28).	The Health Board recognises the importance of providing consistent and accessible information about urgent and emergency care, however, the Health Board notes that the majority of GP and dental practices operate as independent contractors to the NHS, with the Health Board commissioning these services in accordance with The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 and the NHS General Dental Services (GDS) Contracts (Wales) Regulations 2006, respectively. The Health Board is authorised to require only those provisions stipulated within the relevant regulations regarding the provision of patient information and online resources, and compliance with these regulations is assured through standard contract monitoring processes. Beyond these statutory requirements, the Health Board will communicate these findings and ensure that the matter is raised with providers through the appropriate professional collaborative forums.	October 2026	Chief Operating Officer

Recommendation	Management response	Completion date	Responsible officer
Communicating and engaging with patients and staff R4 To strengthen access and understanding of key services within the urgent and emergency care system, the Health Board should review the communication and referral process between secondary care and GPs to identify a more time-efficient channel to discuss patient cases (Paragraph 36).	To enhance communication and referral pathways between secondary care and primary care, and to support more efficient patient case discussions, the Health Board is taking the following actions: • ABUHB was the first Health Board in Wales to introduce a 24/7 single point of access (SPOA) for clinical referrals and advice between primary care, WAST, and secondary care. The service consistently achieves average call answer times of under three minutes, even during periods of high demand. • recognising the need for clearer referral routes into services such as Frailty, Ambulatory Emergency Care, and Urgent Primary Care, we have established a Navigation Hub Project Group. This group is tasked with streamlining access to these pathways and improving the user experience for referring clinicians. • we are actively engaging with primary care and WAST to understand pain points and gather feedback on the current system. This input will directly inform the redesign of SPOA functionality and referral protocols. The Navigation Hub Project Group will deliver recommendations and system refinements over the next nine months, with regular reporting to the Six Goals Programme Board. Improvements will be	October 2026	Chief Operating Officer

Recommendation	Management response	Completion date	Responsible officer
	assessed using agreed KPIs, including response times, referral accuracy, and user satisfaction.		
Directory of services R5 To ensure health and care staff can adequately signpost and refer people to the right urgent and emergency services, the Health Board should: - establish a mechanism to ensure the WAST Directory of Services remains up to date, which includes the identification of an officer with lead responsibility for this task; and - establish a mechanism to share the Directory of Service with community and care home staff which should include referral routes to support their cohort of patients (Paragraph 37).	To strengthen the accessibility and accuracy of urgent and emergency care service information, the Health Board is taking the following actions: 5.1 A named lead officer will be appointed to oversee all Health Board contributions to the WAST Directory of Services. This individual will act as the central point of contact for service updates, ensuring timely and coordinated entries across departments. 5.2 The appointed lead officer will also coordinate dissemination of the directory to community and care home staff, supported by clear guidance on referral pathways relevant to their patient populations. As part of a wider digital improvement initiative, the Health Board is developing a comprehensive, centralised digital Directory of Services which will be accessible to Health Board staff and external partners. In addition, our professional line has been made available to care homes where clinical advice is required particularly in the out of hours periods.	November 2025 November 2026	Chief Operating Officer Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
Referral pathways R6 To improve access and utilisation of referrals for appropriate alternative urgent and emergency care services, the Health Board should work with key staff, including WAST, to develop referral mechanisms that are clear, well-communicated and easily accessible (Paragraph 39).	To improve access to appropriate urgent and emergency care services, and to support more efficient use of alternative referral options, the Health Board is taking the following steps: ABUHB was the first Health Board in Wales to implement a 24/7 SPOA for referrals and advice between primary care, WAST, and secondary care. While this system is functioning well for direct secondary care access, we recognise the need to further strengthen pathways to alternative services. We have established a Navigation Hub Project Group specifically to improve the clarity and accessibility of referral routes to services such as Frailty, Ambulatory Emergency Care, and Urgent Primary Care. This group is reviewing existing referral mechanisms and identifying opportunities to streamline processes for front-line staff.	March 2026	Chief Operating Officer
Use of patient feedback R7 To ensure the Health Board is building on feedback from patients, plans for urgent and emergency care should demonstrate how they have considered patient feedback (Exhibit 9).	To ensure patient feedback actively informs the planning and improvement of urgent and emergency care, the Health Board is strengthening its approach in the following ways: patient stories are regularly incorporated into Six Goals Programme Board discussions. We recognise the value these narratives provide and are committed to expanding their use to inform strategic planning and service redesign.	December 2025	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	- we have recently implemented CIVICA, the national patient-reported experience measure tool, across our services. This will provide robust, real-time data on patient experience in urgent and emergency care. Insights generated will be regularly reviewed and presented to the Programme Board to guide evidence-based decision-making. - we have secured ongoing representation from our regional Llais partner on the Six Goals Programme Board. This ensures that the patient voice is present and that external scrutiny supports continuous improvement. - we are developing a framework to ensure that patient feedback from CIVICA is thematically analysed, tracked, and linked to specific service improvement actions. We will report progress through the Programme Board and publish summary findings to close the feedback loop with patients and the public.		
Staff feedback on service changes R8 To identify potential weaknesses or learning in relation to recent changes to its urgent and emergency care services, the Health Board should introduce regular mechanisms for staff	The Health Board recognises the value of staff and partner feedback in identifying potential weaknesses and learning opportunities related to urgent and emergency care (UEC) service changes.	April 2026	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
feedback. This should include feedback from key partners including primary care and WAST (Exhibit 9).	Staff engagement currently forms a core part of our project methodology for strategic initiatives such as Same Day Emergency Care (SDEC) and Urgent Primary Care (UPC), with structured involvement before, during, and after implementation. Feedback from these engagements directly informs project evaluation and service improvement. To strengthen this approach and ensure more regular and structured feedback, we will: introduce periodic roundtable engagement sessions. These sessions will include representation from across the organisation and key partners, such as, Primary Care and WAST, and will be focused on reviewing recent and ongoing UEC service changes. Feedback gathered will be logged, thematically analysed, and shared with relevant service leads and governance groups to support continuous learning and inform future service planning.		
Primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board R9 To ensure the Health Board has a broad understanding of demand pressures and the interaction of urgent and emergency care services, it should	The Health Board recognises the importance of ensuring that primary care perspectives are fully integrated into the Six Goals for Urgent and Emergency Care Improvement Programme Board to enable a comprehensive understanding of system pressures and interdependencies.	September 2025	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
ensure there is primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board (Exhibit 10).	Current board membership includes broad representation from partners such as WAST, Llais, NHS Executive, and Local Authorities. Primary and Community Care (PCC) Division is represented by two Senior Responsible Officers who are part of the PCC divisional leadership team. In addition, primary care clinicians aligned to transformation initiatives are invited to participate. However, we acknowledge that regular clinical commitments can limit attendance and input from practising primary care clinicians. To address this, we will: • extend a standing invitation to all Neighbourhood Care Network (NCN) Leads, ensuring broader clinical representation across the geography; • review scheduling and format of board meetings to improve accessibility for primary care participants; • explore alternative models of engagement. These changes will be implemented by the end of Q2 2025, and the effectiveness of this enhanced representation will be reviewed at the end of the year as part of the Programme Board's annual effectiveness review.		

Recommendation	Management response	Completion date	Responsible officer
Evaluating project benefits R10 To strengthen its reporting of the benefits achieved from its Six Goals Programme work and associated use of funding, the Health Board should develop and communicate guidance for staff on how to evaluate the effectiveness of projects, initiatives and service changes relating to urgent and emergency care services (Exhibit 10).	The Health Board recognises the importance of consistently evaluating the impact and benefits of projects funded and delivered through the Six Goals Programme. Clear, structured evaluation not only supports continuous improvement but also ensures accountability for use of resources and alignment with patient needs. Strategic projects currently undergo a pre-investment panel review, where proposals are assessed by a multidisciplinary team and escalated to the Executive Committee. Project delivery and evaluation are supported by the Transformation and Delivery team in collaboration with clinical leads. In addition, Quality Improvement (QI) training is promoted across clinical services, delivered by the Patient Quality and Safety team, and includes core methodologies such as the Plan-Do-Study-Act (PDSA) cycle. To strengthen our approach to benefits reporting, we will: • develop clear and practical guidance for staff on how to evaluate urgent and emergency care projects, aligned to best practice in benefits realisation and QI; • incorporate tools and templates to support data collection, outcome measurement, and post-implementation reviews;	November 2026	Executive Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	• ensure the guidance is communicated and embedded through QI training. This guidance will be developed by the end of Q3 2025, and its implementation will be monitored through the UEC Programme Board.		

Source: Audit Wales



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

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.



2004/25 REPORT BACK

All Wales NHS Audit Committee Chairs Group

TABLE OF CONTENTS

Forward	3
Summary of key issues discussed	4
Operating arrangements	6
Supporting our work and looking forwards	8
Group membership	10

“a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives.”

Audit committee chairs in the NHS oversee the governance arrangements for the NHS' £10 billion plus budget in Wales. We help to ensure that money is spent wisely to benefit our communities. How do we do that? We rigorously review the effectiveness of our systems of controls and governance, driven by a commitment to excellence.

For instance, we ensure robust financial reporting and control mechanisms that supports transparency and accountability in the allocation of public funds. We check that we all have comprehensive risk management frameworks designed to proactively identify and mitigate potential threats, including to patient safety and service delivery. We also help to ensure that the NHS learns and acts on lessons from external and internal audit.

The role of audit committees continues to evolve. It is not just about core financial accounts and systems of control. As a group we've discussed the growing challenges around new threats, such as counter fraud as well as the challenges of balancing risk management with innovation and transformation.

The All-Wales NHS Audit Committee Chairs Group provides a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives. I hope this summary report serves as a reminder of the pivotal role audit committee chairs play across the NHS.

Nuria Zolle, Chair of the All-Wales NHS Audit Committee Group

Summary of key issues discussed in 2024-25

We're getting the system back on track after the pandemic

During the pandemic a lot of work was postponed or delayed, including audit work. As a result, the timetable for producing, auditing and signing off accounts across the NHS slipped backwards. Over recent years there has been a concerted effort from Audit Wales and finance teams across the NHS to get things back on track. Audit committees have welcomed the extra efforts being made across the system, and the resulting pressures for everybody. A huge thank you to everybody!

Ensuring our risk and assurance frameworks incentivise the right behaviours

Across Wales risk management and board assurance frameworks continue to evolve. Each body is at a different level of maturity. Overall, the level of risk across the NHS, post pandemic remains high. The danger is that this leads to a defensive 'fire-fighting' mindset. While of course, we must manage risk and prevent harm we also need our systems to incentivise transformation and innovation for the long-term. Getting that balance right is a growing focus of audit committees, not least in the context of our duties to future generations.

Navigating governance arrangements across public bodies

The governance landscape in which NHS bodies operate grows ever more complex. Audit committees oversee board governance arrangements that interact with regional and national NHS systems, including commissioning. The role also involves overseeing multi sectorial partnership governance arrangements and agreements. Keeping on top of these and ensuring everything is aligned and coherent is a growing challenge for audit committees.

Counter fraud and cybersecurity are evolving areas of work

Across the UK, the NHS is vulnerable to £1.316 billion worth of fraud each year. The threat of counter fraud and cybersecurity has become an increasing risk for the NHS. As the threats evolves so do the NHS counter fraud arrangements. Shared learning and shared systems of assurance across NHS Wales are enhancing local control arrangements.

Applying the learning from audit inspections and reviews

Audit and inspection are a key part of our governance system. Audit committees are noticing growing strain across the system in delivering a timely response to recommendations. We recognise that there are competing priorities with pressure to deliver on day-to-day service issues. And there can also be challenges where local action depends on national systems, like IT systems which can be delayed.

However, audit recommendations are often a means to addressing systemic issues that hamper effective and efficient service delivery in the long-run. Audit committees are increasingly focussing on:

- (a) challenging our organisations to set realistic timescales for implementing recommendations and prioritise action to deliver within those timeframes; and
- (b) holding executives to account for not delivering on time and pressing for clear action, especially in those areas that relate to patient outcomes.

Operating arrangements of the NHS all Wales audit committee chairs group

The chairs of the Audit Committee Group was established to provide an opportunity for Wales-wide discussions on emerging issues on governance, risk management, financial controls, cyber security and counter fraud.

Scope and duties

The scope and duties of the group will comprise:

- Discussion of common issues arising from internal and external audit reviews.
- Discussion of the highest risks relating to governance, nationally and locally.
- Sharing cultural and thematic challenges and good practice and learning.

Items to be placed on the agenda will be informed by the group's action plan but can come from several sources such as those below but are not limited to:

- Group members.
- Board or trust committees.
- Chair, vice-chair and other members of the boards.
- Directors of Corporate Governance/board secretaries' network or other all-Wales peer groups.
- Audit Wales and Internal Audit.
- NHS Counter Fraud authority.

Membership

The membership will comprise chairs of Audit committees across Wales.

Should an NHS body Audit Committee Chair be unable to attend, a representative from the organisations will be identified by the body's Audit Chair.

Meetings

Hosting

The hosting organisation of the group will rotate every year.

Quorum

At least six members must be present to ensure the quorum.

Chair

The group will nominate a member to chair and this will rotate on a yearly basis.

Secretariat

The Director of Corporate Governance/Board Secretary of the hosting organisation will determine the secretarial and support arrangements for the group.

Frequency of Meetings

Meetings shall be held quarterly. Thematic working groups will be convened as and when required.

Committee Meetings

A standard agenda will be used as the basis for discussion at each meeting. Notes prepared following a meeting shall be circulated to members and retained by the relevant Director of Corporate Governance/Board Secretary as a formal record of the decision making for a period of seven years.

Withdrawal of individuals in attendance

The group may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion on any matter.

Last reviewed in July 2024

Big thanks!

Thank you to those who have supported the work of the committee

Commissioning arrangements

Chairs would like to thank Abi Harris who was Chief Executive of the NHS Commissioning Service for sharing an oversight of the new governance arrangements.

Audit Wales and Internal Audit

Chairs would like to thank Simon Cookson, Anne Beagan, Dave Thomas and Anthony Veale and Andrew Doughton for providing regular insights and updates. These included updates and insights in relation to new accounting systems and methodologies, risk management, thematics and analysis on areas of limited assurance, as well as findings from local and national reviews.

Audit Trackers

Chairs would like to thank Joanne Wilson and colleagues in Hywel Dda Health Board for openly sharing ideas and progress in relation to the development and implementation of their audit tracker.

Counter fraud activity

Chairs would like to thank Matthew Evans and colleagues for updates in relation to new national initiatives and activities as well as key learning from counter fraud activity in relation to detection and prevention.

Board Governance and oversight

Chairs would like to thank Hazel Lloyd for providing regular updates to the group in relation to the All Wales Director of Governance agenda and insights. We would also like to thank board directors for agreeing to review the training and development offered to Audit Committee Chairs across the NHS.

Board Assurance Framework

Chairs would like to thank Chris Darling for sharing Digital and Health Care Wales board assurance framework.

2024/ 25 Sharing learning and practice

Chairs also discussed and shared ideas on several areas including but not limited to; balancing competing priorities, time commitments, efficiency reviews, HMCA guidance reports, system improvements and NHS finances, committee reviews.

Looking forwards

A new work plan for 2024/ 25 is in the process of being agreed areas for discussion are likely to include:

- Financial savings, sustainability and recovery
- New counter fraud arrangements and directives
- Partnership governance arrangements

Group Membership

Health Boards

Iwan Jones, Aneurin Bevan University Health Board

Karen Balmer, Betsi Cadwaladr University Health Board

Dr Rhian Thomas, Cardiff and Vale University Health Board

Patsy Roseblade, Cwm Taf Morgannwg University Health Board

Rhodri Evans, Hywel Dda University Health Board

Steve Elliot, Powys Teaching Health Board

Nuria Zolle, Swansea Bay University Health Board

All-Wales NHS Trusts

Marian Wyn Jones, Digital Health and Care Wales

Jayne Sadgrove, Health Improvement Wales

Peter Curran, Welsh Ambulance Services

Gareth Jones, Velindre University Trust

Nick Elliot, Public Health Wales

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 September 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 Risk and Assurance.

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

To support effective governance and oversight, the Audit, Risk and Assurance Committee requires a clear overview of its business, including completed items, changes, and forthcoming matters.

Cefndir / Background

Across the 2025/26 financial year, the Committee has received all items as scheduled in its Forward Work Plan.

Asesiad / Assessment

The Forward Work Programme is designed to support the Committee in managing and overseeing its programme of business. It sets out the scheduled timing of report submissions, highlights any deferred items, and records new requests for reports. The Programme also enables the Committee to monitor progress and review its workload at each meeting.

Between June and September, no updates or changes have been made to the Forward Work Programme. However, the Committee Strategic Risk Report, normally a standing item, is not available for the September meeting.

Argymhelliad / Recommendation

The Committee is asked to:

- **Note** the status of Committee business, including completed business, amendments/changes, and forthcoming business.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Strategic Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

ANNUAL PROGRAMME OF BUSINESS 2025/26

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2024 and the Structured Assessment 2024 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:

The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	18 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th 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	√						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	18 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th Feb 2026
Report on the Implementation of the Risk Management Framework	BI	DofCG					√		√
Committee Risk & Assurance Report	SI	DofCG	√		√	√D	√	√	
Financial Governance and Control									
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	√	
Report of Losses and Special Payments (<i>May report will be included in the Accounts</i>)	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 (<i>Feb 2026</i>)	3-Yearly	DofF&P	-	-	-	-	-	-	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	18 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th 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
			22 nd April 2025	20 th May Draft Accounts	24 th June Final Accounts	18 th Sept 2025	21 st Oct 2025	16 th Dec 2025	12 th 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