

Audit, Risk and Assurance Committee Main Meeting

Tue 21 October 2025, 09:30 - 12:00

Agenda

1. PRELIMINARY MATTERS

 1.0 ARAC 20251021 Agenda - final.pdf (2 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 18 September 2025

Attached *Chair*

 ARAC 20251021 1.4 ARAC 20250918 Main Meeting Minutes - Chair Approved.pdf (10 pages)

1.5. Committee Action Log and Matters Arising


Attached *Chair*

 ARAC 20251021 1.5 ARAC 20250918 Action Log - Chair Approved.pdf (5 pages)

2. Items for APPROVAL/RATIFICATION/DECISION

2.1. To Approve Reviewed and Updated Financial Control Procedures

Attached *Director of Finance and Procurement*

 ARAC 20251021 2.1 Finance Governance Report - 21.10.2025.pdf (6 pages)

3. ITEMS FOR DISCUSSION

3.1. To Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

 ARAC 20251021 3.1 ABUHB Oct 2025 Audit Committee Progress Report FINAL (1).pdf (7 pages)

3.2. To Receive Internal Audit Review Reports - Safeguarding Final Report (Reasonable Assurance)

Attached *Head of Internal Audit*

 ARAC 20251021 3.2 ABUHB 2526 16 Final Safeguarding IA Report .pdf (11 pages)

3.3. To Receive External Audit Progress Report 2025-26

Attached *Audit Wales*

 ARAC 20251021 3.3 3997A2024 Audit Risk and Assurance Committee Update - October 2025.pdf (12 pages)


3.4. To Receive the Aneurin Bevan University Health Board Eye Care Report

Attached *Audit Wales*

 ARAC 20251021 3.4 ABUHB Eye Care Review Report (FINAL).pdf (32 pages)


3.5. To Receive the Final Annual Accounts Memorandum

Attached *Audit Wales*

 ARAC 20251021 3.5 5007A2025_ABUHB Audit of accounts addendum 24_25_final.pdf (14 pages)

3.6. To Receive the National Fraud Initiative 2024-25

Attached *Audit Wales*

 ARAC 20251021 3.6 National Fraud Initiative Report_Aneurin Bevan University Health Board.pdf (9 pages)

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

Attached *Director of Finance and Procurement*

 ARAC 20251021 3.7 Single Tender Action Report - 01.09.2025 to 30.10.2025.pdf (4 pages)

3.8. Report of Losses and Special Payments


Attached *Director of Finance and Procurement*

 ARAC 20251021 3.8 Report of Losses and Special Payments - 21.10.25.pdf (6 pages)

3.9. To Review and report upon the adequacy of arrangements for declaring, registering, and handling interests


Attached *Director of Corporate Governance*

 ARAC 20251021 3.9 DoI Update ARAC October 2025 (002).pdf (5 pages)

 ARAC 20251021 3.9a Attachment 1a Board Declaration of Interest May 2025.pdf (4 pages)

 ARAC 20251021 3.9b Attachment 1b Master Register of Interests October 2025.pdf (2 pages)

 ARAC 20251021 3.9c Attachment 2 Register of Gifts Hospitality 2025 October.pdf (1 pages)

 ARAC 20251021 3.9d Attachment 3 SoBC Implementation Plan v1.pdf (4 pages)

3.10. To Receive a Report on Risk Management Maturity across the Health Board

Attached *Director of Corporate Governance*

 ARAC 20251021 3.10 Update on the Health Board's Risk Management Maturity.pdf (10 pages)

 ARAC 20251021 3.10a Appendix A Draft Corporate Risk Register.pdf (5 pages)


 ARAC 20251021 3.10b Appendix B_Schematic of Risk Governance.pdf (1 pages)

 ARAC 20251021 3.10c Appendix C_PQS Governance Structure for Risk Reporting.pdf (1 pages)

3.11. Committee Risk & Assurance Report

Attached *Director of Corporate Governance*

 ARAC 20251021 3.11_Risk and Assurance Cover Report (1).pdf (6 pages)

 ARAC 20251021 3.11a Appendix 1_Committee Risk and Assurance Report Risk Assessment.pdf (45 pages)

4. Items for INFORMATION

4.1. To Receive Internal Audit briefs of audits underway

Attached *Head of Internal Audit*

- Speaking up Safely Final Terms of Reference.

- RGH Decontamination Unit Final Terms of Reference.
- Public Health Final Terms of Reference.

- 📄 ARAC 20251021 4.1a ABUHB 2526 20 Speaking up Safely Final Audit Brief .pdf (4 pages)
- 📄 ARAC 20251021 4.1b ABU-SSU-2526 Centralised Decontamination Unit Final Audit Brief.pdf (4 pages)
- 📄 ARAC 20251021 4.1c ABUHB 2526 13 Final Public Health Brief.pdf (3 pages)

4.2. Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

- 📄 ARAC 20251021 4.2 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- 📄 ARAC 20251021 4.2 Appendix 1 Committee Work Programme 2025-26 Final.pdf (7 pages)

5. OTHER MATTERS

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

Oral *Chair*

5.2. Any Other Urgent Business

Oral *Chair*

5.3. Date of the Next Meeting: Thursday 16th December 2025

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time

Tuesday 21st October 2025 at 09:30

Venue

Microsoft Teams

Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 18 September 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
2.1	To Approve Reviewed and Updated Financial Control Procedures.	Attached	Director of Finance and procurement
3	ITEMS FOR DISCUSSION		
3.1	To Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.2	To Receive Internal Audit Review Reports - Safeguarding Final Report	Attached	
3.3	To Receive External Audit Progress Report 2025-26	Attached	Audit Wales
3.4	To Receive the Aneurin Bevan University Health Board Eye Care Report	Attached	
3.5	To Receive the Final Annual Accounts Memorandum	Attached	
3.6	To Receive the National Fraud Initiative 2024 - 25	Attached	



3.7	To Receive Report of the use of Single Tender Action	Attached	Director of Finance and Procurement
3.8	Report of Losses and Special Payments	Attached	
3.9	To Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	Attached	Director of Corporate Governance
3.10	To Receive a Report on Risk Management Maturity across the Health Board	Attached	
3.11	Committee Risk & Assurance Report	Attached	
4	ITEMS FOR INFORMATION		
4.1	To Receive Internal Audit briefs of audits underway 1. Speaking up Safely Final Terms of Reference 2. RGH Decontamination Unit Final Terms of Reference 3. Public Health Final Terms of Reference	Attached	Head of Internal Audit
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: Thursday 16th December 2025		

Motion to Exclude Members of the Public and the Press

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

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

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





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

DATE OF MEETING	Thursday 18 September 2025
VENUE	Microsoft Teams

PRESENT	Iwan Jones Dafydd Vaughan Neil Patrick	Independent Member (Committee Chair) Independent Member Independent Member
IN ATTENDANCE	Rani Dash Rob Holcombe Robert Jones Lucy Windsor Stephen Chaney Sara Utley David Butler Martyn Lewis Julie Rees Fflur Jones Nicola Prygodzicz Hannah Evans Hannah Capel Sarah Simmonds Gareth Lavington Scott Taylor Collette Keirman Leanne Watkins Jennifer Winslade 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 Performance Audit Lead, Audit Wales Internal Auditor, NWSSP Internal Auditor, NWSSP Finance Audit Lead, Audit Wales Auditor, Audit Wales <i>Chief executive Officer</i> <i>Director of Strategy, Planning and Partnerships (Item 1.5.1)</i> <i>Assistant Director of Strategic Capital (Item 1.5.1)</i> <i>Director of Workforce and OD (Items 1.5.2)</i> <i>Head of Counter Fraud (Item 3.2 and 3.2.1)</i> <i>Head of Health and Safety</i> <i>Deputy Director of Allied Health Professionals and Sciences.</i> <i>Chief Operating Officer (Item 3.9)</i> <i>Director of Nursing (Item 3.9)</i> Secretariat
OBSERVING	None to note	
APOLOGIES	Helen Sweetland Efion Jones Andy Bagwell	Independent Member Deputy Head of Internal Audit, NWSSP Intrim Medical Director (<i>Items 1.5.2</i>)



Minute Reference	Preliminary Matters
ARAC 1809/01	<p>Welcome and Introductions The Chair welcomed everyone to the meeting.</p>
ARAC 1809/02	<p>Apologies for Absence Apologies were noted.</p>
ARAC 1809/03	<p>Declarations of Interest There were no declarations of interest raised to record.</p>
ARAC 1809/04	<p>Minutes of the previous meeting The Committee reviewed the minutes of 24 June 2025 and approved them subject to clarification that only the national Clinical Audit Plan had been agreed. The local clinical audit plan remained outstanding. ACTION: Secretariat</p> <p>Subject to amendment, the Committee APPROVED the minutes of the meeting held on 24 June 2025 as a true and accurate record.</p>
ARAC 1809/05	<p>Committee Action Log</p> <p>The Committee reviewed the updated Action Log, noting progress against previously agreed actions and items requiring further attention.</p> <p>Members raised concerns that sickness absence figures in the annual accounts may underrepresent actual staff absences and operational pressures.</p> <p>Sarah Simmonds, Director of Workforce and OD, confirmed a deep dive into sickness absence data was scheduled for the People and Culture Committee on 15 October which will explore the robustness of existing reporting mechanisms.</p> <p>Members highlighted the Action Log should evolve to reflect strategic priorities, risk mitigation, and impact of completed actions.</p> <p>The Committee NOTED the action log and AGREED removal of completed actions.</p>
ARAC 1809/06	<p>To Receive update report in relation to the checklist for future projects Hannah Evans (HE), Director of Strategy, Planning and Partnerships, supported by Hannah Capel (HC), Assistant Director of Strategic Capital presented an update on the capital projects governance checklist.</p>



Improvements included clearer project board structures, standardised KPIs, stronger change control, and the use of project bank accounts to enhance financial transparency and reduce risk.

The Committee welcomed the introduction of standardised dashboards for consistent reporting and early issue identification. Stephen Chaney (SC), Head of Internal Audit, emphasised the need for thorough application of the checklist to ensure meaningful assurance. Rob Holcombe (RH), Director of Finance and Procurement and Neil Patrick (NP), Independent Member highlighted the importance of incorporating revenue forecasting and benefits realisation in future versions.

The Committee endorsed ongoing refinement of the checklist and requested a follow-up report on its impact and uptake.

Action: Director of Strategy, Planning and Partnerships.

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

To Receive Job Planning Progress update report

Sarah Simmonds (SS), Director of Workforce and OD, provided an update on job planning following a previous action.

Compliance has improved to 50%, with efforts focused on increasing completion rates and improving plan quality. A formal letter from the Medical Director, Chief Operating Officer and Director of Workforce introduced stricter enforcement measures, including withholding vacancy approvals in non-compliant areas unless patient safety is at risk. This has driven improvements in historically non-compliant areas.

The Chair continued to expressed concern over the pace of progress and Neil Patrick (NP), Independent Member queried data comparability across health boards. SS acknowledged the absence of a standardised reporting framework across Wales.

The Committee agreed that job planning should remain a standing item for the People and Culture Committee and requested a further update to ARAC to monitor progress and maintain momentum.

Action: Medical Director.

SS confirmed job planning data will now be included in AAC panel packs to reinforce its importance across the medical workforce. The Committee recognised significant progress but stressed the need for continued focus and improvement.

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

ITEMS FOR APPROVAL / RATIFICATION / DECISION

ARAC 1809/07



Financial Governance Report and Changes to Financial Capital Procedures (FCPs)

Rob Jones (RJ), Assistant Finance Director, provided an update on financial governance, noting no significant technical accounting issues were identified.

The Committee noted, public sector payment performance remained above target, with some supplier non-compliance with the “No PO, No Pay” policy was noted.

One payment exceeded £100,000.

Three Financial Capital Procedures (FCPs), listed below, had been reviewed and updated.

- **Budgetary Controls**
- **Losses and Special Payments** had been revised to promote openness, learning, and safe reporting.
- **Stores and Stocks** had been updated with a one-page summary to support year-end stocktaking

The Committee **NOTED** the Financial Governance Report and **APPROVED** the amendments to the three FCPs.

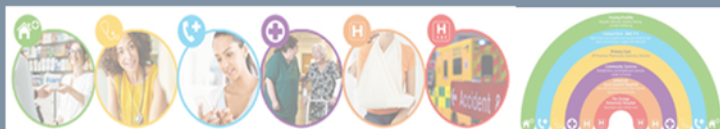
Financial Standing Financial Instruction (SFI) Self-Assessment

Rob Jones (RJ), Assistant Finance Director presented the SFI self-assessment, confirming a high level of compliance.

The Committee discussed ongoing challenges in aligning workforce and financial budgets, noting that while divisional budgets are set, workforce data lacks sufficient granularity. Rob Holcombe (RH), Director of Finance and Procurement, explained that SFIs require budgets in both financial and workforce terms, but maintaining accurate WTE data remains difficult. It was noted that the Health Board is participating in a national pilot to improve integration between finance and workforce systems.

The Chair raised concerns about post-approval processes and accountability when budgetary outcomes are not met. RH confirmed that the TRAC system now ensures finance teams verify funding at cost code level before posts are approved and that SFIs and delegated authority matrices provide clear escalation routes.

The Chair suggested a unified inventory system to reduce waste and improve visibility; RH agreed in principle but noted implementation would be complex given operational scale.



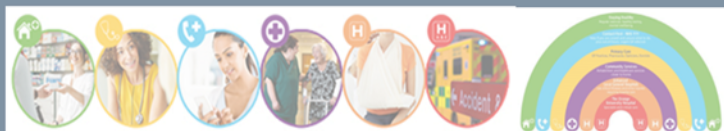
	<p>The Committee acknowledged current limitations and supported ongoing efforts to improve integration and data quality.</p> <p>The Committee NOTED the report.</p>
<p>ARAC 1809/10</p>	<p>To Receive Q1 Audit Recommendation Tracking Report Lucy Windsor (LW), Head of Corporate Risk and Assurance, reported on the status of audit recommendations as of the 30 June 2025.</p> <p>The Chair expressed concern that some high-priority recommendations from limited assurance audits had unrealistic deadlines and now required extensions, citing the “Speaking Up Safely” recommendation as an example. Concerns were also raised about discharge planning, noting assurances given in February that actions would be completed by June, yet the Q1 tracker showed many remained outstanding, with two-thirds of overdue items linked to discharge.</p> <p>LW committed to a deeper analysis of discharge-related recommendations and to work with audit partners to rationalise actions and ensure alignment with original intent. Action: Head of Corporate Risk and Assurance.</p> <p>RD proposed that the Finance and Performance Committee receive a detailed report on discharge planning performance, given its relevance to audit findings and enhanced monitoring for urgent care at the Grange University Hospital. Action: Secretariat.</p> <p>NP requested future reports include trend analysis to assess long-term progress. LW and RD agreed to explore improvements to the report format and consult with internal audit on best practice. Action: Head of Corporate Risk and Assurance.</p> <p>The Committee NOTED the closing position of the audit recommendation tracker and APPROVED the revised deadline extension requested EXCLUDING those related to Discharge Planning.</p>
<p>ITEMS FOR DISCUSSION</p>	
<p>ARAC 1809/11</p>	<p>Use of Single Tender Action (STA) Rob Holcombe (RH), Director of Finance & Procurement, presented the report on Single Tender Actions (STAs) approved between 01 April – 01 September 2025.</p>



	<p>The Committee was informed that eight requests were submitted and approved during this period, with a total annual value of £305,049.40 (excluding VAT). Of those:</p> <ul style="list-style-type: none"> • One was classified as goods only • Six as maintenance • One for services <p>It was noted that one STA was non-compliant, due to its link to a clinical trial procurement.</p> <p>The Committee APPROVED the Single Tender Action Report.</p>
<p>ARAC 1809/12</p>	<p>To Receive a Quarterly Report on Counter Fraud Activity</p> <p>Gareth Lavington (GL), Head of Counter Fraud provided the Committee with an overview of recent Counter Fraud Activity from 01 April- Mid September 2025. It was reported that:</p> <ul style="list-style-type: none"> • e-learning continued to grow, benchmarking well against other NHS organisations. • 69 referrals were received during the period; most required no further action. • salary overpayment referrals dropped significantly compared to the previous year. <p>The Health Board completed its National Fraud Initiative (NFI) match review. One staff member was investigated for dual employment, and 52 staff were prompted to declare secondary employment.</p> <p>The Committee NOTED the Fraud Progress report.</p>
<p>ARAC 1809/13</p>	<p>Risk Fraud Process</p> <p>Gareth Lavington (GL), Head of Counter Fraud presented the Committee with a summary of the Risk Fraud process, in response to the Economic Crime and Corporate Transparency Act.</p> <p>The updated process aimed to improve understanding and engagement across divisions.</p> <p>The Committee NOTED the report and the importance of cascading this guidance to senior managers and directors.</p>
<p>ARAC 1809/14</p>	<p>To Review Compliance with Welsh Health Circulars (WHCs) and Ministerial Directions</p> <p>Rani Dash (RD), Director of Corporate Governance reported that, as of August 2025, 25 Welsh Health Circulars had been reviewed: 13 complete, 3 in progress, and 9 awaiting updates.</p>



	<p>Divisional teams were being supported to provide realistic timeframes and evidence-based updates, and the process now includes routine reporting to ARAC with clear escalation routes for overdue or non-compliant items.</p> <p>It was also noted that 19 Ministerial Directions had been issued, though progress against these is not currently tracked.</p> <p>The Committee NOTED the report.</p>
<p>ARAC 1809/15</p>	<p>ABUHB Audit Handbook</p> <p>Lucy Windsor (LW), Head of Corporate Risk and Assurance informed the Committee that the Audit Handbook had been produced to support employee knowledge and understanding of the purpose and scope of audit and assurance activities and would be covered in risk awareness and training sessions to demonstrate the link to wider governance and risk management.</p> <p>The Chair queried why the Handbook focused solely on internal and external audit and did not include other processes such as clinical or health and safety audits. Rani Dash, (RD), Director of Corporate Governance clarified that separate policies existed for those areas, which operated under different standards and processes. The Handbook was designed specifically to address internal and external audit expectations.</p> <p>The Committee NOTED the report for assurance.</p>
<p>ARAC 1809/16</p>	<p>Internal Audit Progress Report</p> <p>Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report and confirmed good progress against the 2025–2026 plan.</p> <p>The Committee approved the deferment of the Falls Management audit from Quarter 2 to Quarter 4 to allow implementation of a new process aimed at improving falls management.</p> <p>A separate audit on divisional budgetary control was scheduled to focus on escalation, accountability, and recovery mechanisms, complementing wider financial sustainability work.</p> <p>SC also confirmed that a discharge planning audit was scheduled for Quarter 4 to revisit previously audited areas and potentially supersede earlier recommendations if not yet implemented.</p> <p>The Committee NOTED the report for assurance and APPROVED the deferment of the Falls Management Audit.</p>



Internal Audit Review Reports

Stephen Chaney (SC), Head of Internal Audit, provided an overview of the following audits, all receiving reasonable assurance, with detailed discussion on the limited assurance Health and Safety report:

- Medical Equipment and Devices
- Newport East Health and Wellbeing Centre
- Waiting List Management
- Financial Sustainability
- EDRMS

Neil Patrick (NP) Independent Member, requested a timeline for server upgrades, linked to the EDRMS report; Rani Dash (RD) Director of Corporate Governance, confirmed this would be followed up with Digital Services and shared with the Committee.

Action: Director of Digital.

Health and Safety (Limited Assurance)

The review assessed management of key health and safety risks, including RIDDOR reporting. Issues identified included:

- Health and Safety Policy not ratified
- Overdue actions and risks on DATIX
- Inconsistent workplace inspections and incomplete follow-up actions
- RIDDOR compliance improved but remained below expected levels

Collette Kiernan (CK), Assistant Director of Allied Health Professions and Health Science, provided reassurance that significant work had been undertaken since audit fieldwork concluded, including:

- RIDDOR compliance increased to 86.6% (August 2025)
- Revised governance structure implemented
- Policy scheduled for ratification in October, with a three-year strategy due in November
- Mandatory RIDDOR training proposed

RD acknowledged improvements but noted governance remained in development, with a review of divisional accountability underway. The Committee welcomed progress and requested a future update on governance and policy implementation.

Action: Director of Allied Health Professions and Health Science



	<p>The Committee NOTED the reports for assurance.</p>
<p>ARAC 1809/18</p>	<p>To Receive Internal Audit Briefs Stephen Chaney (SC), Head of Internal Audit, provided the Committee with a summary of the nine audits currently underway.</p> <p>The Committee NOTED the for information.</p>
<p>ARAC 1809/19</p>	<p>External Audit Progress Report Sara Utley (SA), Performance Lead, Audit Wales, provided an update on ongoing and planned audit work for the 2025–26 cycle. Planning for the audit of the Health Board’s charitable funds had commenced, and fieldwork for the 2025 Structured Assessment was progressing. The national audit programme remained on schedule with no issues reported.</p> <p>The Committee acknowledged the importance of the Structured Assessment and looked forward to receiving the findings.</p> <p>The Committee NOTED the report for assurance.</p>
<p>ARAC 1809/20</p>	<p>Audit Wales Review of Emergency Care Services report Fflur Jones (FJ), Senior Auditor, Audit Wales presented the findings from the audit of Urgent and Emergency Care services. Ten recommendations were made, with reasonable responses and realistic timelines.</p> <p>Key findings included:</p> <ul style="list-style-type: none"> • Data-informed plans aligned to the Six Goals had been developed, but uptake of new service models remained low. • Governance was strong, though gaps in primary care input and public awareness were identified. • Ambulance handover delays had improved, but funding and referral pathways required further clarity. <p>Jennifer Winlade (JW), Director of Nursing and Leanne Watkins (LWa), Chief Operating Officer, welcomed the report and confirmed actions were being embedded into the Six Goals Programme.</p> <p>Dafydd Vaughan (DV), Independent Member raised concerns about declining primary care appointments and communication barriers between secondary and primary care. LWa acknowledged these issues and confirmed work was underway to improve two-way communication and data capture. Nicola Prygodzicz (NP) Chief Executive, added that further analysis was being conducted on funding disparities in deprived areas. SU confirmed similar issues had been identified in other health boards and would be considered for escalation to Welsh Government.</p>



	The Committee NOTED the report for assurance.
	ITEMS FOR INFORMATION
ARAC 1809/21	All Wales NHS Audit Committee Chairs Group Report The Committee NOTED the report for information.
ARAC 1809/22	Committee Programme of Business 2025/26 The Committee NOTED the report for information.
	Other Matters
ARAC 1809/23	Items to be Brought to the Attention of the Board and Other Committees <ul style="list-style-type: none"> • Assurance gaps in Clinical Audit Plan (Local Elements) to Patient Quality and outcomes Committee • Concerns regarding Discharge Planning Performance to Finance and performance Committee. • Emergency Care Services report to Finance and Performance Committee.
ARAC 1809/24	Any Other Urgent Business <ul style="list-style-type: none"> • Nothing reported
ARAC 1809/25	Date of the next meeting <ul style="list-style-type: none"> • Tuesday 21st October 2025

DRAFT



Outstanding	In Progress	Not Due	Completed	Transferred to another Committee
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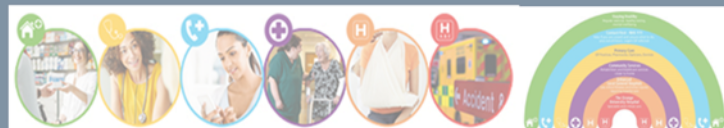
Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2025	ARAC 11802/05 Committee Action Log – Clinical Audit	Provide a summary of progress against national and local audit alongside the next report provided to the Audit Committee.	Medical Director	December 2025	Not Due



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
May 2025	ARAC 2005/05 Action Log	The updated Records Management audit report is to be returned to the Committee, following a review and revision of the management responses to ensure they accurately reflect the scope of the recommendations.	Director of Corporate Governance/Director of Digital and Head of Internal Audit	September 2025	In progress An update paper is scheduled for presentation to the Executive Committee in October 2025, with a further update to be provided to this Committee in December 2025.
September 2025	1809/04 Minutes of the previous meeting	Minutes to be updated to outline that the Committee agreed the national components of the Clinical Audit Plan however the local components of the plan had not yet been reviewed in sufficient detail and therefore	Secretariat	7 th October 2025	Completed Wording updated and published on the ABUHB website.



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		remained subject to further scrutiny.			
September 2025	1809/06 Checklist for future projects	Provide a follow up report to assess the impact of the checklist.	Director of strategy, planning and partnerships	February 2026	Not Due
September 2025	1809/07 Job Planning Progress Update	Further Job Planning update to be brought to the Committee to monitor progress.	Medical Director	December 2025	Not Due
September 2025	1809/10 Q1 Audit Recommendation Tracking	Schedule a meeting with Auditors to complete an analysis of discharge-related recommendations to ensure alignment with original intent.	Head of Corporate Risk and Assurance	October 2025	Completed. Following a meeting between the Health Board and the Auditors, it was agreed that some rationalisation could be made. The Director of Nursing will lead



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					on this work, and an update will be included in the report to the Committee in December.
September 2025	1809/10 Q1 Audit Recommendation Tracking	Engage with Internal Audit to explore opportunities to enhance the audit tracking report format to incorporate trend analysis and performance patterns over time.	Head of Corporate Risk and Assurance	December 2025	In progress Exploration meeting took place 09 October 2025
September 2025	1809/10 Q1 Audit Recommendation Tracking	A detailed report on discharge planning performance to be presented to the Finance and Performance Committee, given its relevance to the audit findings and the Health Board's enhanced monitoring	Secretariat	October 2025	Completed. Email sent to the Secretariat of the Finance and Performance



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		status for urgent care at the Grange University Hospital.			Committee for scheduling
September 2025	1809/18 Internal Audit Report – Health and Safety	Update to be provided to the Committee on the Health and Safety governance structure and policy implementation	Director of Allied Health Professions and Health Sciences	December 2025	Not Due
September 2025	1809/18 Internal Audit Report - EDRMS	Circulate a timeline for server upgrades.	Director of Digital	October 2025	In progress

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

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





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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 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 – Financial Systems & Services

**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.



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.

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.

There are no FCPs to be reviewed at this Committee.

Summary Position on Financial Control Procedures

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
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	
Budgetary Control Policy & Procedure	28/29	Y	Sep-25	18-Sep-28	
Losses and Special Payments	28/29	Y	Sep-25	18-Sep-28	
Stores & Stocks	28/29	Y	Sep-25	18-Sep-28	

2. Technical Accounting Issues

Technical updates

Since the last committee meeting in September 2025, there have been one technical accounting update issued by Welsh Government.

Update Note 1 covered the following areas:



- NHS Wales Indices 2025/26 to 2029/30

Update to the indices provided by the District Valuer which are to be used by NHS Wales for future forecasting of Land & Buildings values. The rate changes will need to be reflected by the Health Board in the ledger and reported through the Annual Accounts.

- Timetable for Agreement of Balances exercises in 2025/26

Detailed timetable for the 2025/26 Month 9 and Month 12 Agreement of Balances exercises.

The Agreement of Balances exercise supports the Year-End Annual Accounts process ensuring that all transactions between the Health Board and other NHS Wales organisations are reconciled.

- Asset Transfers for 2025/26 – S1/S2 process

This provides confirmation of the submission deadlines for organisations if there has been a transfer of asset between NHS Organisations in 2025/26.

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

3. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value	99.8	98.0
	Number	95.4	90.9
Non-NHS	Value	97.4	96.8
	Number	96.1	97.1

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 September 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 September, as it did in August. However, the Health Board is currently below the target on a cumulative basis for the 2025/26 Financial Year.

As reported to the previous committee meeting, an issue was identified, and subsequently addressed, regarding invoices relating to the NHS Salary Sacrifice Scheme administered by Northumbria NHS Trust. 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.

All Wales Performance

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 August 2025. The below table shows that Aneurin



Bevan currently have the best PSPP percentage in comparison to the other Health Boards for Non-NHS by the number of invoices processed.

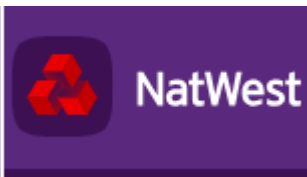

Category	Health Board	In Month %	YTD to August 2025 %	RANK
Non-NHS by Number	Aneurin Bevan UHB	97.6	97.2	1st
	Betsi Cadwaladr UHB	96.9	96.7	=2nd
	Cardiff & Vale UHB	97.0	96.0	
	Cwm Taf Morgannwg UHB	96.9	95.8	
	Hywel Dda UHB	97.0	96.7	=2nd
	Powys tHB	91.3	91.6	
	Swansea Bay UHB	96.6	96.1	3rd

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

As detailed in the SFI's, the Health Board is mandated, as a Government body, to use the Government Banking Service for its' banking and money transmission services.

	<p>Government Banking Service – through NatWest.</p>
	<p>All Banking Arrangements for all Bank Accounts.</p>
	<ul style="list-style-type: none"> • The payment and receiving of BACS, CHAPS, Standing Order payments, Faster payment transactions • Local Banking Services • Issuing Payable Orders
	<p>Barclaycard Purchasing Card</p>
	<p>Exclusively for Credit Card purchases only</p>

The Government Banking Service has recently undertaken a re-tendering process for the banking and money transmission services contract on a national basis on behalf of all government bodies.

Following the contract award, the Health Board has now signed a Memorandum of Understanding as part of this process – which ensures that the contracted supplier, NatWest, is required to provide all banking services to us as its customer, through the Government Banking contract.



The contract is between Government Banking, the Supplier and us as the Customer, and runs from 19th June 2025 to 18th June 2033, with an additional option for four further year to a maximum of 18th June 2037.

There are no further updates on the SFI's.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to note the report.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators



	SFI – Standing Financial Instructions
Partion / 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: <ul style="list-style-type: none"> • Workforce • Service Activity & Performance • Financial 	Is EIA Required and included with this paper? A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



Internal Audit Progress Report

Audit, Risk and Assurance Committee

October 2025

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

<i>1. Introduction</i>	3
<i>2. Progress against 2025/26 Internal Audit Plan</i>	3
<i>3. Summary of Findings for Recently Completed Work</i>	3
<i>4. Summary of Audit Briefs Recently issued</i>	4
<i>5. Recommendation</i>	4
<i>Appendix A: Progress against 2025/26 Internal Audit Plan</i>	5
<i>Appendix B: Audit Assurance Ratings</i>	6
<i>Appendix C: Audit / Review Briefs Issued</i>	7

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2025/26 Internal Audit Plans for Aneurin Bevan University Health Board (the 'Health Board') to the October 2025 Audit, Risk and Assurance Committee (the 'Committee'); and
- provide details (with attached copies) of audit briefs for information purposes to the Committee.

2. Progress against 2025/26 Internal Audit Plan

The following final report has been issued since the meeting of the Audit, Risk and Assurance Committee on 18th September 2025:

AUDIT ASSIGNMENT	ASSURANCE RATING
Safeguarding	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	3
Draft reports	3
Work in Progress	6
Planning	8
Not started	10
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 report issued since the last meeting on 18th September 2025.

Safeguarding (reasonable assurance)

The internal audit of safeguarding arrangements within the Health Board confirmed that statutory obligations are being met and appropriate governance structures are in place to protect vulnerable individuals. The audit reviewed safeguarding policies, procedures, training compliance, and governance, including a sample of staff-

related allegations. Notably, safeguarding referrals have surged since 2022/23, with a 94% increase in adult cases and 132% in child cases. In 2024/25, 105 staff-related safeguarding concerns were raised, with 26 substantiated and 29 progressing to criminal investigation. The Safeguarding Team were supported by a revised team structure and increased capacity.

However, several areas require management attention. Key safeguarding policies and SOPs were incomplete or overdue for review, including the overarching Safeguarding and Public Protection Policy. Level 3 training compliance remains significantly below the Welsh Government target, despite being mandated in April 2025. The current 2022–2025 Safeguarding Strategy is outdated and does not reflect recent developments such as the new reporting framework and training requirements. Additionally, two Duty to Report forms tested were not submitted within the required 24-hour timeframe due to external agency delays.

4. Summary of Audit Briefs Recently issued

A summary of the briefs issued since the last Audit, Risk and Assurance Committee is provided within Appendix C, with copies of the final audit briefs included for information.

5. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report.

Appendix A: Progress against 2025/26 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Planning for Q3
2. Standing Orders Compliance		Planning
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	Reasonable	Draft Report
7. Capital Projects: Service Readiness		Planning
8. Falls Management		Deferment to Q4
9. Directorate Review - CAMHS		Planning
10. Professional Staff Registration		Planning
11. Clinical Audit		Planning
12. Directorate Review – Ophthalmology / ENT		Planning
13. Public Health		Work in Progress
14. Six Goals Programme		Planning for Q3
15. Discharge Planning		Planning for Q4
16. Safeguarding	Reasonable	Final Report
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)	Reasonable	Draft Report
23. Shadow IT		Planning
24. Welsh Intensive Care Information System		Planning
25. RGH Central Decontamination Unit (capital systems from 2024/25)	Reasonable	Draft Report
26. Estates Assurance – Space Utilisation		Work in Progress
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
Public Health	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	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.
RGH Decontamination Unit	Brief issued	The audit will focus on the delivery and management arrangements established by Aneurin Bevan University Health Board (ABUHB) to progress the development of the Centralised Decontamination Unit at the Royal Gwent Hospital.
Capital Projects – Service Readiness	Draft brief issued	A sample of capital projects will be reviewed to ensure that robust arrangements were in place to achieve service readiness, post-handover from the contractor.
Standing Compliance Orders	Draft brief issued	The audit will assess the Health Board's compliance with the model SOs through an examination of practice and protocols linked with a sample of its key sections. As the Health Board has recently completed a review of adherence to the SFIs, we will test the process adopted and if appropriate, exclude further detailed testing against the SFIs.
Directorate Review - CAMHS	Draft brief issued	To ensure that appropriate arrangements are in place for the management of risk and performance within the CAMHS directorate.

Safeguarding

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary1

Findings & Agreed Action Plan3

Appendix A10

Review Reference

ABU-2526-17

Fieldwork

August – September 2025

Executive Sign Off

October 2025

Audit Committee

October 2025

Executive Lead

Jennifer Winslade, Director of Nursing

Audit Team

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

The audit sought to provide assurance that key policies and procedures are in place within Aneurin Bevan University Health Board (the 'Health Board') to ensure compliance with safeguarding regulations.

Overview

This audit examined the corporate safeguarding team's role in ensuring Health Board arrangements meet statutory and legislative arrangements, primarily:

- The Social Services and Well-being (Wales) Act 2014;
- The Wales Safeguarding Procedures for Children & Adults at Risk of Abuse or Neglect; and
- The Safeguarding Allegations & Concerns About Practitioners and Those in a Position of Trust Protocol.

We reviewed key safeguarding elements and processes for both adults at risk and children, including a sample of four allegations made against staff and their conduct.

Since 2022/23, Duty to Report referrals submitted to the local authorities and processed by the ABUHB Safeguarding team have risen significantly, adult and children safeguarding cases have increased by 94% and 132%, respectively. In 2024/25, 105 safeguarding allegations or concerns were raised involving Health Board staff, with 26 substantiated and 29 progressing to criminal investigation, this has increased from 10 substantiated cases the previous year.

In response to this, the team structure was reviewed in September 2024, with additional hours allocated to both teams. During the audit, it was clear to see the team demonstrated strong focus, expertise, and a commitment to appropriately addressing all allegations.

We have concluded reasonable assurance on this area as the audit found statutory obligations were being met effectively, strong measures were in place in preventing and mitigating harm to vulnerable individuals, with robust governance structures in place to support safeguarding practices within the Health Board.

The matters requiring management attention include:

- There were gaps in the completeness of key policies and standard operating procedures (SOPs), several of which were due for review. This included the overarching Safeguarding and Public Protection Policy. Strengthening of all-Wales guidance at a local level was also needed to ensure consistency across the Health Board. Timely completion and implementation were essential to ensure they are fully embedded across the organisation.
- Training and awareness compliance for Levels 1 and 2 in both adult and child safeguarding was close to the Welsh Government target of 85%. However, Level 3 compliance remained significantly below target following its introduction as a mandatory requirement on ESR in April 2025. Delivery across the Health Board was affected by limited capacity within the Safeguarding team and by staff not showing up to scheduled training sessions.
- The 2022–2025 Safeguarding Strategy was in place and clearly outlined key priorities. It referenced relevant legislative requirements and set out how the Health Board intends to fulfil its safeguarding responsibilities for children and adults at risk of harm. There had been no request to develop a new strategy to document strategic direction of the team. A recent annual report had been produced, from which the current work plan was derived.

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:

- Instances where Duty to Report forms were not completed within the 24-hour timeframe, due to external agency involvement, should be kept under review to manage associated risks.

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	There were policies and procedures that conform to legislation and guidance including DBS controls for staff and volunteers.	1	Reasonable
2	Confirmation of multi-agency cooperation in place and this was working in accordance with legislation.	-	Substantial
3	Staff had received adequate training and support in relation to the protection of children and adults at risk, to include the sharing of good practice.	2	Reasonable
4	Governance arrangements exist to manage safeguarding issues, allegations and concerns as well as there being a clear strategy in place.	3, 4	Reasonable

Management Actions



High Priority



Medium Priority

Themes



- Policies & Procedures
- Communication & Engagement
- Training & Development
- Strategy

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There were policies and procedures that conform to legislation and guidance including DBS controls for staff and volunteers.

Reasonable

Overview / Summary of Observations

Safeguarding within the Health Board is guided by legislation such as the Social Services and Well-being (Wales) Act 2014 and a range of safeguarding procedures for Wales. The Health Board remains up to date through its role in the all-Wales Safeguarding Board, ensuring best practice and compliance. New guidance is shared with teams and embedded into training. Local safeguarding policies and SOPs are maintained on SharePoint, a sample review confirmed alignment with current legislation; however, some policies and SOPs were incomplete or due for a review. This was a similar issue identified within the 2023/24 Safeguarding audit.

We sought assurance that an appropriate policy was in place for DBS checks. A DBS policy was introduced in November 2024 which aligns with the current legislation/ guidance. DBS checks for new staff, contractors, and volunteers are managed via TRAC, with managers determining requirements. Alongside this, allegations against staff must be reported to the Safeguarding team and addressed through a multi-agency process lead by the relevant local authority, as stated in relevant Section 5 of the 'Safeguarding Allegations/Concerns about Practitioners and Those in Positions of Trust' guidance. Testing showed workforce involvement in professional strategy meetings when the allegation met the threshold of safeguarding, a strengthened SOP and clear policy statement defining roles and responsibilities should be produced to assist with the Practitioner Concerns process and promote consistency.

The Safeguarding Team is transitioning to Datix for managing adult and child cases. A Duty to Report (DTR) form must be submitted within 24 hours of identifying a concern, accessible via SharePoint. These are submitted to local authorities but processed by the Health Board's Safeguarding team if there is a safeguarding concern.

Key Findings	Risk & Impact	Agreed Management Actions
<p>1 Safeguarding Policies and SOPs</p> <p>Ten policies and SOPs were reviewed (five key policies and five safeguarding SOPs).</p> <p>The main issues identified were:</p> <ul style="list-style-type: none"> • Four of five key policies tested required review: two ABUHB policies are under active review and approval, one of which is the overarching Safeguarding & Public Protection Policy, while two all Wales policies are being reviewed within the Health Board to localise them; and • Four of five SOPs tested required review and update: it was not clear if they were up to date as there was no review date or information on the documents. 	<p>Staff adhering to out-of-date policies and SOPs</p> <p>Risk of non-compliance when it comes to statutory legislative requirements</p>	<p>Agreed Action:</p> <p>We acknowledge the need to ensure safeguarding policies and SOPs are current, clearly dated, and aligned with statutory requirements. While safeguarding operates within a multi-agency framework via the Gwent Safeguarding Board, the Health Board has agreed through the Safeguarding Strategic Group to develop a localised suite of policies and SOPs.</p> <p>Actions will include:</p> <ul style="list-style-type: none"> • Development and implementation of updated safeguarding policies and SOPs, incorporating statutory requirements and organisational needs. • Clear version control and review dates on all documents.

<p>Strengthening and reviewing policies and SOPs will ensure all stakeholders understand their specific duties and consistently follow established protocols, promoting a more co-ordinated and compliant approach to Safeguarding.</p>		<ul style="list-style-type: none"> Interim communication to staff highlighting which policies and SOPs are under review and where to access the most current guidance. <p>Planned Policy Updates:</p> <ul style="list-style-type: none"> ABUHB Safeguarding Supervision Policy – renewed April 2025 ABUHB Chaperone Policy – launched September 2025 ABUHB Domestic Abuse Policy – scheduled for Clinical Standards & Policy Group November 2025 ABUHB MAPPA Policy – scheduled for Clinical Standards & Policy Group November 2025 ABUHB Safeguarding Policy – scheduled for Clinical Standards & Policy Group February 2026 ABUHB People in Positions of Trust Policy – to be scheduled for Workforce Policy Group <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Minutes from the approving forums Availability of policies on AB Pulse (staff intranet) Governance information clearly visible on the document
<p>Theme: Policies & Procedures</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Head of Safeguarding</p> <p>Target Implementation Date: 28 February 2026</p>

Overview / Summary of Observations

The Corporate Safeguarding Team provides expert advice, guidance, and support to divisions across the Health Board. Daily strategy discussions are held with relevant agencies, where appropriate, to agree on safeguarding actions.

Minutes from key forums including the Joint Gwent Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) forum, and the NHS Wales Safeguarding Network were reviewed. These confirmed regular discussions on legislation, guidance, and updates from adult and child practice reviews. Meetings were well attended by a range of partner agencies, including NHS organisations, probation services, social services, and, when necessary, the police.

In addition, Health Board focused safeguarding meetings were in place, such as the newly established Strategic Safeguarding Group and the Quality Management Group. The Strategic Safeguarding Group brings together Divisional representatives to share updates from multi-agency meetings, updates from adult and child subgroups, highlight internal risks, and disseminate key information and guidance. Also, all policies and SOPs are subject to discussion at the Strategic Safeguarding Group prior to formal approval. These meetings are well attended to ensure Safeguarding is discussed through the Health Board.

A review of 16 cases (10 child and six adult) found two child Duty to Report forms were not completed within the 24-hour timeframe due to external agency involvement. Whilst not explicitly raised within this review, it was recommended to management that this should be kept under review to manage associated risks. All cases were appropriately closed or under review. Practitioner concerns involving allegations against staff are also logged in Datix, requiring timely updates and documentation. However, it is recognised that external agency involvement may delay case closure and follow-up actions. Management should keep this, and the associated risks, under review.

Objective 3: Staff had received adequate training and support in relation to the protection of children and adults at risk, to include the sharing of good practice.

Reasonable

Overview / Summary of Observations

Safeguarding training ensures staff understand their responsibilities in protecting adults at risk and children. Intercollegiate guidance defines required competencies, with Level 1 mandatory for all staff and Level 2 for patient-facing roles. Training is delivered across three levels for both adult and child safeguarding.

Level 3 targets staff involved in high-level safeguarding duties (e.g. assessments, investigations, policy). It requires eight hours of training, delivered by the Safeguarding Team. The number of staff requiring this training is over 8,000 staff across the Health Board, Level 3 was mandated on ESR in April 2025, and this has significantly increased demand. Compliance remained below the Welsh Government target of 85%.

As of July 2025, 1,264 of 6,225 staff completed adult Level 3, and 860 of 2,457 completed child Level 3. Although numbers have improved since the last audit in 2023/24, capacity and staff availability continue to hinder progress. Many staff book training but fail to attend, and waiting lists are managed via ESR.

To support awareness, Safeguarding staff conduct regular ward visits and attend team and Divisional meetings, promoting visibility and engagement.

Key Findings Risk & Impact Agreed Management Action

2 Training and awareness

Level 1 and 2 adult and child training compliance as of Q1 2025/26 were close to meeting the Welsh Government target of 85%, however level 3 compliance was considerably below target:

Adult safeguarding	Child safeguarding
Level 1 = 82%	Level 1 = 81%
Level 2 = 83%	Level 2 = 82%
Level 3 = 15%	Level 3 = 28%

As of July 2025, 1,264 of 6,225 staff completed adult Level 3, and 860 of 2,457 completed child Level 3.

A review should be conducted to identify opportunities to improve compliance, otherwise concerns of compliance should be escalated.

Patient harm if staff are not adequately trained in safeguarding.

Potential litigation for failing in duty to protect patients from harm.

Reputational risk from staff failing to adhere to safeguarding arrangements.

Agreed Action:

We recognise the need to improve compliance with Level 3 safeguarding training, which is currently significantly below the Welsh Government target of 85%.

Actions will include:

- Continued monitoring of compliance through the Safeguarding Strategic Group, with escalation to the Executive Committee where progress is insufficient.
- Implementation of a three-year delivery plan for Level 3 training, launched in April 2025, with clear milestones and capacity planning.
- Short-term measures to increase training availability, supported by temporary funding, and review of sustainable long-term delivery options (SBAR to Executive Committee October 2025).
- Measures to reduce non-attendance, including overbooking strategies and targeted reminders.
- Communication to Divisional Leadership Teams to reinforce accountability for compliance.

		<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • ESR compliance data showing upward trend towards 85% target. • Approved three-year training delivery plan with milestones. • Minutes from Safeguarding Strategic Group and Executive Committee showing monitoring and escalation. • Evidence of actions to address non-attendance (e.g., attendance reports, reminder communications). • Reduction in risk score for CRR 003 (corporate safeguarding risk).
	<p>Medium Priority</p>	<p>Officer: Head of Safeguarding</p> <p>Target Implementation Date: 31 January 2026</p>
<p>Theme: Training & Development</p>	<p>Control Operation</p>	

Objective 4: Governance arrangements exist to manage safeguarding issues, allegations and concerns as well as there being a clear strategy in place.

Reasonable

Overview / Summary of Observations

The Corporate Safeguarding team responds swiftly to concerns, supported by strong governance. The audit evidenced that safeguarding issues were processed promptly, and recent changes to the reporting structure included adult and child sub-groups, the Strategic Safeguarding Group (replacing the Safeguarding Committee), and Executive level oversight via the Quality Management Group. The Safeguarding Risk Register is a regular agenda item at the Strategic Safeguarding Group. There is only one active risk (CRR006) on the Corporate Risk Register as of October 2024 relating to potential breaches in safeguarding duties. This risk was deescalated from the Strategic Risk Register and remains under active management within relevant Divisions.

Since 2018, the Safeguarding Maturity Matrix has supported quality assurance across Welsh health boards. It includes five standards: governance, safe care, ACE-informed practice, learning culture, and multi-agency collaboration. The Health Board’s 2024 submission scored well overall, though training remains an amber RAG rated area for improvement.

The existing 2022–25 Safeguarding Strategy delineates legislative responsibilities and organisational objectives; however, it is increasingly outdated, as it references a former reporting framework and does not reflect the development of level 3 safeguarding training. A refreshed strategy would offer clearer direction and align with current governance and training requirements.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 Safeguarding Strategy</p> <p>The Corporate Safeguarding Team had developed a Safeguarding Strategy for 2022-25. The document would benefit from an update to better reflect the breadth of work being undertaken across the Health Board. A refreshed strategy would not only showcase the current achievements but also clearly outline future safeguarding priorities. There is also an opportunity to update the document to reflect changes in approach e.g. the changed reporting framework, level 3 safeguarding training requirements.</p>	<p>There is neither review of past actions nor planning for future improvements.</p>	<p>Agreed Action:</p> <p>We acknowledge the need to refresh the Safeguarding Strategy to ensure it reflects the breadth of safeguarding activity across the Health Board and aligns with current priorities and frameworks.</p> <p>Actions will include:</p> <ul style="list-style-type: none"> • Ratification of the new Safeguarding Strategy for 2025–2028 at the Safeguarding Strategic Group on 18 November 2025. • Incorporation of a review of progress against the 2022–2025 strategy and inclusion of measurable objectives for the new period. • Alignment with the overarching Quality Strategy and integration of recent developments, including the revised reporting framework and Level 3 training requirements. • Publication of the approved strategy on AB Pulse and dissemination through appropriate communication channels

			<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Minutes from the Safeguarding Strategic Group confirming ratification. • Approved strategy document published on AB Pulse. • Communication evidence (e.g., staff bulletins, intranet updates).
		Medium Priority	<p>Officer: Head of Safeguarding</p> <p>Target Implementation Date: 30 November 2025</p>
	Theme: Strategy	Control Design	
4	<p>Workforce representation</p> <p>Four Practitioner Concerns were reviewed and one did not have Workforce involvement even though it met the threshold.</p>	<p>The absence of key parties may lead to inconsistency and/or delays in handling concerns.</p>	<p>Agreed Action:</p> <p>We acknowledge the importance of Workforce involvement in Practitioner Concerns processes to ensure consistency and timely resolution.</p> <p>Actions will include:</p> <ul style="list-style-type: none"> • Ratification and implementation of the People in Positions of Trust Policy, which explicitly requires Workforce involvement in all relevant cases. • Completion of a documentation audit to confirm whether the identified case was an isolated incident or indicative of a wider issue. • Reporting of audit findings to the Safeguarding Strategic Group on 18 November 2025, with escalation of any systemic issues and implementation of corrective actions if required. • Publication of the approved policy on AB Pulse and communication to relevant stakeholders.
		Medium Priority	<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Minutes from the Workforce Policy Group confirming policy ratification. • People in Positions of Trust Policy published on AB Pulse. • Completed audit report and evidence of presentation to the Safeguarding Strategic Group. • Any resulting action plans if gaps are identified.
	Theme: Communication & Engagement	Control Operation	<p>Officer Head of Safeguarding</p> <p>Target Implementation Date: 28 February 2026</p>

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](#)

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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.



Audit, Risk and Assurance Committee Update – Aneurin Bevan University Health Board

Date issued: October 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.

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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	11

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 was 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
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.	Final	Report to this committee
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	<p>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:</p> <ul style="list-style-type: none"> • Board and committee cohesion and effectiveness; • Corporate systems of assurance; <p>Corporate planning arrangements; and Corporate financial planning and management arrangements.</p>	Report at drafting stage	December 2025
Local project work 2025 – GP Managed Contact Arrangements	Chief Executive Officer	<p>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.</p>	Report at drafting stage	December 2025

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2025 – Deep Drive Estates	Chief Executive Officer	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.	Scoping	Spring 2026
All-Wales thematic review of cancer services	Chief Operating Officer	<p>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:</p> <ul style="list-style-type: none"> • 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	Spring 2026

Other relevant publications

- 6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update. We will be bringing the Cancer Services in Wales report to the Committee for presentation once a response to the recommendations has been received from Welsh Government.

Exhibit 3 – Relevant examinations and studies published by the Auditor General

Title	Publication Date
<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

Additional information

- 7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. The links to the reports on our website are provided.

Exhibit 4 – Corporate documents published by Audit Wales since the last committee update

Title	Publication Date
<u>Welsh Language Report 2024-25</u>	September 2025

- 8 There are no relevant Audit Wales consultations currently underway.



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Rydym yn croesawu gohebiaeth a
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Eye Care Review – Aneurin Bevan University Health Board

Audit year: 2024

Date issued: August 2025

This document has been prepared as part of work performed in accordance with statutory functions.

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Contents

Summary

About this report	4
Key messages	5
Recommendations	6

Detailed report

Regional partnership working	8
Health Board plans for eye care services	10
Leadership and governance arrangements	13
Ophthalmology performance	15
Managing the risk of harm	18

Appendices

Appendix 1 – Audit methods	19
Appendix 2 – Audit criteria	21
Appendix 3 – Management response	24

Summary

About this report

- 1 Eye care services are becoming more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, [age-related macular degeneration](#) and [glaucoma](#). Many, if caught early, can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss. As a result of the increased risk of harm, in 2019 NHS Wales introduced the 'Eye Care Measure' which is an approach for prioritising and measuring waiting times based on clinical condition and risk of harm. Ophthalmology waits also continue to be recorded and reported as part of the wider referral to treatment time metrics.
- 2 In March 2021, Welsh Government published [NHS Wales Eye Health Care - Future Approach for Optometry Services](#). The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:
 - 47% increase in the numbers of people with age-related macular degeneration;
 - 50% increase in the numbers of people having cataracts; and
 - 44% increase in the numbers of people living with glaucoma.
- 3 At the end of May 2025, across Wales, 32,683 ophthalmology patient pathways had waited over a year for treatment and 1,730 over two years, and 20,283 over a year for their first outpatient appointment¹. The three health boards with the most challenging position in respect of ophthalmology waits are Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University health boards.
- 4 Given these challenges Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards committed to work in partnership and launched the [2022-2025 South East Wales Regional Ophthalmology Strategy](#) (the regional strategy). Aneurin Bevan University Health Board is the lead organisation for the regional ophthalmology programme. The Auditor General has included a review of eye care services within his local audit plans for all three health boards.
- 5 This report sets out the findings of our work at Aneurin Bevan University Health Board (the Health Board). We reviewed local and regional plans to improve eye care services, leadership arrangements to drive improvements and address barriers to progress; and whether the Health Board is actively managing the harms resulting from long ophthalmology waits.
- 6 The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with

¹ Data source: Referral to treatment times, Welsh Government.

INTOSAI² audit standards. **Appendices 1 and 2** provide more information about our work.

Key messages

Overall conclusions

- 7 Whilst the Health Board has been able to reduce its longest ophthalmology waits, it has not met the Welsh Government's planned care recovery targets. Performance against the 'eye care measure' is poor and, as a result, some patients are likely to be coming to avoidable harm.
- 8 In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working, secure further productivity and efficiency gains, and strengthen board and committee oversight of ophthalmology services.

Key issues

Regional partnership working

- Delivery of the regional eye-care approach sets out a positive direction of travel. However, it was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity for cataract procedures.
- The regional cataract approach is targeting long waits, but it is not making a marked difference on overall numbers of patients waiting for treatment.
- Governance arrangements to oversee regional strategy delivery are in place, but the process for decision making on business cases can be slow and cumbersome involving multiple groups across the three Health Boards.

Health Board plans for eye care services

- The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.
- The Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, but it has not yet led to sustained improvements.
- Ophthalmology service capacity remains a concern, with consultant vacancies and a 30% reduction in the ophthalmology medical workforce between March 2021 and March 2025.

² International Organisation of Supreme Audit Institutions

Leadership and governance

- There is good executive, clinical and operational leadership that are focussing on driving short-term improvements in eye care services.
- There is insufficient Board and committee oversight of eye care services. In particular, the Patient Quality Safety and Outcomes committee should receive clear assurance on the harms caused as a result of a delay and lessons learnt.
- Risk management arrangements do not adequately cover eye-care risks.

Ophthalmology performance

- While referral to treatment ophthalmology waits over two years have significantly reduced, the Health Board has missed Welsh Government's target for those waiting longer than one year. Since April 2023, waiting lists have grown from around 19,000 waits to over 23,000 waits.
- The Health Board has consistently failed to meet Welsh Government's eye-care measure target. Most recent nationally report performance is 44.3% falling substantially short of the 95% target.

Managing the risk of harm

- While appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.

Recommendations

- 9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations

Regional ophthalmology strategy

- R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases. (**see paragraph 17**)
- R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy. (**see paragraph 18**)

R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy. (see paragraph 18)

Health Board plan for eye care services

R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is:

- based on current and projected future demand for services.
- includes capacity plans based on realistically ambitious levels of productivity.
- costed, at a minimum, for the medium term (3-5 year).
- supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models.
- supported by clear delivery actions and milestones.
- approved by the Board. (see paragraph 26)

R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery. (see paragraph 38)

Managing eye care risks

R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed. (see paragraph 40)

Managing the risk of harm

R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on:

- how patients on the ophthalmology waiting list are managed to prevent harm;
- lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and
- actual harm caused by ophthalmology waiting delays. (see paragraph 54)

Detailed report

Regional partnership working

- 10 We considered whether the regional ophthalmology strategy supports the delivery of sustainable ophthalmology services, and whether there are appropriate governance arrangements in place to support its implementation.
- 11 We found that **while now progressing, delivery of the regional eye-care approach was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity.**
- 12 In 2022, Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards launched the [2022-2025 Regional Ophthalmology Strategy](#) (the regional strategy). It responds to key issues from the 2021 Pyott Review³, including rising demand, limited specialist capacity, and reliance on English providers.
- 13 The strategy sets out a clear vision for sustainable, high-quality services, with complex care delivered regionally and routine care closer to home. It aims to establish a Regional Centre of Excellence and deliver complex eye care regionally, while less complex care is provided closer to patient's homes.
- 14 The regional strategy identifies key clinical risks, including sight loss from long waits, rising demand, and workforce shortages. It sets high-level targets for 2023–2025, including expanded cataract and emergency services, a regional vitreoretinal service, workforce development, and plans for a Regional Centre of Excellence.
- 15 Aneurin Bevan University Health Board is the regional lead for the new partnership approach, with involvement and engagement from its regional partners. The programme is split into three phases with annual milestones, these are:
 - by 2023: Regional expansion in capacity for cataracts will be fully utilised, Regional Vitreo Retinal Service will be operational, Regional Eye Casualty and Out of Hours Care will be in place (**Phase 1**).
 - by 2024: Research, Innovation and Development will be well established, Workforce Development Programme will be in place (**Phase 2**).
 - by 2025: Regional Centre of Excellence network funding will be agreed (**Phase 3**).
- 16 While governance arrangements to oversee regional strategy delivery are clear, there is a risk that the structure is too complex, causing delays. The Regional Ophthalmology Programme Board meets monthly and is supported by the Delivery and Development Group. Both have clear objectives, effective management, and strong clinical engagement from each health board. The Programme Board reports to the Regional Portfolio Oversight Board, which oversees all regional programmes. In April 2025, the Cabinet Secretary for Health and Social Care instructed the south-east region to further establish a joint regional committee during 2025–26.

³ [External Review of Eye Care Services in Wales \(rcophth.ac.uk\)](#) undertaken by Andrew Pyott

- 17 While decisions are being made through the established governance groups, they are also being taken separately by each health board. For example, the business case for regional cataract services required approval at ten different meetings, resulting in delay. The creation of the joint regional committee presents an opportunity to also consider how delegated authority and decision-making processes are streamlined (**Recommendation 1**).
- 18 Phase 1 of the strategy aimed to expand key regional services by 2023, but overall progress has been slower than planned. The focus on creating regional cataract service capacity was pragmatic because of the waiting list backlog, but slow to progress. Other elements of the regional strategy have also been slower to deliver particularly those set out in phases 2 and 3 above relating to a specialist centre of excellence and research. There are many factors constraining progress. This includes the focus on short-term planning detracting attention from the longer-term priorities, and operational and clinical workforce challenges (**Recommendation 2**). To help better monitor strategy delivery, there needs to be clearer reporting against the original strategy commitments, setting out clear delivery timescales (**Recommendation 3**).
- 19 It is clear that the new regional arrangements are creating new service activity in addition to the core activity provided by each Health Board. In July 2023, Welsh Government agreed £7 million recurrent funding to deliver the Regional Cataracts Business Case. From a slow start, particularly because of recruitment challenges in the Nevill Hall north hub, the levels of cataract procedures have now increased (**Exhibit 2**).

Exhibit 2: Profiled and actual delivery of cataract procedures facilitated by recurrent Welsh Government funding, by delivery hub

Financial year	Provider	Profiled	Actual
2023-24	South hub	2905	2764
	North hub	39	26
	Regionally outsourced	750	676
	Total	3694	3466
2024-25	South hub	2049	1930
	North hub	950	846
	Regionally outsourced	1308	1308
	Total	4307	4084

Source: Aneurin Bevan University Health Board

- 20 While the regional cataract approach is targeting long waits, it is not making a marked difference on overall numbers of patients waiting across the region. The funding used for regional working is being used to treat patients waiting a long time for cataracts services. However, there are more people on the referral to treatment ophthalmology waiting list now than there was in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in reduced overall level of ophthalmology waits.
- 21 In October 2024, Welsh Government awarded the region a further £7.5 million non-recurrent funding to help reduce the long waits, particularly those waiting more than 2 years. Following Ministerial Advisory Group recommendations, and supported by £19.5 million non-recurrent funding, the region may further increase its use of the independent sector during 2025-26.
- 22 To support equitable access to treatment, regional capacity has not been distributed equally across the three health boards. Instead, it has been focused on patients who have been waiting the longest. Because the proportion of very long waits are not the same across the health boards, the Welsh Government has provided more regional funding to Cwm Taf Morgannwg University Health Board than the others. This targeted allocation aims to reduce waiting lists in a way that promotes fairness across the region. While this may not appear a 'fair share', it reflects a practical and equitable approach to addressing variation in access across the region. This approach is also supported by a regional booking team, helping to ensure more consistent access to treatment

Health Board plans for eye care services

- 23 To ensure patients receive timely eye care in an appropriate setting, and prevent avoidable, irreversible harm, it is essential that the Health Board has a clear plan to improve its current, community and hospital-based eye care services and develop a sustainable model of care for the future. We considered whether there are realistic plans to improve eyecare services at a local level, considering whether:
- the Health Board has an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges; and
 - the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services.
- 24 We found that **the Health Board's planning approach for local eye care is fragmented and lacks clear long-term direction, and while steps have been taken to improve efficiency, these have yet to deliver sustained results.**

Local eye care plans

The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.

- 25 The Health Board has a good understanding of the barriers to improving eye care services. These include growing service demand, insufficient workforce capacity and inadequate digital and estates infrastructure. However, the Health Board does not have an overarching eye care plan to guide long-term service improvement and address these challenges. Instead, its eye care priorities are articulated in several plans. These include the Health Board's Annual Plan, the supporting ophthalmology service plan, eye care action plan covering hospital and community eye care, and focused plans such as implementing the Getting it Right First Time (GIRFT) recommendations and Welsh General Ophthalmic Services (WGOS) pathways⁴. Whilst there is crossover between these plans, the current approach is uncoordinated and short-term in nature. The Health Board recognises the need to develop a single eye care plan and is in the early stages of this process.
- 26 The Health Board has recently developed an eye care action plan. The action plan is aligned to the [National Clinical Strategy for Ophthalmology](#), which was launched in October 2024, mirroring its strategic themes⁵. The Health Board reported that it is in the process of developing an approach to deliver its action plan. Initially it will focus on priority areas, with task and finish groups being established to progress work in these areas. The task and finish groups⁶ will report to the Eye Care Board. While this progress is positive, the eye care action plan is high-level, the timescales for delivery are unclear, as are the Health Board's long-term ambitions for eye care services. Given the challenges with ophthalmology waiting times, the Health Board must urgently complete its eye care plan, which should be Board approved, to guide long term, sustainable service improvements **(Recommendation 4)**.
- 27 In the short term, the Health Board's service intentions are effectively shaped by demand, capacity and what can realistically be delivered. Each service, including ophthalmology, completes an annual planning template, which includes high-level demand and capacity planning. This helps the Health Board understand current pressures and plan accordingly. For example, the ophthalmology annual plan compares planned and actual activity, such as referrals, outpatient appointments, and emergency admissions, to adjust plans for the following year and identify capacity gaps.

⁴ The WGOS ([Wales General Ophthalmic Services](#)) pathway is a structured framework designed to enhance eye care services in Wales.

⁵ The strategic themes are organisational reform, clinical networks, pathway transformation and sustainable delivery model.

⁶ The task and finish groups are as follows: ophthalmology cataract group, regional ophthalmology delivery and development group, medical retina clinical reference group, estates accessibility group and digital ophthalmology groups.

28 The approach above supports the development of a sustainable eye care plan by providing clearer insight into long-term resource needs. However, the capacity of the ophthalmology service is a concern. The Health Board has had three long-standing vacancies for ophthalmology consultants. Encouragingly, all positions have now been successfully filled; however, two of the appointed consultants are not expected to commence their roles until August 2026. In overall terms the Health Board has seen a 30% decrease in its ophthalmology medical workforce between March 2021 and March 2025⁷.

Plans for improving service efficiency

While the Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, it has not yet led to sustained improvements.

- 29 The Health Board's is focussing on improving efficiency and productivity. It aims to increase theatre utilisation, increase cataract surgery productivity and reduce outpatient inefficiencies. It also seeks to optimise optometrist roles by implementing the WGOS pathways and upskilling hospital optometrists. Similar measures are outlined in the Health Board's Annual Plan for the planned care service, which includes ophthalmology. This pragmatic approach supports sustainable services by maximising use of current resources. The hospital and community eye care action plans also address broader barriers, with workstreams targeting waiting times, regional collaboration, workforce development, integrated care, and digital transformation.
- 30 Despite the past and current focus on productivity and efficiency, there are significant opportunities for improvement. As at 4 August 2025, the theatre utilisation rate for the ophthalmology service was 80% against the Health Board target of 90%, the average late start and early finish theatre rates were 37% and 49% respectively, the short notice theatre cancellation rate was 11.9%, attributable to both the patient and hospital, and the 'Did not Attend rate for new ophthalmology outpatients was 8.4%⁸.
- 31 The report from the Ministerial Advisory Group on NHS Wales Performance and Productivity also makes recommendations to reduce unwarranted variation in treatment waiting times and adopting best practice in theatre management. This includes a recommendation to create Local Theatre Optimisation Boards to boost productivity within theatres, and best practice of cases per theatre session. For ophthalmology this means 10 cataract procedures in a 4-hour theatre session, and 8 procedures if it is a training session. Currently, the Health Board's cataract surgery lists include 7-8 patients per list. In June 2025, the service successfully

⁷ In March 2021, there were 18 full time equivalent ophthalmology medical staff, compared to 12.5 in March 2025. Data source: Welsh Government medical workforce data.

⁸ Data source: Aneurin Bevan ophthalmology referral to treatment compelling scorecard, fiscal week 19. Figures shown are based on a 12-week rolling average.

trialled a 10-patient cataract list, with an improvement plan in place to consistently deliver high-volume lists.

Leadership and governance arrangements

- 32 Clear leadership and governance arrangements are key to supporting well managed service improvement. We considered whether the Health Board has:
- clear and effective executive, operational and clinical accountability;
 - appropriate Board and committee level oversight and scrutiny; and
 - appropriate arrangements to capture, manage and oversee operational and corporate risks.
- 33 We found that **there is good executive, clinical and operational leadership to drive short-term improvements, but there is insufficient Board oversight, and risk management for eye-care services needs improving.**

Operational and clinical leadership

The Health Board has good executive, clinical and operational leadership to drive short-term improvements in eye care services.

- 34 The Health Board has clear leadership and accountability for its eye care services, with the Chief Operating Officer overseeing both acute and primary care. The ophthalmology service, within the surgery division, is led by a strong triumvirate leadership team. The team is made up of an ophthalmology directorate manager, clinical director and two senior ophthalmology nurses. The service has appropriate executive and operational clinical leadership, who oversee clinical governance, performance, and incidents, while community optometry contracts are overseen by the Primary Care Divisional Lead and a dedicated optometry professional lead.
- 35 In general, we found good executive and operational oversight of ophthalmology performance. Performance is reviewed routinely through the Health Board's Planned Care Programme Board structure, Chief Operating Officer's directorate performance assurance meetings, surgery directorate meetings and ophthalmology service meetings. Oversight mechanisms tend to focus on improving waiting times and service efficiency and productivity, which are valid but have a short-term focus.
- 36 The Health Board has re-established its Eye Collaborative Care Board and Eye Care Working Group. The Eye Care Working Group is responsible for overseeing development of the Health Board's overarching eye care plan. This should improve the focus on longer-term service improvements.

Board and committee oversight

There is insufficient Board and committee oversight of eye care services.

- 37 Board level oversight of eye care services needs strengthening. While various committees receive updates, these are often ad-hoc or embedded within other

reports. This makes it difficult to fully understand the totality of service, quality and performance risks. Ophthalmology is featured within the planned care update of the integrated performance report received by the Finance and Performance Committee and the Board, but ophthalmology performance is not separated. The Patient, Quality, Safety Outcomes Committee receive various reports where ophthalmology is mentioned such as the Primary Care Annual Quality Report and the Putting Things Right Annual Report. Only the Partnership Population Health and Planning Committee receives consistent updates focused on regional ophthalmology work.

- 38 In June 2024, the Health Board conducted a comprehensive ophthalmology deep dive, but this has not featured in any committee papers, neither have updates against the ophthalmology GIRFT recommendations. Given the level of risk posed by the ophthalmology waiting list, there needs to be a greater level of Board assurance. Once the eye care plan has been approved by the Board, an appropriate committee should receive routine progress updates (**Recommendation 5**).

Risk management arrangements

Risk management arrangements do not adequately cover eye-care risks.

- 39 Generally, the Health Board's ophthalmology directorate and surgery division risk registers capture operational risks. These include issues with medical equipment, follow-up outpatients over their target dates, retina clinic capacity, estate issues, specialist ophthalmic nursing capacity and difficulties recruiting a cornea specialist. However, we note some fundamental gaps, such as risks related to current gaps in the paediatric and glaucoma ophthalmologist workforce and inadequate digital infrastructure, especially related to the use of Open Eyes electronic patient record. The Health Board should review its ophthalmology service risk register to ensure all risks are adequately managed. The Health Board is currently developing its approach to managing corporate risks.
- 40 Our 2025 planned care review found that planned care risks, including ophthalmology, are reported to the Planned Care Programme Board. However, there is no Planned Care Programme Board specific risk register, which may result in some risks or mitigating actions not being effectively tracked or prioritised. At Board level, the Health Board's strategic risk register includes several risks which are relevant to ophthalmology, such as those related to maintaining high quality and safe services, and inadequate digital and estate infrastructure. However, there is insufficient focus on the risk of patient harm associated with treatment delays (**Recommendation 6**).

Ophthalmology performance

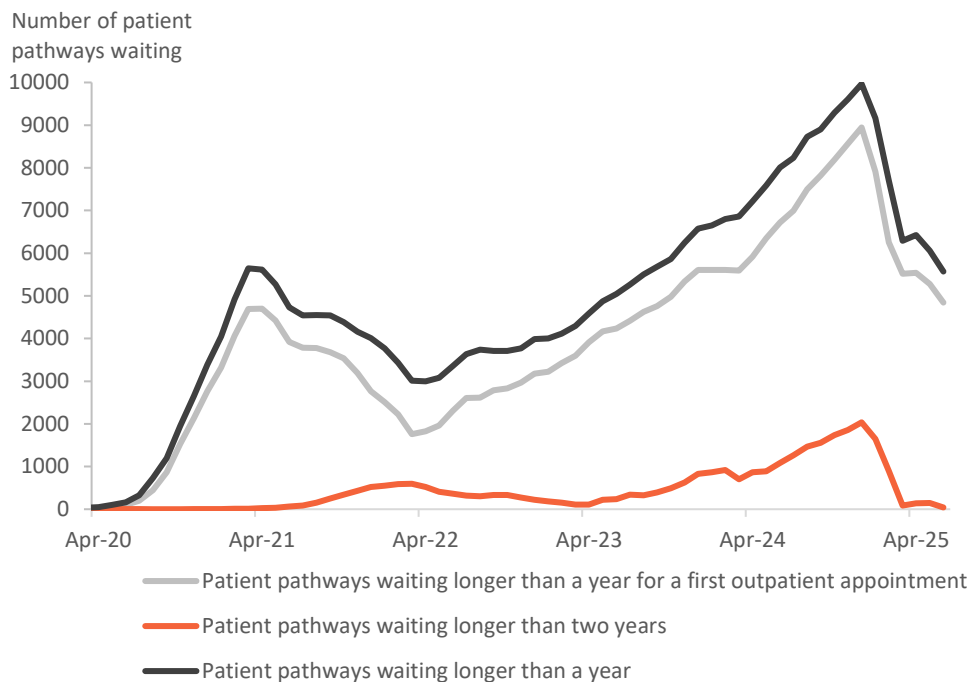
- 41 We analysed ophthalmology waiting list performance and trends to determine whether the Health Board is meeting Ministerial priorities and Welsh Government national targets related to reducing long waiting lists. The targets are as follows:
- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023);
 - eliminate the number of people waiting longer than two years in most specialities by March 2023 (target date revised to March 2026); and
 - eliminate the number of people waiting longer than one year in most specialities by Spring 2025.
- 42 In addition, ophthalmology services are measured using the eye-care measure. This measures the extent of delay for those patients at most risk of harm because of a delay in treatment. This approach is explained in **Exhibit 4**.
- 43 We found that **while long waits over two years for ophthalmology have significantly reduced, the Health Board continues to fall short of Welsh Government’s targets for the eye-care measure and patients waiting over one year.**

Performance against Welsh Government planned care targets

While ophthalmology waits over two years has significantly reduced, the Health Board has missed Welsh Government’s target for those waiting longer than one year.

- 44 **Exhibit 3** shows the Health Board’s performance against Welsh Government planned care waiting list targets. In June 2025 the Health Board had:
- 5567 patients waiting longer than a year on the ophthalmology waiting list;
 - 4842 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
 - 44 patients waiting longer than two years on the ophthalmology waiting list.
- 45 All three measures have seen a general deterioration since the pandemic. Whilst there has been some improvement from January 2025 onwards, the improvements coincide with additional Welsh Government non-recurrent funding to address long cataract waits. Between April 2021 and April 2025, the Health Board has seen 51% increase in ophthalmology referrals. Overall referral to treatment waits in the last two years has increased from around 19,000 to over 23,000. This growth alongside the long-term trends identified in **Exhibit 3** suggest that the Health Board needs to do much more to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than two years and one year, Aneurin Bevan University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

The Health Board has consistently failed to meet Welsh Government’s eye-care measure target, falling substantially short of the 95% target.

46 In addition to the referral to treatment time waiting list, NHS Wales reports patient waits for those who are most at risk of harm because of a delay. **Exhibit 4** provides a basic explanation of this measure.

Exhibit 4: A basic introduction to the eye care measure

Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk (R1)⁹ waits 25% longer than the clinically assessed target date, then it counts as a breach.

⁹ The highest risk is known as Risk Factor 1 or R1. R1 category is for patients that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

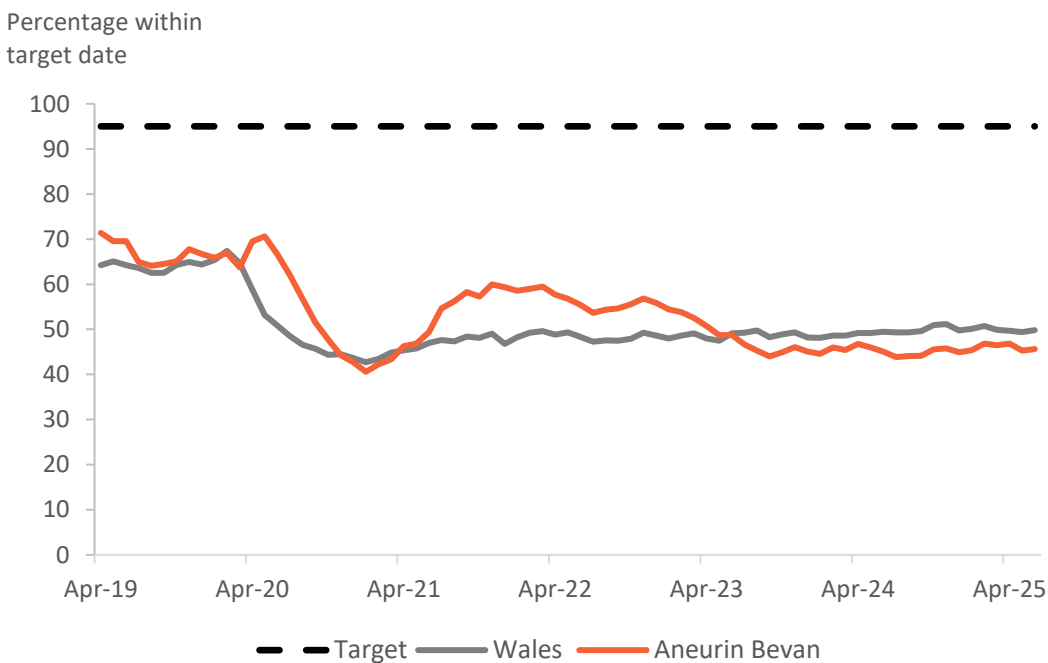
Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in 4 weeks. Mrs Jones waits just over 6 weeks – therefore the target has been breached. Within 5 weeks, this would not have been a breach.

The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

Source: Audit Wales

47 **Exhibit 5** shows performance against the Welsh Government eyecare measure target. Since July 2023, the Health Board’s performance dropped below the Welsh average and has not recovered. In June 2025, performance was 45% against the national target of 95%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss.

Exhibit 5: Percentage of eye care patients seen by their target date or within 25% beyond their target date, Aneurin Bevan University Health Board



Source: Eye Care Measure performance, Welsh Government

48 The Health Board’s performance against the eye care measure remains a significant concern and means that there is a real and continued risk of patients coming to avoidable harm and suffering irreversible sight loss.

Managing the risk of harm

- 49 Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affect their quality of life and ability to work or care for others. It is important that the Health Board actively manages harms associated with long waiting list delays. We considered whether the Health Board:
- has effective processes to record and report on incidence of harm that results from eye care waiting list delays; and
 - is taking appropriate action to manage the risk of patient harm, particularly sight loss.
- 50 We found that **while appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.**
- 51 The Health Board has appropriate mechanisms in place to prioritise its waiting list. It uses a risk stratification tool, as recommended by the GIRFT review, to prioritise ophthalmology patients based on clinical need, with R1 patients at highest risk. A separate tool supports glaucoma care decisions, helping to determine whether patients can be managed by community optometrists or require hospital care.
- 52 Waiting list validation is primarily carried out by validation clerks with clinical input. Some of the validation clerks are relatively new and training is being provided to support more complex case management.
- 53 The Ophthalmology Service has several processes to identify and review harm. It has invested in a senior nurse dedicated to reviewing current and historic ophthalmology harms recorded on the DATIX system. Regular patient safety meetings and weekly Executive Hub reviews support oversight of serious incidents, some of which may trigger Duty of Candor or Welsh Government's serious incidents process. These reviews help identify learning, shared through forums such as clinical audit meetings and ophthalmology team meetings. They also help correct patient pathways and prioritisation, which may be lost or delayed on the waiting list.
- 54 The Health Board reported that between July 2024 and July 2025, 10 ophthalmology related incidents involving delays were recorded on Datix. Nine concerning delays in patient assessment and one in treatment. Of these, two were graded as low harm, five as moderate harm, and three as severe harm. We have seen evidence of serious incidence and harm being reported through executive performance reviews, a service specific deep dive and monthly eye care measure reports. While executive and operational oversight arrangements for ophthalmology harms and serious incidents are sound, there is very little reporting of actual ophthalmology harms to the Patient, Quality, Safety Outcomes Committee or assurances that lessons are being applied to reduce the risk of harm in future (**Recommendation 7**).

Appendix 1

Audit methods

Exhibit 6 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Element of audit methods	Description
Documents	<p>We reviewed a range of documents, including:</p> <ul style="list-style-type: none">• Regional Ophthalmology Strategy, associated programme management documentation and progress reports.• Local eye care plans (ophthalmology and optometry), delivery/implementation plans and progress reports.• Documentary evidence on the use of Welsh Government funding.• Performance dashboards/reports related to eye care services.• Documents related to programme governance and oversight arrangements related to delivery eye care plans, harms reviews and learning from incidents of harm.• Plans or proposals for insourcing / outsourcing / waiting list initiatives.• Operational risk register(s) for eye care services.• Documents showing procedures, including responsibilities, for clinical assessment of patients on the ophthalmology waiting list.
Interviews	<p>We interviewed the following:</p> <ul style="list-style-type: none">• Chief Operating Officer• Deputy Medical Director• Deputy Director of Nursing• Ophthalmology Directorate Manager• Assistant Ophthalmology Directorate Manager• Ophthalmology Consultant and Clinical Director• Senior Nurse Ophthalmology• Senior Interim Nurse Ophthalmology• Assistant General Manager Surgery• Primary Care Divisional Lead• Primary Care Ophthalmology Lead• Consultant ophthalmic surgeon

Element of audit methods	Description
	<ul style="list-style-type: none"> • Chair of Patient, Quality, Safety Outcomes Committee • Regional Eye Care Programme Lead.
Observations	We observed the South East Wales Regional Ophthalmology Programme Board.
Data analysis	<p>We analysed key ophthalmology service data on:</p> <ul style="list-style-type: none"> • waiting list performance; • referrals; • medical workforce; • outpatient and inpatient activity and efficiency; • surgical cancellations; and • inpatient and day case admissions.

Appendix 2

Audit criteria

Main audit question: **Does the Health Board have effective arrangements to improve eye care services?**

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
Does the Health Board have realistic plans to improve eyecare services at a regional and local level?	Does the Health Board have an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges?	<ul style="list-style-type: none"> The Health Board has a clear eye care plan, which has been approved at Board level which: <ul style="list-style-type: none"> seeks to address current and future challenges with a view to developing sustainable eye care services; and supports delivery of the Health Board’s strategic objectives/priorities and aligns with the ambitions set out in national strategies/plans and legislation. The eye care plan appropriately reflects regional plans, which the Health Board is invested in, which aim to deliver sustainable ophthalmology services on a regional basis.
	Is the Health Board’s eye care plan realistically deliverable?	<ul style="list-style-type: none"> The eye plan is supported by/includes a clear delivery plan with clear actions and milestones. The eye care plan is based on current and projected future demand for services. Capacity plans are based on realistically ambitious levels of productivity. The plan is costed, at a minimum, for the medium term (3-5 year). The plan is deliverable within the resources available to the Health Board.
	Do the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services?	<ul style="list-style-type: none"> The Health Board is proactively targeting and improving eye care service efficiency in a range of areas such as reducing DNAs and cancellations in outpatients and surgical settings, improving surgical productivity (particularly cataracts), maximising eye-care theatre list utilisation, and utilising see on symptom and patient initiated follow ups.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		<ul style="list-style-type: none"> • Plans include national and local performance and efficiency measures, and draw upon the work of GIRFT reviews where relevant. • The Health Board is working with others effectively to drive wider efficiency improvements. • The Health Board is making use of digital systems to improve service efficiency. • Use of outsourcing has been considered / implemented as a mechanism to help reduce waiting list backlogs, supported by the necessary considerations of value for money and service safety.
<p>Does the Health Board have appropriate leadership arrangements to drive improvements in eye care services and address the barriers that might inhibit progress?</p>	<p>Are there appropriate governance and leadership structures to drive forward the necessary improvements?</p>	<ul style="list-style-type: none"> • There is clear Executive and Senior Management accountability for the delivery of eye care improvement plans. • There is clear clinical leadership for the delivery of eye care improvement plans. • There is evidence of operational oversight of the delivery of eye care improvement plans. • There is evidence of oversight and scrutiny of the delivery of eye care plans at the appropriate Committee and at Board. • Risks are appropriately captured within operational and corporate risk registers. • There are escalation mechanisms in place in the event of services failing to meet required standards / targets / milestones.
	<p>Is the Health Board identifying and addressing the barriers to improving its eye care services?</p>	<ul style="list-style-type: none"> • The Health Board has a clear understanding of the barriers that might prevent it delivering its eye care improvements/improvement plans and intentions. • The Health Board can demonstrate that it is putting in place arrangements to tackle the barriers that could impede delivery of the improvement plans.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Is the Health Board effectively delivering its improvement plans for eye care services?	<ul style="list-style-type: none"> • The Health Board can demonstrate that it is making good overall progress implementing eye care plans and initiatives, and the achievement of milestones, targets and outcome measures identified within its plans.
Is the Health Board actively managing the risk of harm resulting from ophthalmology waiting list delays?	Does the Health Board have effective approaches to record and report on incidence of harm that results from eye care waiting list delays?	<ul style="list-style-type: none"> • The Health Board has appropriate arrangements to identify, capture, and report on harm associated with long waits for eye care treatment: <ul style="list-style-type: none"> – There is a clear process for identifying and capturing patient harm caused by delays to eye care treatment. – The Health Board is reporting on actual harm caused by delays to eye care treatment to its Quality and Safety Committee. – The Quality and Safety Committee receives assurances that the Health Board is learning from incidence of harm to prevent it in the future.
	Is the Health Board taking appropriate action to manage the risk of patient harm, particularly sight loss?	<ul style="list-style-type: none"> • The Health Board has an appropriate system to assess patients on the eye care waiting list to ensure those most at risk of sight loss are treated first. • The eye care waiting list is frequently reviewed by a clinician to ensure clinical risks are up to date and correctly prioritised. • The Health Board is managing potential health inequalities in access to eye care services. • The Health Board is applying the principles of Welsh Governments' promote, prevent, and prepare policy to help patients on eye care waiting lists.

Appendix 3

Management response

Exhibit 7 below sets out the Health Board's response to our recommendations.

Recommendation	Management response	Completion date	Responsible officer
R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	December 2025	Chair of Regional Ophthalmology Programme Board
R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	March 2026	Chair of Regional Ophthalmology Programme Board

Recommendation	Management response	Completion date	Responsible officer
<p>R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.</p>	<p>The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities.</p>	<p>March 2026</p>	<p>Chair of Regional Ophthalmology Programme Board</p>
<p>R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is:</p> <ul style="list-style-type: none"> • based on current and projected future demand for services. • includes capacity plans based on realistically ambitious levels of productivity. • costed, at a minimum, for the medium term (3-5 year). • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models. • supported by clear delivery actions and milestones. • approved by the Board. 	<p>The Health Board acknowledges the urgency and importance of completing the Eye Care Plan and is actively progressing work to meet the outlined requirements. The following steps are being taken to ensure the plan is robust, sustainable, and Board-approved:</p> <p>1. Demand-Based Planning</p> <ul style="list-style-type: none"> • The draft Eye Care Plan has been completed. • Ophthalmology capacity and demand modelling takes place yearly, ensuring data remains up to date as service capacity flexes. • The plan is being developed using current service activity data and projected demand modelling, including cataract treatment volumes and outpatient trajectories. • Regional benchmarking and national variation intelligence are being used to inform future service needs. <p>2. Capacity and Productivity</p> <ul style="list-style-type: none"> • Capacity plans incorporate realistic yet ambitious productivity targets, including improvements in theatre utilisation and outpatient throughput. • Initiatives such as the “golden patient” process, interface GP schemes are being scaled to optimise clinical efficiency and the planned insourcing activity with HBSUK. 	<p>April 2026</p>	<p>Associate Director of Planned Care</p>

Recommendation	Management response	Completion date	Responsible officer
	<p>3. Medium-Term Costing</p> <ul style="list-style-type: none"> • Financial modelling has been completed for FY25/26, with further costing underway for a 3–5-year horizon, including sustainability plans for ophthalmology. • Further sustainability plans will be submitted via division by March 2026. <p>4. Resource Planning</p> <ul style="list-style-type: none"> • Workforce plans include confirmed appointments for three ophthalmology consultants (cornea, glaucoma, paediatrics) with start dates through 2026. <ul style="list-style-type: none"> – Cornea consultant will start 01/09/2025 – Glaucoma consultant has accepted and will start fellowship August 2025 and due to be in post August 2026 – Paediatric consultant has accepted and will start fellowship August 2025 and due to be in post August 2026. • Infrastructure and digital enablers (e.g., E-consent, clinic room booking, theatre system replacement) are being scoped and procured to support service delivery. <p>5. Delivery Actions and Milestones</p> <ul style="list-style-type: none"> • Four key Task and Finish Groups have been established to monitor the workstreams arising from the Eye Care Plan • The Task and Finish Groups meet monthly, with progress updates provided to the Eye Care Board (ECB) on a quarterly basis. 		

Recommendation	Management response	Completion date	Responsible officer
	<ul style="list-style-type: none"> The Eye Care Working Group and Programme Board have agreed Terms of Reference and are tracking delivery milestones, including pathway redesign and discharge protocols. Monthly Planned Care Programme Board meetings oversee progress and escalate risks as needed. <p>Governance and Timelines</p> <p>The completed draft Eye Care Plan will be further refined and submitted for formal Board approval by April 2026.</p>		
<p>R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery.</p>	<p>The Eye Care Plan has now been approved by the Eye Care Board, which meets bi-monthly to review progress against key workstreams. Updates on performance, risks, and mitigation actions are discussed regularly through this forum, ensuring continuous oversight and alignment with Board governance expectations.</p> <p>Once the Eye Care Plan is approved by the Board, the Health Board will ensure that the Finance and Performance Committee receives updates on delivery at least twice a year. These updates will clearly articulate progress, risks to delivery, and any mitigating actions to support transparency and accountability.</p> <p>This will be ensured by adding the Eye Care Plan to the Committee's Forward Work Programme.</p>	<p>April 2026</p>	<p>Associate Director of Planned Care / Director of Corporate Governance</p>

Recommendation	Management response	Completion date	Responsible officer
<p>R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed.</p>	<p>The Health Board acknowledges the recommendation and is committed to ensuring that risks related to eye care services are appropriately captured and managed within its established governance framework.</p> <p>Ophthalmology risks are managed through the Health Board’s Risk Management Framework to support safe, sustainable, and high-quality service delivery.</p> <p>At the operational level, divisional risks - including those related to long waits, workforce shortages, and service pressures are actively monitored and reviewed through directorate and divisional governance structures to ensure timely mitigation and oversight where required.</p> <p>At the strategic level, there are currently no discrete ophthalmology risks recorded on the corporate or strategic risk registers.</p> <p>Relevant issues are reflected within broader strategic risks, such as recruitment and retention across specialties, the adequacy of strategic planning, and the delivery of planned care waiting list targets, which collectively encompass ophthalmology.</p> <p>Specialty-specific risks are owned and managed at the directorate and divisional level, assessed against the Health Board’s approved risk appetite and tolerance. This position will be kept under review, with escalation to a corporate ophthalmology risk if thresholds are met.</p> <p>Oversight is maintained through regular reporting to the Eye Care Board and via Directorate and Divisional Assurance meetings.</p>	<p>December 2025</p>	<p>Associate Director of Planned Care</p>

Recommendation	Management response	Completion date	Responsible officer
	<p>The Health Board is further strengthening assurance by:</p> <ul style="list-style-type: none"> • Ensuring ophthalmology risks are captured and updated within the relevant risk registers. • Providing regular updates on the delivery of the Eye Care Plan to the Finance and Performance Committee, with clear articulation of risks and mitigating actions. • Drawing on learning from harm reviews and best practice to inform a review of long-waiting patients, overseen by the Planned Care Board. 		
<p>R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on:</p> <ul style="list-style-type: none"> • how patients on the ophthalmology waiting list are managed to prevent harm; • lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and • actual harm caused by ophthalmology waiting delays. 	<p>The Health Board acknowledges the recommendation and recognises the need to strengthen assurance on ophthalmology patient safety and waiting list management.</p> <p>The Health Board is committed to ensuring that the Patient Quality, Safety and Outcomes Committee (PQSOC) receives clear assurance on harm prevention, lessons learned, and any actual harm arising from ophthalmology waiting delays.</p> <p>All patient safety incidents in Ophthalmology are assessed via Datix to determine risk and required actions. Any incident resulting in moderate or greater harm triggers a formal harm review, which includes a detailed patient timeline and is assessed using ophthalmology-specific harm criteria. Rapid harm reviews are coordinated by the Quality and Patient Safety (QPS) Team and escalated to the weekly Executive Safety Huddle, ensuring timely oversight and shared learning across the Health Board.</p> <p>Lessons identified from harm reviews are translated into service-level action plans, and shared across the wider clinical team. Thematic</p>	<p>October 2026</p>	<p>Clinical Director for Ophthalmology</p>

Recommendation	Management response	Completion date	Responsible officer
	<p>findings and learning outcomes are reported through Divisional governance, and will form part of the assurance reports to the PQSOC.</p> <p>Through these reports, PQSOC will receive assurance on: The waiting list for <u>initial</u> Ophthalmology appointments is currently being addressed through HBSUK insourcing activity, with the aim of significantly reducing the backlog by the end of the financial year. Early indications show that a good number of patients are being discharged to alternative care pathways, and efforts are being made to target all areas of eye care, noting cataracts are being progressed as part of the regional solution.</p> <p>Additionally, the Patient Initiated Follow-Up (PIFU) initiative is in place as a flexible outpatient care model. This allows eligible patients to arrange hospital appointments themselves when their symptoms worsen, rather than relying on routine scheduling.</p> <p>Together, these activities are part of a broader strategy to minimise harm caused by delays in care and improve patient outcomes.</p> <ul style="list-style-type: none"> • Lessons learned from harm reviews and how they have been applied, through summaries of completed reviews, resulting actions, and thematic learning. • Any actual harm arising from ophthalmology waiting delays, via aggregated and case-level data from Datix, rapid harm reviews, and formal investigations coordinated by the QPS team and reported through the established governance pathway. 		

Recommendation	Management response	Completion date	Responsible officer
	<p>While monitoring and reporting harm remains primarily retrospective and resource intensive this process provides robust assurance of oversight, learning, and continuous improvement.</p> <p>Forward-looking actions, including a bespoke review of long-waiting patients (covering Referral to Treatment and Follow-ups), will further inform PQSOC assurance and strengthen governance around ophthalmology waiting list risks.</p>		



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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Audit of Accounts Report Addendum – Aneurin Bevan University Health Board

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Contents

Contents	2
Introduction	4
Recommendations from this year's audit	5
Recommendations from previous year's audit	10
Audit quality	12
Supporting you	13

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Introduction

This report is an addendum to our Audit of Accounts Report that we presented to you on 24 June 2025. The report sets out the recommendations arising from our audit of the 2024/25 accounts and an update on the progress you have made against previous years' recommendations.

We should like to take this opportunity to once again thank all your staff who helped us throughout the audit.

Recommendations from this year's audit

We summarise in **Exhibits 1 to 5** our recommendations arising from this year's audit.

Exhibit 1: Matter arising 1

Completeness of Declaration of Interests

During the audit, we identified eight instances where a member or officer did not declare interests that they had previously declared but remained extant. The omissions were not picked up by officers when preparing the accounts disclosures.

We recommend training for members and officers on completing the form as well as clearer guidance within the form to reduce the number of incomplete declarations. A central check by officers reviewing the received forms would also be advised.

Accepted in full by management:

Yes

Management response:

Following the Board's approval of a revised Standards of Business Conduct Policy in September 2024, work has been progressing to implement the policy throughout the organisation. Following an internal audit review in January 2025 which concluded substantial assurance, two recommendations were made. In addition, challenges experienced during the annual accounts audit by Audit Wales, highlighted the need for further action.

To address these points a Standards of Business Conduct Policy Implementation Plan will be presented to the Audit, Risk and Assurance Committee in October 2025. The Implementation Plan will set out the actions required to fully embed the Policy throughout the organisation, including:

- Processes by which declarations are requested, targeted at key groups, and recorded;
- Validation processes to ensure the Register remains comprehensive and up-to-date throughout each financial year;
- Review of declarations made with enhanced checks for Board Members, including a review of Companies House records;
- Further development of guidance to support declaration processes;
- Training and awareness of the Standards of Business Conduct Policy with key staff groups;
- Processes for monitoring compliance with the Policy.

Implementation date:

March 2026

Exhibit 2: Matter arising 2

Declaration of Interest from Leavers

During the audit, we identified two cases where members had left their position but a Declaration of Interest has not been recorded prior. A related party must be disclosed if the member or officer was in post at any point during the year, even if they started after 1st April or finished before 31st March.

We recommend that validation processes are established throughout the financial year to ensure that declarations are received from all related parties and that the Register remains comprehensive and up-to-date throughout.

Accepted in full by management:

Yes

Management response:

Please refer to the response to recommendation 1. The actions detailed in the response will also address this recommendation.

Implementation date:

March 2026

Exhibit 3: matter arising 3

Performance and Accountability Report supporting working papers

During the audit we review the performance and accountability reports in the Annual Report for consistency with the financial statements and check the disclosures are as required by the NHS Manual for Accounts. There is scope to improve the audit trails supporting financial information included in these reports and we identified one table as required by the manual for accounts was missing.

We recommend working papers supporting the performance and accountability reports are provided on the inflo platform at the start of the audit and recommend the manual for accounts Annual Report requirements are reviewing annually to ensure all required disclosures are included.

Accepted in full by management:

Yes

Management response:

To address the recommendation, the following actions will be implemented for future accounting years:

- **Access to Inflo:** The Corporate Governance Directorate will be granted access to the Inflo platform for future accounting years. This will enhance information sharing, improve transparency, and strengthen audit trails.
- **Provision of Working Papers:** To ensure completeness and efficiency, we request that the audit team provides a comprehensive outline of all required working papers at the outset of the audit process. This will allow us to prepare and upload all supporting documentation to Inflo in preparation of the audit.
- **Annual Review of Requirements:** We will review the NHS Manual for Accounts Annual Report requirements each year to confirm that all mandatory disclosures are included and that any updates are reflected in our reporting process.

These actions will ensure compliance, improve audit readiness, and reduce the risk of omissions in future reporting cycles

Implementation date:

March 2026

Exhibit 4: matter arising 4

Prolease system user passwords to be strengthened to enforce a minimum of 12 characters

During our IT audit we identified the password strength for the MRI Prolease system user account is set at a minimum of 8 characters.

The National Cyber Security Centre guidance on setting passwords requires a minimum of 12 characters.

We recommend the Health Board request the Prolease system supplier, MRI, increase the minimum password requirement to 12 characters in future versions of the system.

We also recommend that, pending a system update to enforce a minimum of 12 characters, the Health Board should advise its Prolease users to employ passwords of 12 characters or more.

Accepted in full by management:

Yes

Management response:

The Health Board has implemented the maximum password controls available in the current version of the Prolease system (a complex password of at least 8 characters).

We will submit a request to the system supplier to increase the password length to 12 characters in future versions of Prolease. Pending a future system update, or if the request cannot be actioned by the system supplier, we will advise the five system users to employ passwords of 12 characters or more.

Implementation date:

November 2026

Exhibit 5: matter arising 5

The IT disaster recovery standard operating procedure needs to be updated and regularly tested

The Disaster Recover standard operating procedure is not up to date.

We recommend it is updated and regularly reviewed going forward, as well as tested at appropriate intervals e.g. annually. This will provide confidence to the Health Board that it can rely on its plans should they need to use them to recover key financial systems in a disaster/system loss scenario.

Accepted in full by management:

Yes

Management response:

The document submitted for audit was the most up-to-date version of the IT Disaster Recovery Standard Operating Procedure (SOP), last updated in November 2024. However, the review date on the document was not amended at the time of update, which resulted in it incorrectly showing a review date of July 2024. This has now been corrected, and the SOP will be reviewed and updated annually or sooner if infrastructure or architectural changes require.

In addition, ABUHB utilises Assured Recovery for backup systems. This provides automated verification of backup data integrity and recovery time objectives, giving confidence that information can be reliably restored. To further strengthen assurance, the failover process between data centres will be formally tested on an annual basis. The next test is scheduled for Spring 2025, and the outcomes of this exercise will be documented and reported to provide assurance to the Health Board that recovery arrangements remain robust and effective.

Implementation date:

June 2026

Recommendations from previous year’s audit

We summarise in **Exhibit 6** recommendations arising from previous years’ audits along with our comments on the progress you have made against those recommendations.

Exhibit 6: progress against previous years’ recommendations

Audit year	Recommendation	Progress
2023-24	<p>Treatment of Pooled Budget transactions</p> <p>Clarity sought from Welsh Government on the accounting treatment prior to 24-25 drafting.</p>	Closed
2023-24	<p>Existence of Fixed Assets</p> <ul style="list-style-type: none"> • Ensure there is a system in place to facilitate frequent and periodic scanning of assets. • Ensure all assets on the Fixed Asset Register have a serial number or equivalent unique identifier. • Ensure assets are listed on the Fixed Asset Register individually. 	Closed
2023-24	<p>Senior Officer Remuneration</p> <ul style="list-style-type: none"> • Signed versions of all contracts are retained and are available on request at the start of the audit • If any unusual instances occur during the year, information to be disclosed at the beginning of the audit alongside any relevant documentation. 	Closed

2023-24

ProLease user reviews

The Health Board should undertake regular, for example, every six months, user access reviews of ProLease.

The Health Board system admins (for Prolease) should also monitor the audit log for what actions any MRI users have taken and to regularly review users with MRI staff access.

Closed, however please see a linked recommendation in Exhibit 4.

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- Selection of right team
- Use of specialists
- Supervisions and review



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- Ethics
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- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

National Fraud Initiative 2024-25: update for Aneurin Bevan University Health Board

About the National Fraud Initiative

- 1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It helps prevent and detect fraud by electronically sharing and matching data sets. **Appendix 1** provides further information on how the NFI works.
- 2 In Wales, the NFI operates under the Auditor General's statutory powers. Participation is mandatory for unitary local authorities, NHS bodies, police forces, and fire and rescue authorities. Participating on a voluntary basis in the latest exercise are the Welsh Government, some Welsh Government arm's length bodies (Natural Resources Wales, Arts Council of Wales, Sport Wales, National Library of Wales, Transport for Wales), and South East Wales Corporate Joint Committee.
- 3 This briefing note provides an update on the latest NFI 2024-25 exercise at a national level and as at 31 July 2025. It also provides some local level data for your organisation, although we are encouraging those charged with governance to seek further local detail from lead officers.

Data submission for 2024-25

- 4 The NFI 2024-25 exercise is underway. Participants submitted data for the biennial batch data matching exercise in October 2024. This included data on housing benefits, housing tenants and waiting lists, blue badge parking permits, licences, and various payments such as creditor payments, payroll, and pensions.
- 5 The UK Public Sector Fraud Authority released most data match reports to participants by the end of December 2024. Council tax and electoral register data are submitted annually. The most recent deadline for submitting this data was February 2025.
- 6 Supplementary data runs take place during the exercise to process new, incomplete or missing data submissions. For example, progress is being made to amend the Public Audit (Wales) Act 2004 through a Legislative Reform Order which will enable the NFI to resume the matching of adult social care data during the NFI 2024-25 exercise.

National update

Data matches and investigation

- 7 To date, almost 440,000 data matches have been identified for the Welsh NFI 2024-25 exercise participants. **Exhibit 1** shows that most of these matches are for unitary authorities and health bodies.

Exhibit 1: NFI 2024-25 Welsh participant data matches by type of organisation, at end of July 2025

Type of organisation	Number of data matches	% of data matches
Unitary authority	373,114	84.9
Health	50,409	11.5
Police	2,641	0.6
Fire and rescue	740	0.2
Other	12,749	2.9
Total	439,653	100.0

Source: Audit Wales analysis of NFI web-application data

Note: % total does not match the sum of the parts due to rounding.

- 8 Data matching identifies potentially fraudulent or erroneous claims and payments. No assumption can be made about whether there is fraud, error, or another explanation until an investigation is carried out. There can, for example, be false positives around creditor payments if bodies are deliberately making staged payments of the same amount.
- 9 We recognise it is not practical to investigate all data matches, particularly for bodies with large numbers of matches. Bodies are encouraged to take a risk-based approach to assessing data match reports and deciding what type of, and how many, data matches they review.
- 10 By the end of July 2025, five participating bodies had not yet closed any data matches. Some participants are making good progress with reviewing NFI 2024-25 data matches, while others have made limited progress.
- 11 **Exhibit 2** shows the total number of data matches for each data match area. It also shows the number of data matches closed in a data match area, along with the number of participants that have matches in that area.

The absence of closed matches indicates that the participant has not reviewed any matches in that area.

Exhibit 2: NFI 2024-25 Welsh participant data matches processed and closed, at end of July 2025

Data match area	Data matches	Data matches closed	Participants with data matches	Participants with no closed statuses for their matches
Council tax single person discount	198,146	5,385	22	11
Creditors	187,228	19,791	48	16
Council tax reduction scheme	16,578	3,547	22	1
Blue badges	10,377	5,849	22	3
Payroll	8,150	1,705	46	6
Housing waiting lists	6,359	1,392	18	5
Housing tenants	4,636	879	11	2
Pensions	2,962	1,098	12	4
Resident parking	2,405	2,368	8	1
Procurement	1,985	400	42	28
Housing benefit	826	483	22	2
Taxi drivers	1	1	1	0
Total	439,653	42,898	49	5

Source: Audit Wales analysis of NFI web-application data

Note: After risk assessing data match reports and any subsequent investigations, each data match should be 'closed' and given a match status. There are a range of 'closed' statuses. Matches not investigated should be given the status 'Closed – Not selected for investigation'. Assigning match statuses to data matches can be done individually or by bulk selection.

Outcomes

- 12 Welsh participants recorded outcomes of £4.7 million for the period 1 April 2024 to 31 July 2025. **Exhibit 3** shows which matching process the outcomes relate to.

Exhibit 3: Welsh participant reported NFI outcomes, 1 April 2024 to 31 July 2025

NFI exercise	Outcomes (£s)
NFI 2024-25 biennial exercise	1,719,037
Late savings from the NFI 2022-23 biennial exercise	867,157
Annual council tax data matching exercises	2,080,831
Total	4,667,025

Source: Audit Wales analysis of NFI web-application data

Note: Outcomes are made up of (i) actual amounts participants have recorded as fraud or error; and (ii) estimated elements which seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match. Most datasets have a methodology to calculate estimated savings. All methodologies are reviewed by the Cabinet Office's NFI Governance Board and approved by the Cabinet Office's Fraud Prevention Panel.

Local update

- 13 Data matches are released in data match reports. Each report has a different purpose and compares data from two or more datasets. The reports are broken down into dataset types: for example, housing benefit, payroll, or creditors.
- 14 An organisation's risk assessment of the data match reports should determine the types and numbers of data matches to be investigated. To aid risk assessment, the NFI web application flags some data match reports as 'key reports' with historically high success rates in identifying fraud or error. Also, most individual data matches are assigned a fraud risk score.
- 15 **Exhibit 4** shows the total number of data matches identified for Aneurin Bevan University Health Board, along with those recorded in key reports. **Appendix 2** provides some further analysis of these data matches by fraud risk score.

Exhibit 4: Aneurin Bevan University Health Board’s NFI 2024-25 data matches, at end of July 2025

Data match area	Data matches in all reports	Data matches in key reports with historically high success rates
Creditors	7,204	5,596
Payroll	327	199
Procurement	60	60
Total	7,591	5,855

Source: Audit Wales analysis of NFI web-application data

Note: Council tax single person discount data match reports are not formally designated as ‘key reports’ but are treated as such in practice.

- 16 Various factors can influence which data match reports are reviewed and when this takes place. For example, an organisation may prioritise looking at data match reports linked to areas where it has concerns about internal controls or where there is a history of fraud or error. Also, local resourcing will dictate the pace of progress. For these reasons, this general update does not provide further detail on where processing work and outcomes are recorded by your organisation at this stage.
- 17 The NFI web application features a dashboard and provides various reports on outcomes and processing activity. We encourage those charged with governance to seek more detailed updates on processing work and outcomes recorded from their NFI Senior Responsible Officer and NFI Key Contact.

Future Audit Wales work

- 18 For this NFI exercise we will carry out a high-level assessment of participants’ governance and follow-up arrangements. We will engage with bodies over the autumn/early winter to consider issues covered in our [NFI self-appraisal checklist](#).¹ We will also analyse the risk assessment and data

¹ In December 2024, we shared the updated checklist with NFI senior responsible officers and key contacts. We encouraged all bodies to complete it and share it with those charged with governance.

match processing work carried out, and the outcomes recorded by participants, as reflected in the NFI web application.

- 19 This work will help us understand the factors influencing the outcomes reported by individual bodies and the variations between them. Findings from this assessment will inform our next national report in autumn 2026.

Appendix 1 – The National Fraud Initiative

The NFI uses data matching to detect and prevent fraud. It electronically compares sets of data against other records held by the same and other bodies, to see to what extent they match.

The data matching flags anomalies or inconsistencies that indicate potential fraud or error. Indicators of potential fraud are reported to the participants, who are responsible for following up these matches.

The effectiveness of the NFI depends on the thoroughness of the assessment and investigation of matches and recording of outcomes.

Bodies record the outcomes in the NFI web application. Each participant body has a nominated Senior Responsible Owner and Key Contact for the NFI, who in some cases may be the same individual.

The UK Public Sector Fraud Authority, part of the UK Government's Cabinet Office and HM Treasury, oversees the NFI across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales.

We published a report on the outcomes from the 2022-23 NFI exercise in October 2024. Reports on the NFI for other parts of the UK are produced by the Public Sector Fraud Authority, Audit Scotland, and the Northern Ireland Audit Office.

There is no direct cost to participants for taking part in the exercise. Audit Wales receives funding, through the Welsh Consolidated Fund, to pay for bodies to participate in the NFI. This covers the central data matching processing for the biennial exercise, as well as the annual exercise for council tax and electoral register datasets. This remained the case for the NFI 2024-25 exercise. The main costs to participants are, therefore, the resources used to submit data and conduct follow-up work once data matches are released.

Appendix 2 – Analysis of data matches by fraud risk score for Aneurin Bevan University Health Board

The NFI assigns a fraud risk score of very high risk, high risk, or medium risk to most, but not all, data matches. This risk score is based on a combination of two factors:

- Risk logic – a set of criteria for each dataset combination that, when met, indicates a fraudulent outcome is more likely to occur.
- Footprint score – the number of times an individual in a match appears at the address across all NFI data. It is an indicator of whether that person resides at that address.

Exhibit 5 and **Exhibit 6** provide further analysis of Aneurin Bevan University Health Board's data matches by risk score for data matches in all data match reports and those in key reports. This analysis builds on **Exhibit 4** in the main body of this briefing note. Not all data matches are formally assigned a risk score. Council tax single person discount data matches and matches in key reports that are not formally assigned a risk score should generally be treated as 'very high risk' in practice.

Exhibit 5: Aneurin Bevan University Health Board's NFI 2024-25 data matches by risk score for data matches in all reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	7,204	739	6,465	0	0
Payroll	327	36	123	100	68
Procurement	60	0	0	0	60
Total	7,591	775	6,588	100	128

Source: Audit Wales analysis of NFI web-application data

Exhibit 6: Aneurin Bevan University Health Board's NFI 2024-25 data matches by risk score for data matches in key reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	5,596	727	4,869	0	0
Payroll	199	33	33	69	64
Procurement	60	0	0	0	60
Total number of data matches	5,855	760	4,902	69	124

Source: Audit Wales analysis of NFI web-application data

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Single Quotation and Tender Actions –1st September 2025 to 30th 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.

In the period 1st September 2025 and 30th September 2025 there were no approved Single Tender Actions to report.

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 that in the period 1st September 2025 to 30th September 2025 there were no Single Tender Actions (STAs) to report.

There continues to be occurrences of STAs, with the next approval requests anticipated in October and will be reported as required in the next Audit Committee.

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);	-	-
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	-	-
The need to retain a particular contractor for genuine business continuity issues (not just preferences	-	-
An interim agreement prior to joining an all-Wales Collaborative Agreement.	-	-
In line with Policy and justified STA	-	-
Not in accordance with STA rationale	-	-

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.



Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Finance Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	STAs = Single Tender Actions
Partion / 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	Choose an item. Choose an item.



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



DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Report of Losses and Special Payments
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Director of Finance – Financial Systems & Services

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

This report provides the Audit, Finance & Risk Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2025 and 31st August 2025.

Cefndir / Background

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

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

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



Asesiad / Assessment

The losses and special payments recorded during the period 1st April 2025 to 31st August 2025 totalled £7.4m of which £6.4m is recoverable from the Welsh Risk Pool (WRP), this means the actual loss to the Health Board is £1.0m.

The losses & special payments for which the Health Board are accountable for, including movements in provisions, are recorded as expenditure and are reflected in the reported and forecasted expenditure.

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability as advised by Welsh Health Legal Services of the maximum possible future cost for all known cases. It has increased by £22.8m since 31st March 2025 to an overall provision of £221.5m of which it is expected that £215.5m is recoverable from WRP leaving potential future losses to the Health Board of £6.0m.

1 Financial Analysis of Losses

LOSSES AND SPECIAL PAYMENTS						
01.04.25-31.08.25						
	No. of Cases	Amount of Loss or Payment			Type of loss/ payment	Where reported/reviewed
		ABUHB £'000	Welsh Risk Pool £'000	TOTAL £'000		
LOSSES:						
Bad Debts	0	0	0	0	Various	Authorised by Division and notified/approved by Audit Risk and Assurance Committee
SPECIAL PAYMENTS:						
Loss of personal effects	10	5	0	5	Minor Losses	Losses form completed - Authorised by Division and Putting Things Right team
Clinical negligence with advice	153	686	6,342	7,028	Clinical Negligence	Clinical negligence and personal injury - payment verified and lessons learnt addressed by the litigation committee for claims over £25K. Feedback into the quality and patient safety committee via Lessons Learnt. Reimbursement of payment to be made is not processed by WRP until satisfied that lessons learnt have been clearly documented and implemented. Annual Report to Quality & Patient Safety Committee by the Litigation Department. Includes case type, numbers, financial information, and historic comparisons.
Personal injury with advice (includes Permanent Injury Benefit)	70	228	12	240	Personal Injury	As above



Other clinical negligence and personal injury	6	7	52	59	Clinical Negligence and Personal Injury - claims under £25K	Redress committee for payments under £25K. Lessons learnt fed back to division
Penalties	35	88	0	88	Penalties	Penalties issued by Welsh Risk Pool for late submission of Learning from Events. Authorised by the Head of Legal Services.
Other	4	13	0	13	Various	Ombudsman cases - confirmed by putting things right team, other losses reports completed as appropriate
TOTAL LOSSES AND SPECIAL PAYMENTS	278	1,027	6,407	7,433		
Of which, cases of £300,000 or more:						
Clinical negligence with advice	6	14	3,720	3,734		

The penalties section above refer to invoices raised by Welsh Risk Pool to the Health Board in relation to the late submission of learning from event reports to the Welsh Risk Pool litigation committee for cases that have settled. Fines will be raised to the Health Board if the committee do not receive the reports by the deadline imposed by the committee.

The Health Board have seen a significant increase in the volume of these fines in recent months. In 2024/25 there were 8 invoices received. Up to August, we have received 35. The reason for the increase is that there are a number of settled cases for which learning from events reports have not been submitted to the committee.

During September a paper was presented to the Executive Committee highlighting the implications of failing to submit lessons learnt on a timely basis. This included not only the direct fines, but the consequential increase in the sharing mechanism that may result from the Welsh Risk Pool. The Executive committee have sought to review the area and improve control in order to minimise further occurrences.

2 Clinical Negligence and Personal Injury Provisions

The following table presents a comparison of the estimated liability for losses as of 31st August 2025 with the position reported on 31st March 2025. The figures include cases of clinical negligence, personal injury, and redress, as advised by Welsh Health Legal Services, and have been updated to reflect any new or revised cases.

After accounting for expected recoveries from the Welsh Risk Pool, the Health Board's estimated liability as of 31st August 2025 is £6.0 million.



Losses & Special Payments Provisions	31-Mar-25		31-Aug-25	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	286	195,202	310	217,927
Personal Injury	63	158	70	250
Permanent Injury Benefit	21	3,169	21	3,131
Redress	19	164	20	140
Sub Total	389	198,693	421	221,448
Less WRP Recoverable: Clinical Negligence	-175	-192,868	-191	-215,306
Less WRP Recoverable: Personal Injury	0	0	-2	-10
Less WRP Recoverable: Redress	-19	-155	-20	-131
Net Liability	195	5,670	208	6,002

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of August only 2 of the Personal Injury cases out of the 70 cases are over £25K whereas 191 of the 310 Medical Negligence cases are over £25K.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the content of this report for assurance.

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

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

**Effaith: (rhaid cwblhau)
Impact: (must be completed)**

Resource Assessment:

- **Workforce**
- **Service Activity & Performance**
- **Financial**

Is EIA Required and included with this paper

A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:

- Not Applicable
- Yes, outlined within the paper
- Yes, outlined within the paper

**Asesiad Effaith
Cydraddoldeb
Equality Impact
Assessment (EIA) completed**

Choose an item.
An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

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

Choose an item.
Choose an item.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Declarations of Interest and Register of Gifts and Hospitality
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance on the adequacy of arrangements for declaring, registering, and handling interests and offers of gifts and hospitality, including the current Register of Interests and Register of Gifts and Hospitality.

This report also presents the Standards of Business Conduct Policy Implementation Plan.

Cefndir / Background

It is a requirement within the Health Board's Standing Orders that all Board members and those employed by the Health Board declare any personal or business interests they may have, which may affect, or could be perceived to affect, the conduct of their role as a Board member or employee of Aneurin Bevan University Health Board.

In line with Standing Orders, the Audit, Risk and Assurance Committee is required to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship.

Asesiad / Assessment

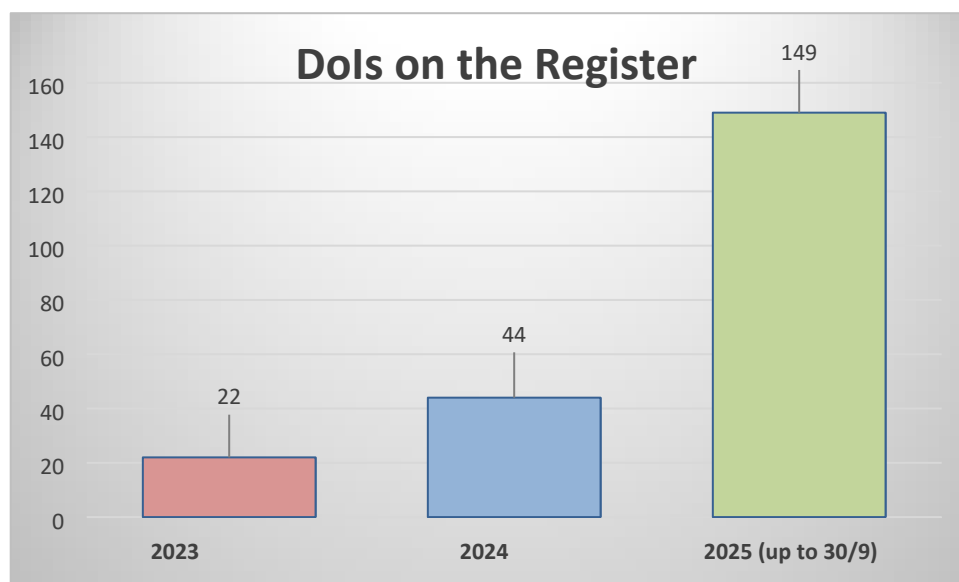
The Board approved a revised Standards of Business Conduct Policy in September 2024. This Policy expands on the previous policy and provides more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

Declarations of Interest

In support of the revised policy online Microsoft forms have been introduced for completing declarations, which automatically populate the relevant register. A copy of the current Register of Interests, which includes declarations made since the introduction of the revised policy in October 2024, is provided as **Attachment One**.

Declarations of Interest are also a standard agenda item at each Board and Committee meeting to enable individual Board members to declare any interests in relation to any specific aspect of the agenda. Any declarations made are formally recorded within the minutes of the meeting. An annual review is also undertaken to ensure that all Board members review their Declarations of Interest.

The following graph shows the number of declarations submitted and added to the register on an annual basis (excluding Board members).



National Fraud Initiative

A National Fraud Initiative earlier in the year highlighted individuals who were in receipt of financial remuneration from employment, pensions or benefits and identified if those individuals held employment elsewhere, or were registered as Company Directors, or Trade Creditors, with the purpose of identifying financial discrepancy and / or suspected fraud.

As a result, a number of employees were identified as having secondary employment who had not submitted a Declaration of Interest in respect of this. These individuals were contacted by the Counter Fraud Team at ABUHB with a request to complete a DoI form. This has also led to a number of 'nil declarations' and an increase in the overall number of DoIs registered.

Gifts, Hospitality and Sponsorship

In line with current policy, prior to accepting any gifts, the employee should consult with their line manager or Director of Corporate Governance for advice. If following advice the employee decides to accept the gift a declaration is made and the gift is retrospectively added on to the Health Board's Register of Gifts and Hospitality (Attachment 2).

The number of submissions made to the Gifts, Hospitality and Sponsorship register on an annual basis is provided below:

Year	No. submissions
2023	5
2024	14 (7 since implementation of new system)
2025 (up to 30/9)	10

In line with Standing Orders, the Audit, Risk and Assurance Committee will continue to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship. This will be undertaken bi-annually.

Standards of Conduct Policy Implementation Plan

In support of the revised policy, an Implementation Plan has been developed to support the roll out and increase awareness of the Policy across the organisation. This includes findings and recommendations identified by Internal Audit and Audit Wales.

Internal Audit

Internal Audit reviewed the arrangements for registering and managing potential conflicts caused by the receipt of gifts, hospitality and external interests during January 2025 and concluded substantial assurance in this area.

Two findings were identified in the report:

- 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.
- Whilst it is the responsibility of individuals to declare interests, there is a requirement for some staff groups (e.g. Band 8A and above) to complete a mandatory declaration (either nil or otherwise). Currently, there is no central process (including reminders) for ensuring all staff required to do this complete the declaration process in a timely manner.

Audit Wales

In August 2025 Audit Wales published an addendum to the Audit of Accounts Report, which set out 2 recommendations in relation to Standards of Business Conduct:

- Training for members and officers on completing the form as well as clearer guidance within the form to reduce the number of incomplete declarations. A central check by officers reviewing the received forms would also be advised.
- Validation processes established throughout the financial year to ensure that declarations are received from all related parties and that the Register remains comprehensive and up-to-date throughout.

A copy of the Standards of Business Conduct Policy Implementation Plan is provided as Attachment Three.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the current arrangements in place, the Register of Interests and Register of Gifts and Hospitality as at September 2025 and the Standards of Business Conduct Policy Implementation Plan.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Set out within Policy

Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Full name	Position held in health Board	Division	For 'nil declaration' please select this box	Declaration	D. Financial Transactions or benefits in kind	I confirm a nil declaration
Leanne Watkins	Chief Operating Officer	Executive Board	Nil Declaration			Agree
Neil Patrick	Independent Member	N/A		Innovation Evolution Credit PLC NED from Dec 2023-present MRAL UK Ltd Director from Nov 2024 to present MRAL UK Group Ltd Director from November 2024 to present Vigorate Ltd. Director/Partner from August 2022 to present Neil Patrick Associates Ltd. Director from July 2020 to present		
Iwan Jones	Independent Member	Corporate	Nil Declaration			Agree
Penelope Anne Jones	Independent Member	Community		The Palmer Centre, Chepstow Trustee - 2years Daughter - Laura Anne Jones MS - The Senedd - 2023-2007 and 2020- present day.	Paid County Councillor Penny Jones Monmouthshire County Council - from 2012	
Sarah Simmonds	Executive Director of Workforce and OD	Chief Executive	Nil Declaration			Agree

Prof Helen M Sweetland	Independent Member (Uni)	Corporate	Nil Declaration			Agree
Dr James Calvert	Executive Medical Director & Deputy Chief Executive	Corporate	Nil Declaration	Personal - Calvert Services Ltd - Director. Does not function in health sector therefore no attributable conflict In the past 12 months I have been sponsored to attend respiratory educational meetings by Astra-Zeneca and GSK. Astra-Zeneca has also provided support via a donation of goods and services contract to ABUHB to support pathway redesign for the Severe Asthma	I undertake writing of medico-legal reports on behalf of claimants and defendants in the area of occupational lung injury. I do not undertake this work for patients in ABUHB	
Jennifer Winslade	Executive Director of Nursing	Executive Nursing	Nil Declaration			Agree
Hannah Evans	Executive Director of Strategy, Planning and Partnerships	Chief Executive	Nil Declaration			Agree
Paul Deneen	Board Member	Headquarters	Nil Declaration			Agree
Nicola Prygodzicz	CEO	Corporate				Agree

Peter Carr	Executive Director of Allied Health Professions and Health Science	Corporate		Digital Health & Care Wales, since July 2023 as Chair of the LIMS 2.0 Programme	Paid 0.1 WTE at current Executive pay scale	
Rob Holcombe	Director of Finance and Procurement	Finance	Nil Declaration			Agree
Rani Dash	Director of Corporate Governance	Corporate	Nil Declaration			Agree
Tracy Daszkiewicz	Exec Director of Public Health	Public Health		Swindon Womens Aid, Swindon, June 2020 - present Faculty of Public Health - Vice President, June 2022- June 2025 I will then take over as President June 2025- 2028	None	
Ann Judith Lloyd	Chair ABUHB	Welsh Government	Nil Declaration			Agree
Paul Solloway	Director of Digital	Executive Team	Nil Declaration			Agree
Dafydd Vaughan	Independent Member (Digital)	Board		Cedyrn Ltd Sept 2016-present Chief Technology Officer Public Digital Ltd October 2023-present Spouse - Mimulus HQ Ltd July 2024-present		
Philip Robson	Vice Chair ABUHB	Corporate	Nil Declaration			Agree

Richard Giles Clark	Independent Member	Board		CSC Foundry Ltd Director since 2017 SRS Ltd Director since 2017 Co Sec and trustee Torfaen Coluntary Alliance since 2019 Elected member, executive portfolio holder (Children Families & Education) Deputy Leader Torfaen Borough Council since 2004		
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Staff Name	Staffs Position	Staffs Department	Date of Submission	Line Manager Approved	Declaration
Star Moy	Senior Nurse	Primary & Community	14/10/2024	Approved	Director Wenpower CIC Non profit organisation providing coaching therapies
Gareth Lawington	Head Counter Fraud	Corporate Finance	22/11/2024	Approved	Nil declaration
Mark Rose	Assistant Finance Director	Finance	22/11/2024	Approved	Nil declaration
Nicola Turner	Head Orthoptist	Scheduled Care	25/11/2024	Approved	Nil declaration
Dr Nidhika Berry	Consultant medical microbiologist	Clinical Services	27/11/2024	Approved	Director Sandeep and Nidhika Berry Pvt Limited - dividends as per rules/BAPIO Wales Executive Committee - sponsorship to attend conference
Nick Jones	Directorate Manager	Primary Care	03/12/2024	Approved	Nil declaration
Heidi Richardson	Administrator	CRF	11/12/2024	Approved	Nil declaration
Amelia Colner	Speech and Language Therapist	Speech and Language Therapy	13/01/2025	Approved	Self employed Astra Aesthetics 1 year
Susan Kennelly	Obesity Medicine Physician	Nutrition and Dietetics	14/01/2025	Approved	Directorship S Kennelly Medical Ltd, 2017 to present & Ongoing Boots online Dr October 2024 Ongoing Seasonal GP at the Independent GP Practice in Cardiff 2019-Ongoing
Lynne Robinson	Senior Occupational Therapist	Therapies and Health Sciences	24/01/2025	Approved	Self-employment private occupational therapy work external to the health board, commencing January 2025 - providing clinical supervision to an occupational therapist employed by Craig-Y-Parc Independent Special School.
Elizabeth Andrew	Consultant Clinical Psychologist & Head of Adult Psychology	Mental Health & Learning Division	28/01/2025	Approved	I act as a tutor for the Association of Psychological Therapies (APT) delivering up to 3 courses a year for them on a paid basis. The Health Board also commission this organisation on occasion (though I would not teach for them within ABUHB). I am not a director in this company and do not own any shares in it, nor do I have a vested interest in its functioning or success. I have provide consultation (one day per year) on mental well-being to Welsh Rugby Union (WRU). This is not paid in monetary terms but I may receive payment in kind on occasion (e.g. offers of match day tickets) Dr Liz Andrew, Psychological Services (currently operational). The provision of psychological therapy/psychological consultation to individuals who are not associated with ABUHB waiting lists or services at the point of contact. Financial details on form
Eleanor Maybury	Consultant Clinical Psychologist	MHLD	29/01/2025	Approved	I provide some psychological support to activists who volunteer with Youth Demand
Clare Fisher	Clinical Psychologist	MHLD	30/01/2025	Approved	South Wales CAT training Ltd (since about 2018) I am the course director for a course in Cognitive Analytic Therapy (CAT) run by South Wales CAT training Ltd. ABUHB has funded people to go on this course. I do this work outside my NHS hours (which are four days per week). I am paid for this work such as for teaching or course administration. South Wales CAT Training Ltd will be offering this training in the future. The company will also likely be bidding for HEW funding to provide training in CAT.
Marcia Talario	Nutrition support worker	Family and therapies	30/01/2025	Approved	Marcia Talario Own Business is whole body approach, nutrition advice included as part of this, but not seeking any business with ABUHB or would not be in the future/ Volunteers but not in senior leadership role within Foodcycle
Helen Shannon	Lead dietitian oncology	family and therapies	03/02/2025	Approved	Nutricia ONS advisory board for 2025-2026. Providing monthly by email clinical perspective on types of ONS and how they may benefit certain patient groups.
Hannah Capel	Assistant Director for Strategic Capital	Planning	06/02/2025	Approved	Nil declaration
Carragh Williams	Physiotherapist	F&T	07/02/2025	Approved	Nil declaration
Lisa Forey	Head of Pharmacy - Operational Services	PCG	20/02/2025	Approved	Nil declaration
Dr Marufa Sultana	Speciality Doctor	Obstetrics and gynaecology	21/02/2025	Approved	Nil declaration
Nicola Collett	Principal Clinical Psychologist- Early Intervention in Psychosis	sult Mental Health and Learning Disability	22/02/2025	Approved	I deliver clinical supervision at Oxford University/OCTC for the PGCert in CBT for Psychosis and Bipolar, as part of my role in Adult Mental Health Psychology. The trust receive payment for this work. However, I will be taking on an additional limited paid role from March 2025 to September 2025, marking therapy tapes. This will be undertaken outside of my role, in my own time. The reason for this is my one day role does not allow capacity for me to undertake this additional commitment within this time. I also run a small private psychological therapy practice online. None of my clients have been under the care of any service in Aneurin Bevan NHS University Trust.
Sophie-Ella Stark	Oncology dietitian	Family and therapies	25/02/2025	Approved	I will be working with Nutricia on the oncology advisory board for 2025/26. As a result of this, I will be paid £700.
Miss Ebube Obi	Consultant	Scheduled Care - Ophthalmology	12/03/2025	Approved	2021 and ongoing NaniChi Ltd T/A SosoChi Medical Personal: 1. Research and provision of samples of digital adaptations for slit lamps and where necessary or where needed to enable digitisation of slit lamps to help further integrated eye care between primary and secondary care. 2. Research and provision of sample USB microscope / mobile phone clip on magnifying lens accessory to enable remote acquisition of eye/ skin lesions or cancers by optometrists and GPs. Research and or provision of skin and eyelid care information and or products.
Rhannon Bailey	Team Lead - CAMHS CMHT	Family and Therapies	19/03/2025	Approved	Director of Gateway Support & Care Ltd Responsible Individual/Small private care home Eriskey Residential Care
Clare Lipetz	Divisional Director, Consultant in Sexual and Reproductive Health	Family and Therapies	23/03/2025	Approved	Employment with Nurture Health and Care, commissioned by South Wales Police as providers of forensic medical services for victims of sexual assault
Pippa Cotterill	Designated Education Clinical Lead Officer	Family and Therapies	01/04/2025	Approved	Secondment as Head of the Wales Office for the Royal College of Speech and Language Therapists
William Batten	Clinical Effectiveness & Formulary Pharmacist	Pharmacy	08/04/2025	Approved	Nil declaration
Sara Garland	general manager	F&T	10/04/2025	Approved	Nurse Advisor, WAST, bank work FRN
Bryony Allen	Mental Health In Reach to School's Specialist Practitioner - Staff Manager	Families and Therapies	14/04/2025	Approved	Director - Rosemonte Holdings. Property Holding Company which part owns Eriskey Residential Care Ltd and has direct links with Gateway Support & Care Ltd. Set up in 2023 Partner part owns Gateway Support & Care Ltd
Emma Jones	Third Sector Contract Monitoring Officer	Mental Health & Learning Disability	14/04/2025	Approved	Nil declaration
Alex Steptoe	Consultant in Emergency Medicine	Urgent Care	12/05/2025	Approved	Permanent contract role as a HEMS doctor with East Anglian Air Ambulance. 2 shifts per month commitment Occasionally volunteer for this organisation as a CPR trainer or at public events.
Marie-Claire Griffiths	Head of Strategic Planning	Planning	15/05/2025	Approved	Trustee with Newport Live
Dr Adam Carrn	Clinical Psychologist	Specialist Services	19/05/2025	Approved	Private Practice as a Clinical Psychologist/Cognitive Behavioural Therapist - advertised on line to self funding clients Provide therapy to Canopi (department of Cardiff University) providing mental health support to NHS Wales staff
Philip Campbell	Divisional Director	Medicine	19/05/2025	Approved	Private Practice P Campbell Consultancy LTD Own <0.5% of shares of St Joseph's Hospital - no dividends ever paid Sponsorship to attend training events organised by Medtronic, Abbott & Biomed
Naomi Michelle Lenina Jones	Senior Community Dentist	Community Dental Service	22/05/2025	Approved	Speciality Dentist in Restorative Dentistry - part time employment for 15 years
Sarah Butt	Physiotherapy Administrator	Outpatient Therapies	22/05/2025	Approved	Staff Bank HCA with Cwm Taf Health Board October 2015 to present
Carl Lane	Directorate Manager	Urgent Care	22/05/2025	Approved	St John's Ambulance Cymru - Bank HCP Swansea Bay Trust B7 Bank Emergency Practitioner Hallam Medical Ltd - Advanced Paramedic
Rebekah Da Silva Teixeira	Research Midwife	R&D	23/05/2025	Approved	Bank NHS contract with Gloucester Royal Hospital and Newmedica Limited Bank 6
Elizabeth Keddie Gray	Clinical Trials Pharmacy Technician	Primary Care and Community	23/05/2025	Approved	Nil declaration
Belinda Cook	Lead educator NICU/ Senior sister	Families and therapies	23/05/2025	Approved	Bank contract with Cardiff & Vale for a Welsh Risk Pool project - very infrequent shifts
Jacob Lovell	Research Contracts Officer	Research and Development	23/05/2025	Approved	Nil declaration
Lauren Carpenter-Barrett	Health Care Support Worker	Family and Therapies	23/05/2025	Approved	Social Care Wales - Newport City Council employed on 0 hour contract - bank staff
Rhannon Rogers	Clinical Specialist Paediatric Physiotherapist	trauma and orthopaedics - scheduled ca	23/05/2025	Approved	Employed in Cwm Taf Morgannwg as clinical lead physiotherapist for 21 years
Hatham Barhouk	Consultant Psychiatrist	mental Health (Addictions/Drugs and Alcohol)	23/05/2025	Approved	Out of hours locum work with Cardiff & Vale, Cwm Taf & Swansea Bay
Jaysy Siby	Senior Clinical Fellow	General Surgery	23/05/2025	Approved	Bank staff with Barts Health, occasional locum shifts in Barts Health on days off. Previously surgical clinical fellow in Whiplash Cross Hospital before joining ABUHB
Sarah Elizabeth Argent	Consultant Psychiatrist	Mental Health and Learning Disabilities	23/05/2025	Approved	Honorary Research Fellow Contract with Cardiff University - no financial benefits Employed by CTM as a Consultant Psychiatrist for the duration of my employment with ABUHB Both roles are clearly job planned to protect time in each Health Board. Clinical Lead in Forensic Adolescent Consultation Service with CTM & fixed term Clinical Director for Specialised Services within MH&LD
Laura Owen	ED Consultant	Urgent Care	23/05/2025	Approved	Employed with West Midlands Ambulance Service since 2018. 2 SPA contract agreed and signed off by Urgent Care. Ad Hoc locum shifts
Wendy Munro	Consultant	Medicine	23/05/2025	Approved	Medical Examiner employed by NHS Shared Services since November 2022. 1 PA a week
Helen Francis	CAMHS Emergency Liaison Practitioner	CAMHS	24/05/2025	Approved	Bank Registered Mental Health Nurse with Cardiff & Vale since October 2019 Registered Mental Health Nurse with Richmond Nursing Agency since June 2023
Shamira Ritigahawattage	Health Care Support Worker	Radiology	27/05/2025	Approved	Bank HCWSW with Cwm Taf since 2024
Hannah Louise smith	Sexual Health Outreach Worker	Urgent	27/05/2025	Approved	Employed with Caerphilly CBC as a Youth Worker since 2007
Clair Balchin	Research Laboratory Co-ordinator	Research and Development	27/05/2025	Approved	Nil declaration
Cilla Benga	Research Governance Administrator	Research and Development	27/05/2025	Approved	Nil declaration
Christopher edwards	consultant clinical scientist	scheduled care	28/05/2025	Approved	Directorship with The Private Phototherapy Clinic Ltd since 2005
Louise Parfitt	Research Development	Research Development	05/06/2025	Approved	Director with Mulberry Orthopaedics
Phil Lansdown	Rotational Band 5 Physiotherapist	Therapies	06/06/2025	Approved	Applying for a bank physiotherapy role with Bristol Childrens Hospital. Will be ad-hoc shifts.
Cheryl Chingtho	CAMHS Support Worker	SCANHS and Ty Forrest BOOST	06/06/2025	Approved	Nil declaration
Sara Louise MORRIS	Fraud Investigator	Finance	18/06/2025	Approved	Community County Councils/ Monmouthshire County Council
Helen Penny	Consultant Clinical Psychologist	Adult Psychology	12/06/2025	Approved	Private Practice. 1-3 clients at any given time and offer supervision to 0-3 supervisees/groups at a time. I only work with clients outside of ABUHB or clients commissioned by solicitors as part of a medico-legal claim who would not accept support through the NHS. Supervision is provided to private practitioners or to support cohorts of the CT-PTSD Top up training programme in England. Very occasionally design and deliver training outside of ABUHB as part of this private practice. Line manager fully aware of private work. This is paid work and a tax self assessment is completed each year
Sarah Ilett	Community dentist	Community dental	24/06/2025	Approved	Nil Declaration
Dafydd Pritchard	Physiotherapist	Band 5	03/07/2025	Approved	Employment with St Joseph's Hospital for the last 10 months Employment with Nuffield Vale Hospital for the last 8 months
JANE	MEDICAL SECRETARY	FAMILY AND THERAPIES	04/07/2025	Approved	Private Secretary to Dr M Oliver
Natalie Simon	Clinical Psychologist	Psychology - Adult Mental Health	14/07/2025	Approved	Yin yoga teaching and private psychology consultancy work outside of NHS hours
Roxanne Green	Assistant Director	Planning	21/07/2025	Approved	NEE Ston Housing Association
Julie aze	Consultant Gastroenterologist, clinical director	Unscheduled care - gastroenterology	24/07/2025	Approved	Nil declaration
Leigh Michael Roberts-Jones	GP with specialist interest cardiology	Cardiology	24/07/2025	Approved	GP Partner Forest View Medical Practice since 2021 & Medical Examiner's Service since February 2023
Bernadette Bustin	Psychologist	Cancer/Hepatology	24/07/2025	Approved	Run a private psychology practice since April 2024
Louisa Fleetwood	Reporting Radiographer	Clinical support services	01/08/2025	Approved	Bank contract with Gloucestershire Hospitals NHS Foundation Trust
Zoe Hall	Band 5 Rotational Physiotherapist	Physiotherapy	05/08/2025	Approved	Searly Physiotherapy Involved from 05/08/2025 - 3 hours maximum from 17:00 on Tuesday Evening
Amy Louise Miller	Team Lead Physiotherapist	Family and Therapies	11/08/2025	Approved	Shareholder FL Wangler Ltd since 2018
Tanya Scully	Rotational paediatric physiotherapist	Band 6	11/08/2025	Approved	Rumney RFC Head of Physio 2025-26 season. Welsh Gymnastics Physio for events since 2024. England Touch Rugby physio 2025-26 season
Julie Knight	Senior Physiotherapy Technician	Family & Therapies	11/08/2025	Approved	Nil Declaration
Suzanne Fincham	Administration Officer	Family and Therapies	11/08/2025	Approved	Nil Declaration
Jennifer Christie	Paediatric Physiotherapist	Child and family	11/08/2025	Approved	Queny nil declaration
Hannah Bradbury	Physiotherapist (Rotational 6 in Paeds/ALD)	Families & Therapies	11/08/2025	Approved	Nil Declaration
Carragh Williams	BF Physiotherapist ALD	Family & Therapies	11/08/2025	Approved	Nil Declaration
Mrs Sheona Louise Stubbs	Team Lead Paediatric Physiotherapist	Family & Therapies	11/08/2025	Approved	Nil Declaration
Alexandra Thomas	Paediatric Physiotherapist	Family and Therapies	11/08/2025	Approved	Nil Declaration
Debbie Paris	Band 7 Specialist Physiotherapist	Family & Therapies	12/08/2025	Approved	Nil Declaration
Emma Catherine Enoch	Band 7 Paediatric Physiotherapist	Family and Therapies	12/08/2025	Approved	Nil Declaration
Cory Jenkins	Senior Finance Analyst	Finance - Surgery	12/08/2025	Approved	Nil Declaration
Monica Reading	Paeds Physio	Family and Therapies	12/08/2025	Approved	Sirona Care & Health Employment since March 2025
Tamin Jackson	Primary Care Pharmacist	Pharmacy	13/08/2025	Approved	Nil Declaration
Corys Dyll Rackham	Antimicrobial Pharmacist	Pharmacy	13/08/2025	Approved	Nil Declaration
Amanda Duggan	Pharmacy Manager	Primary Care and Networks	13/08/2025	Approved	Nil Declaration
Rhys Lewis	Pharmacist	Primary care and networks	13/08/2025	Approved	Nil Declaration
Louise Leach	Operational manager Physiotherapy	Family & Therapies	14/08/2025	Approved	Nil Declaration
Joanne Reid	Pharmacist	Primary Care and Networks	14/08/2025	Approved	Nil Declaration
Jenna Rudman	Pharmacy Technician	Primary care and networks	17/08/2025	Approved	Nil Declaration

Nadine Mayley	Physiotherapist Adult Learning Disabilities	Family & Therapies	18/08/2025	Approved	Nil Declaration
Daniel Phillips	Antimicrobial Pharmacist Secondary Care Lead	Primary and community care	18/08/2025	Approved	Nil Declaration
Hayley Randall	Physiotherapist	Family and Therapies	19/08/2025	Approved	St Joseph's Hospital - working as a bank physiotherapist since May 2022
Judith Harding	Pharmacist	Primary care and networks	18/08/2025	Approved	Nil Declaration
CHERIE LAMONT	PHYSIOTHERAPY TECHNICIAN BAND 4	FAMILY AND THERAPIES	19/08/2025	Approved	Nil Declaration
Gavin Rose	Pharmacist	Medicine	19/08/2025	Approved	Nil Declaration
Noelle Cramp	Clinical Specialist Orthotist	Families and Therapies	20/08/2025	Approved	Planning to under take temporary employment with a private orthotic company one day a week providing scoliosis bracing. This would be a non NHS working day due to my part time role. Temporary 6 month contract for 1 day a week.
Cameron Forde	Antimicrobial Pharmacist	Pharmacy	20/08/2025	Approved	Nil Declaration
Aimee Jones	Programme Divisional Pharmacist - Surgery	Pharmacy	21/08/2025	Approved	Nil Declaration
Heath Cassidy	Pharmacy Manager, NHH	Primary Care	21/08/2025	Approved	Nil Declaration
Rhys Williams	Pharmacist	Primary Care and Communities	21/08/2025	Approved	Nil Declaration
Joanna Peacock	Divisional Pharmacist Mental health and learning disability	Primary care and communities	21/08/2025	Approved	Nil Declaration
Sarah Ails Wyburn	Band 6 Paediatric Physiotherapist	Families and Therapies	21/08/2025	Approved	Pontypool RFC 2 years. Pay monthly - self assessment
Jonathan Simms	Clinical Director of Pharmacy	Primary Care, Community, Complex Care	21/08/2025	Approved	Nil Declaration
Jane Hoidn	Pharmacy Manager GUH	Primary Care	27/08/2025	Approved	Nil Declaration
Lynne Margaret Herring	Pharmacist	Primary Care and Community	28/08/2025	Approved	Nil Declaration
Hans Thoburns	Principal Pharmacist Workforce Modernisation / Education and Training	Primary Care and Community	28/08/2025	Approved	Nil Declaration
Samantha Louise Shadbolt	Physiotherapist	Families and Therapies	28/08/2025	Approved	Nil Declaration
Tina Makzal	Mental Health Pharmacist	Mental Health	28/08/2025	Approved	Nil Declaration
Rachel Raymond	Clinical Lead and service Manager for Public Health Nursing	Family and Therapies	29/08/2025	Approved	Nil Declaration
Emma Knott	Programme Divisional Pharmacist	Primary Care and Community	30/08/2025	Approved	Nil Declaration
Bethan Jones	Principal Pharmacist for Procurement, Homecare and Clinical Informatic	Primary Care and Communities	01/09/2025	Approved	Nil Declaration
Jennifer Toomey-Lewis	Physiotherapist (Symptom management)	Physiotherapy	01/09/2025	Approved	Living Proof (Non profit organisation) Feb 25- Sept 24. Jennie Toomey Chronic Pain/Symptom Coaching for recovery and symptom reduction - Mind/Body coaching
Lena Evans	Public Health Nursing Manger Torfaen	Family & Therapies	01/09/2025	Approved	Nil Declaration
Lowri Frances Benjamin	Physiotherapist	Family and Therapies - Physiotherapy	01/09/2025	Approved	Nil Declaration
Jill Davis	Band 7 Physiotherapist	Family and Therapies	01/09/2025	Approved	Voluntary leadership role in Vineyard Church Cardiff since 2019 (and spouse) Ambassador for Tropic Cosmetics since 2022. Consultant for Neals Yard Cosmetics since 2019. Sporadic & part time sales. Spouse - ambassador for Utility Warehouse since 2019
Lianne Betts	Physiotherapy technician Band 3	Family and therapies	01/09/2025	Approved	Nil Declaration
Hannah Wedge	Clinical Psychologist	Family and Therapies	01/09/2025	Approved	PAINd app - co-creating a course for children and young people with persistent pain. Period will be finite with no ongoing financial agreements
Ceri Phillips	Consultant Antimicrobial Pharmacist	Primary Care	01/09/2025	Approved	Father worked for Pfizer until 2005 - in receipt of Pfizer pension and holds shares
Naik Collard	Manager	Primary Care & Communities	01/09/2025	Approved	Nil Declaration
samantha street	Health Visitor	Family Therapies	01/09/2025	Approved	Nil Declaration
Hayley Jones	Senior Nurse - Health Visiting	Families and Therapies	01/09/2025	Approved	Nil Declaration
Aimee Hawkins	Biomedical Scientist	Microbiology	03/09/2025	Approved	Aimeemayd Crochet Ety Store (est 2023)
Sharon Lois Taylor	Personal Assistant - Children's & ALD Physiotherapy	Family & Therapies	04/09/2025	Approved	Nil Declaration
Emma Jenkins	Deputy Head of Diagnostics & Weight Management Services	Family & Therapies	05/09/2025	Approved	Nil Declaration
Danielle Gutter	R&D Manager	Corporate	05/09/2025	Approved	Nil Declaration
Fion Evans	Rotational Physiotherapist	Band 5	05/09/2025	Approved	Part time rugby pitchside/training physio for Cardiff Quilms since August 2025
Christopher Phillips	Public Health Nursing Borough Manager	Family and Therapies	05/09/2025	Approved	Nil Declaration
Michelle Dando	Health Visitor	Families & Therapies	05/09/2025	Approved	Rejuvenate Aesthetics since April 2025
Kyriaki Sianou	HCSW	Families and therapies	05/09/2025	Approved	Nil Declaration
Kirsten Gibbins	8a Strategic and operational Lead Children Continuing Care	CAMHS	05/09/2025	Approved	Chair of Governors for Special School
Sarah-Jayne Johnson	Health visitor	Family and Therapies	08/09/2025	Approved	BS bank shifts needs ward ABUHB
Laura Gray	Specialist Biomedical Scientist	Pathology	08/09/2025	Approved	Self employed sole trader online retail business since June 2025
Katherine Joanne Holland	Health Visitor	Families & Therapies	09/09/2025	Approved	Run aesthetics business
Danielle Barrett-Wyatt	Health Visitor	family & therapies	09/09/2025	Approved	Self love life coach - self loves solves everything
keny hawkins	Health Visitor	Families and Therapies	09/09/2025	Approved	Cariad aesthetics
Ms Avril Jones	Specialist Health Visitor	Family and Therapies	09/09/2025	Approved	Licensed trainer of Solihull Approach, paid to deliver training modules since 2015
Katharine Susan Hobbs	Health Visitor	Health Visiting	09/09/2025	Approved	Cardiff Lymphatic Clinic since August 2025
Amelia Mason	Administrator	Health Visiting	09/09/2025	Approved	Nil Declaration
Rhian Wyn Iohn	Administrative assistant	Family and Therapies	09/09/2025	Approved	Nil Declaration
Lesley Ann Watkins	Assistant Practitioner	Ringland	10/09/2025	Approved	Nil Declaration
Lynne Margaret Herring	Pharmacist	Primary Care and Community	12/09/2025	Approved	Nil Declaration
caryl brown	ABUHB	Medicine	12/09/2025	Approved	10 hours paid work in a nursery September 2025 ongoing
Victoria Bodger	Senior Nurse	Family & Therapies	15/09/2025	Approved	Nil Declaration
Joanne Buchanan	Analytics & Modelling Capability Programme Manager	Corporate	16/09/2025	Approved	Bank Physiotherapist with Nuffield Health from 15 September 2025
Catherine Louise Harrigan	Biomedical Scientist	Microbiology	18/09/2025	Approved	SNAP Cymru (Children's Charity) Volunteer Independent Parental Support. Time and expenses claimed - no wage
Abigail Plum Ward	Specialist Nurse - Obesity	Family & Therapies	18/09/2025	Approved	Open University Part time lecturer since 2022
Cerys Ridley	Lead Pharmacist Clinical Specialities	Primary Care	22/09/2025	Approved	Nil Declaration
Joanne Bissex	Registered Nurse	Family and Therapies	26/09/2025	Approved	True Elegance Aesthetics Ltd Since July 2023 Aesthetics by Jo since April 2025
Jane Thomas	Senior Pharmacist	Primary care and community	30/09/2025	Approved	Nil Declaration
Belinda Lydon	Parent-Infant Mental Health Specialist	Child and Family Therapies	01/10/2025	Approved	USW Hourly paid lecturer ad hoc since 2019. Music Therapy Supervisor (hours fit around paid employment)
Susan Millar	Health Visitor	Families and Therapies	02/10/2025	Approved	Foster Carer
Halina Jane Moulton	Caephilly East NCN Pharmacist	Pharmacy	03/10/2025	Approved	Employed by Vauxhall Practice since October 2021 15 hours per week £23,734
Katherine Freeman	Clinical Psychologist	Child & Family Psychology	06/10/2025	Approved	Nil Declaration
Alessandra Roberts	Clinical Psychologist	Child & Family Therapies	08/10/2025	Approved	Nil Declaration

Name of Member/Officer	Date of Disclosure	Department	Nature of Gift	Company	Accepted/Declined
Hannah Capel	09/10/2024	Planning Strategy and partnerships	Train tickets and ticket to an awards event that the Health Board was invited to	Kier Construction	Accepted
Lorraine Morgan	30/10/2024	Planning	Travel & Lunch for Awards Ceremony	Arcadis	Accepted
Hannah Capel	25/11/2024	Planning	Meal at an event	Gleeds Management Services	Accepted
Kathryn Campbell	26/11/2024	Unknown	6 Lead Coats	Mermaid Medical	Accepted
Belinda Lydon	27/11/2024	G-PIMHS	Garden Centre voucher from a mother		Accepted
Rebecca Pepper	28/11/2024	Gwent Parent Infant Mental Health Service	Garden Centre voucher from a mother		Accepted
Nicola Quiller	29/11/2024	Digital Data and Technology	Laptop Cart	Kinetic ID	Accepted
Laura Bolton	29/11/2024	G-PIMHS (gwent parent infant mental health service)	Garden Centre voucher from a mother		Accepted
Claire Parkes	08/01/2025	Urgent Care	Hotel gift card - internal gift from colleagues		Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Nutricia	Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	iMEDicare	Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Pennamed Ltd	Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Viatrix UK	Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Marja Cross	Accepted
Heather McGregor	31/01/2025	Colorectal Nurses	£100 to support a training/study day for team	Norgine.com	Accepted
Dr Marufa Sultana	04/03/2025	Obstetric & Gynaecology	Funding for transport, hotel & meals to attend symposium	Smith & Nephew UK	Accepted
Nicola Quiller	08/05/2025	Digital Data and Technology - Business Change Team	The electronic Prescribing & medicines administration programme ran a roadshow event across the 5 main sites. Kinetic-ID provided the raffle prizes. Winners drawn using Random.Org. Winners Emma Lloyd-Jones GUH Ward A3 (Samsung Tablet) Manju Mathew RGH Ward D2 East.	Kinetic ID	Accepted
Craig Gane	14/08/2025	HSDU	Sponsorship for contribution to degree. 20%=£1576 Bachelor of Science in Decontamination Management	Surgical Holdings Ltd	Accepted
Helen Shannon	02/10/2025	Dietetics	BAPEN Conference 11-12/11/2025. Conference fees paid - £300	Nutricia	Accepted
Robert Garland	03/10/2025	Dietetics	BAPEN Conference 11-12/11/2025. Conference fees paid - £390	Stanningley Pharma	Accepted

Standards of Business Conduct Policy: Implementation Plan

Objective	Tasks	Timeline	Progress	Rating
Training and Awareness of the Standards of Business Conduct Policy	Develop AB Pulse site with advice and guidance on implementing the policy	November 2024	Included within the Corporate Governance pages Standards of Business Conduct - Declaring Interests, Gifts, Hospitality, Sponsorship and Honorary	Complete
	Implement electronic forms to facilitate the submission of DoIs, Gifts, Hospitality and Sponsorship	November 2024	Electronic forms implemented	Complete
	Include SoBC Policy requirements in Corporate Induction and Employee Handbook	January 2026		Underway
	Introduce 'digital prompts' for all staff to make/review DoIs and register gifts/hospitality/sponsorship and honorarium	June 2026		Not due
Implement Measures to target and monitor uptake, including Targeting 'High Risk' Groups identified in the Policy	Request 'starters' list to identify key individuals at the start of their employment	January 2026		Underway
	Request list of staff at band 8a and above in order to send targeted emails/communications	January 2026		Underway
	Contact Managers of high risk staff groups to identify staff who meet the criteria	March 2026		Not due
	Monitor uptake against agreed 'high risk' lists, with updates to managers of non responders and escalation to Director of Corporate Governance	September 2026		Not due
	Add list of 'high risk' groups to DoI section in PADR paperwork to prompt submissions	March 2026		Not due
<ul style="list-style-type: none"> Staff at Band 8a and above Research and Development Staff* Pharmacy Staff* Informatics Staff* Estates and Facilities Staff* 				

Objective	Tasks	Timeline	Progress	Rating
Whose role necessarily brings them in to contact with external companies, contractors or suppliers, if you are able to initiate orders, are a budget holder, or strategic decision maker				
Validation of the Declaration of Interests Register (Non-Board Member)	Request 'leavers list' in order to remove staff from the register when leaving the Health Board	March 2025	Leavers list received on a weekly basis	Complete
	Contact 'High Risk' staff on an annual basis to confirm no changes	September 2026		Not due
	Introduce a 'removals log' to be held as a reference archive for leavers and changes to declarations	November 2025	Log established	Complete
Board Member Validation to ensure register remains comprehensive and up to date throughout each financial year	Annual DoI request to be made in February of each year	February 2025	Annual declarations currently requested in support of the Annual Accounts reporting process	Complete
	Validation checks to be undertaken in September each year to confirm changes/no change to DoI submission	September 2025	Form reviewed to enable members to view previous submission and confirm no changes, or provide new declaration.	Underway
	Validate changes to DoIs, requesting confirmation in writing where previous declarations are removed	October 2025		Not due
	Enhanced checks for Board members, including review of Companies House records	November 2025		Not due

Objective	Tasks	Timeline	Progress	Rating
	Request that members leaving the Board confirm current DoI is correct on leaving	Routine		Underway

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on the Health Board’s Risk Management Maturity
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
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u>
<p>The purpose of this report is to provide the Audit, Risk and Assurance Committee (the Committee) with assurance on the effectiveness of the Health Board’s Risk Management Framework in developing a mature, consistent, and proactive approach to risk management.</p>
<u>Cefndir / Background</u>
<p>The Risk Management Framework, approved by the Board in January 2024, provides the foundation for a systematic and consistent approach to risk management across the Health Board. It defines the core components, principles, and organisational arrangements required to embed risk management into all aspects of the organisation’s work.</p> <p>The framework supports the Corporate Governance Directorate in delivering three key objectives:</p> <ul style="list-style-type: none"> • Embedding the Health Board’s risk appetite statements, ensuring decisions are informed by a clear understanding of the balance between risk and opportunity; • Strengthening operational risk management capability by improving understanding and application of risk principles, and embedding the organisation’s risk appetite into everyday practice; and

- Maturing and continuously improving risk management processes across all services, ensuring they contribute to patient safety, organisational resilience, financial sustainability, and delivery of strategic objectives.

By embedding risk awareness and accountability at all levels of the organisation, the framework aims to support informed decision-making, strengthen the Board's ability to anticipate and mitigate threats, and optimise opportunities. This ensures that potential risks to patient safety, service quality, financial sustainability, and the long-term viability of the Health Board are managed effectively, thereby protecting the Health Board's ability to achieve its strategic objectives and deliver safe, sustainable healthcare.

To provide assurance that these goals are being achieved, this report outlines the risk management activities undertaken since the implementation of the framework and its supporting documents, demonstrating progress in embedding a mature, proactive approach to risk management across the Health Board.

Asesiad / Assessment

Since Board approval of the Risk Management Framework, significant work has been undertaken to advance risk maturity, with a focus on strengthening systems, processes, and staff capability. This report outlines the progress made to date, the initiatives currently underway, and the planned developments to ensure that risk is managed consistently and effectively at all levels.

Progress to Date

Strengthening Staff Capability and Engagement

The Corporate Governance Risk Management team consists of just two whole time equivalents (WTEs), supporting a workforce of approximately 14,000 staff across the Health Board. With such limited capacity, embedding and maturing risk management principles across the entire organisation presents a significant challenge.

To address this, the team adopts a strategic, top-down approach to training and engagement. By focusing initially on senior leaders and key decision-makers, we aim to cascade knowledge, build awareness, and promote good practice throughout the Health Board. This approach helps maximise impact, foster a culture of shared responsibility, and ensure that risk management becomes an integral part of everyday decision-making.

Targeted training sessions have been delivered to senior managers, including at the Chief Operating Officer's and Workforce and Organisational Development (WOD) Divisional sessions, Primary Care and Community and Clinical Support Service meeting. These sessions emphasised the critical role of leadership in cultivating a culture of accountability and embedding risk management into both strategic and operational discussions.

Further training has been provided at the directorate level to support operational teams as well as to clinicians through the Acute Medicine Training Programme. These sessions have helped demystify risk processes, build confidence in using risk management tools, and encourage consistent practice across the organisation.

Encouragingly, we have seen a notable increase in requests for support and engagement with the risk management process. This reflects a growing recognition of the value of structured risk management in strengthening governance, improving services, and safeguarding patients. Risk is increasingly becoming embedded in everyday activity and decision-making.

We continue to drive this agenda forward through a combination of focused training, enhanced governance reporting, and closer alignment with operational teams. By working collaboratively with directorates to tailor support and resources, we ensure that risk management remains relevant and practical. Through sustained visibility, open dialogue, and leveraging existing governance structures, we are steadily building capacity and embedding a more mature and resilient risk culture across the Health Board.

Improved Risk Identification and Escalation

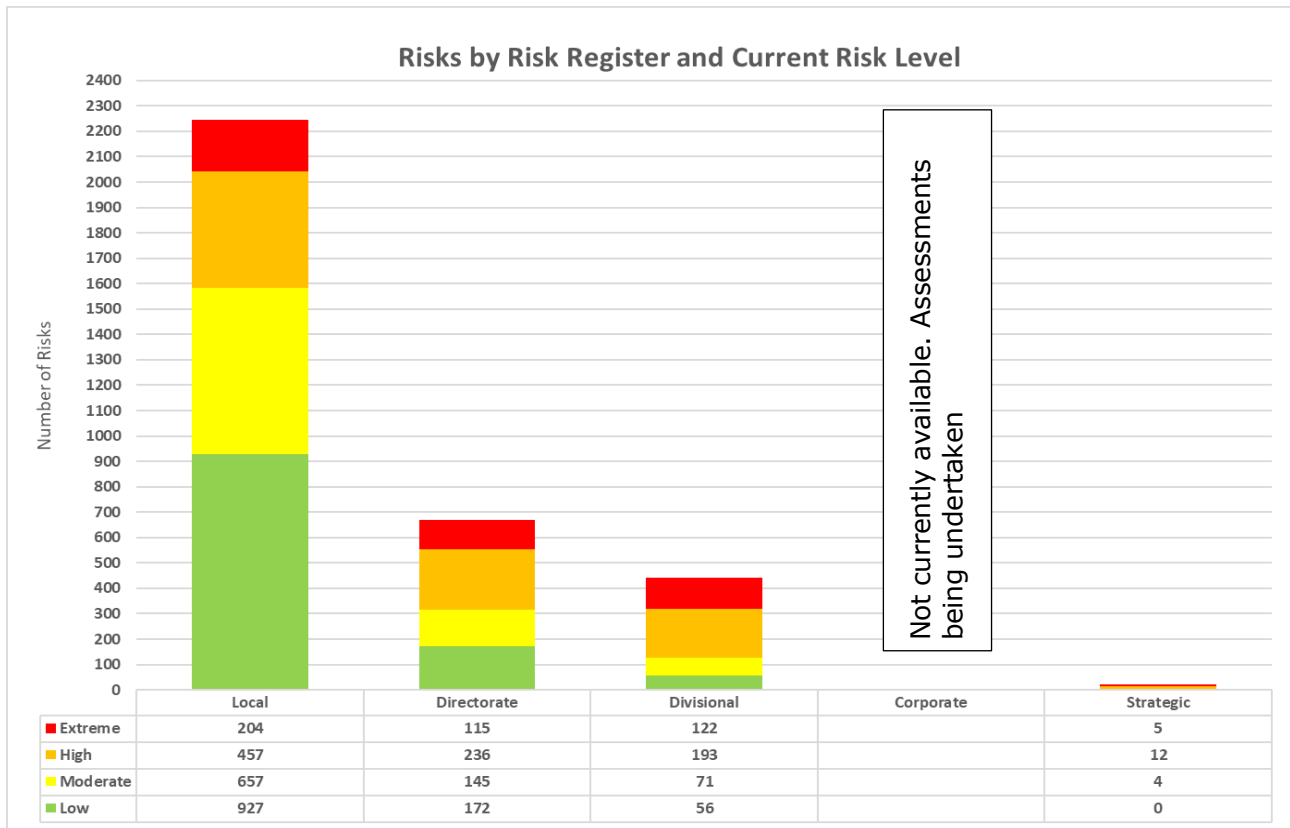
There has been a notable improvement in the use of Datix across the organisation. Most divisions have actively engaged in cleansing the system, removing outdated risks to ensure the data is current and meaningful. The accompanying infographic offers a clear visual representation of the number and distribution of risks at various organisational levels.

As anticipated, the number of risks decreases progressively up the hierarchy, reflecting the consolidation of individual risks into broader, themed overarching risks. This structured approach enhances strategic oversight and supports more effective risk management.

The infographics below illustrate the Health Board's overall risk profile, showing the number of risks at each hierarchical level and the corresponding risk exposure. It is acknowledged that further work is required to validate risk scores and enhance the consistency of scoring determination.

NB: The data presented in both infographics was accurate at the time it was extracted from Datix.





The planned decommissioning of DatixWeb in November 2027, together with the transition to a new risk management platform, provides an ideal opportunity to ensure that only accurate and validated risks are migrated. This will reinforce ongoing efforts to make the system a robust and reliable source of intelligence.

The data-cleansing work completed to date has been instrumental in identifying risks that warrant consideration for escalation to the corporate level. It has also supported the development of the Corporate Risk Register (CRR), which strengthens the interface between the Health Board’s strategic and operational functions by consolidating high-priority operational risks into a single, coherent framework. The CRR is attached to this report as **Appendix A**.

Looking ahead, the Corporate Governance Directorate will maintain a continued focus on enhancing organisational understanding of risk identification, assessment, and escalation. This will remain a key objective on an annual basis, supporting a culture of informed risk management and continuous improvement.

Building Governance and Reporting Structures

Work is underway to establish a consistent reporting hierarchy for risks across the Health Board. This structure will provide clarity on where risks should sit, who is accountable for monitoring them, and how escalation or de-escalation decisions are made.

To reinforce this structure, an overarching schematic, **Appendix B**, has been developed to illustrate the flow of risks through the organisation, with themed based reporting structures being developed, an example of the patient quality and

safety schematic is attached at **Appendix C**. Similar schematics will be developed for all thematic risk areas.

These visual representations will help staff understand the escalation and de-escalation process, promoting transparency and consistency in how risks are managed across operational, divisional, and corporate levels.

This work remains in progress, and with the continued support and engagement of key stakeholders, the schematics will be further refined to accurately reflect the Health Board's governance structure, within which risk management plays a central and integral role.

Embedding Risk in Forward Work Planning

Specialist groups across the Health Board, such as the Medical Devices Group and the Falls Management Group, are increasingly embedding risk management principles into their forward work programmes. This marks a meaningful shift toward more proactive, data-informed planning. By leveraging risk registers and trend analysis, these groups are able to identify areas of concern and prioritise actions that directly address known vulnerabilities and emerging risks.

For instance, the Medical Devices Group is using risk insights to inform procurement decisions, optimise maintenance schedules, and shape training priorities. This ensures that device-related risks are mitigated before they can impact patient safety or service delivery. Similarly, the Falls Management Group is aligning its work programme with risk data to target high-risk areas, develop preventative strategies, and monitor the effectiveness of interventions.

With the support of the Corporate Governance Directorate, the corporate Health and Safety Team is developing a governance framework and structure to ensure that key areas of health and safety risk drive the agenda of both the Health and Safety Operational Group and the Health and Safety Committee and the work programmes of the health and safety team.

This approach not only strengthens operational resilience but also supports a more integrated governance model, where specialist groups contribute directly to the organisation's overall risk profile. It reflects a growing maturity in how risk is understood and applied across the Health Board, with specialist teams playing an increasingly active role in identifying, managing, and mitigating risks within their domains.

Importantly, this work is being taken forward with the support of Clinical Directors and the Patient Quality and Safety teams. Their involvement ensures that work plans are not only aligned to operational needs but also focused on areas with the greatest potential impact on patient safety and service delivery. This demonstrates a clear shift toward embedding risk management as a core component of planning and decision-making, rather than a reactive or standalone process.

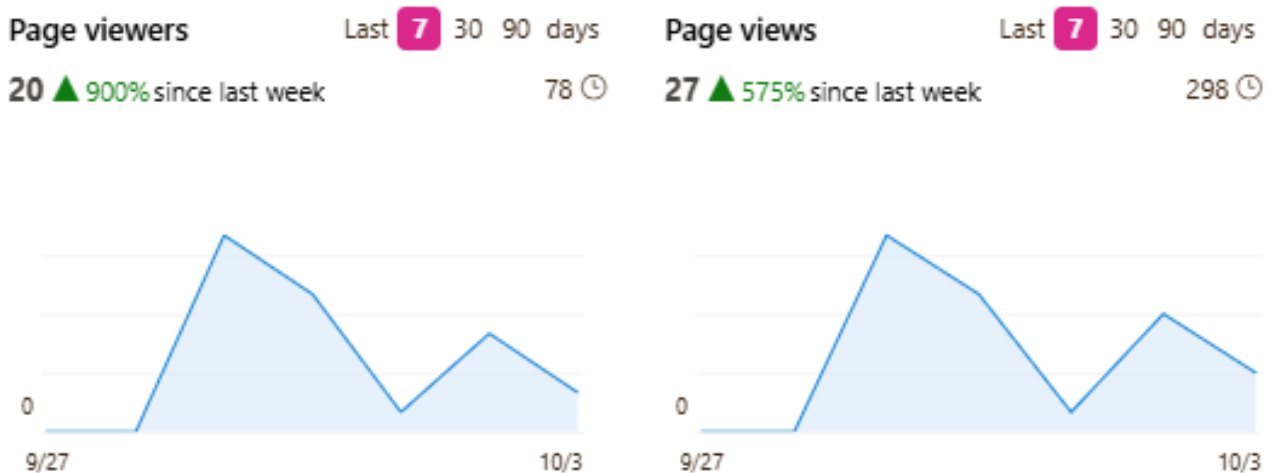
Supporting Structures and Resources

The establishment of the [Corporate Governance Hub](#) has created a centralised, easy-to-access resource for staff, bringing together risk management tools, guidance, and support materials. This has improved both accessibility and consistency, ensuring teams have what they need to manage risks effectively.

Recent data (captured on 03/10/2025) shows a positive trend in traffic to the Risk Management page. While numbers remain modest, the upward movement is encouraging and reflects growing engagement with these resources.

To build on this momentum, we will publish regular News Items on AB Pulse, directing staff to key tools and guidance. By continuing to raise awareness and make resources visible, we aim to embed risk management as a core part of everyday practice across the organisation.

Page Analytics



As mentioned earlier in the report, the decommissioning of the current electronic risk management system, DatixWeb, and the vote of no confidence in the cloud-based version, RL Datix, an opportunity has presented itself in that the Health Board has the opportunity to scope and consider a stand-alone option that would fit the needs of the Health Board, noting a national once for Wales system may be a compromised version in order to consider the nuances of individual organisations.

Looking ahead, the appointment of a Senior Project Manager on a fixed term contract will be pivotal in identifying and implementing a fit-for-purpose risk management system. This role will provide dedicated capacity to modernise infrastructure, streamline processes, and drive the transition to a more integrated and mature approach across the Health Board.

Working with Audit Partners

Independent audit plays a critical role in strengthening risk management across the Health Board. By providing objective assurance on the effectiveness of governance, control, and assurance systems, audit processes help identify areas of risk exposure and highlight gaps that may compromise organisational resilience.

The findings and recommendations from these audits are key to closing control gaps, enhancing accountability, and supporting the development of a more mature and embedded risk culture.

Audit outcomes also help align risk management with strategic priorities, ensuring that risks are not only identified but actively managed in the context of organisational goals. This external scrutiny reinforces good governance and supports continuous improvement in how risks are understood, escalated, and mitigated.

In 2024, the internal audit of risk management recognised progress in embedding risk principles but identified areas for improvement, particularly around consistency of application and clarity in escalation and reporting. The audit acknowledged growing engagement with risk processes and highlighted the need to strengthen alignment between strategic risks and organisational objectives.

Similarly, the 2024 Structured Assessment by Audit Wales found that the Health Board's governance arrangements were broadly effective, but recommended clearer links between strategic risks and annual plan objectives. It also called for improvements in assurance reporting and committee oversight.

Looking ahead, we await the outcome of the 2025 Structured Assessment, which will provide further insight into the Health Board's progress in strengthening governance and risk management. In addition, the internal audit of Strategic Risk and Assurance, scheduled for Quarter 4, will offer a focused review of how strategic risks are identified, monitored, and integrated into decision-making.

These forthcoming assessments will be instrumental in shaping our next steps and ensuring that risk management continues to evolve in line with best practice and organisational needs.

Development of a Risk Maturity Matrix

To strengthen our approach to risk management, we are developing a Maturity Matrix aligned to the core principles of risk management. This tool will be shared with teams across the organisation for completion and self-assessment. The purpose of the matrix is to:

- Identify and share areas of healthy practice where risk management is embedded and effective, for implementation.
- Highlight gaps and opportunities for improvement, enabling us to target support and resources where they are most needed.

The Risk Maturity Matrix will assess how well risk management is embedded across the organisation. The matrix will focus on key areas such as governance, strategic alignment, risk identification, assurance, reporting, and culture. Each area will be assessed against a five-level scale (from *Ad hoc* to *Embedded/Optimised*)

This structured approach will provide a clear picture of our current maturity levels and inform a roadmap for continuous improvement.

In addition, we are developing a set of Key Performance Indicators (KPIs) to measure both progress and performance over time, below is an example of the KPI's:

- % of risks reviewed within required timeframes
- % of risks with an assigned owner and next review date
- % of risks with current and validated risk scores
- % of risks with active mitigation plans and identified actions
- % of overdue risk actions
- % of staff completing risk management training
- % of audit recommendations linked to risks completed within agreed timeframes

These KPIs will help us track the impact of improvement actions and ensure that risk management practices remain robust, consistent, and aligned with organisational objectives.

Next Steps and Ongoing Work

- Finalising the reporting hierarchy and schematic to ensure clarity and consistency in escalation and de-escalation processes.
- Continued roll-out of training programmes, tailored to both senior leaders and directorate teams, to maintain momentum and build organisational capability.
- Further embedding of the CRR into Board reporting and strategic decision-making.
- Supporting the new Senior Project Manager to lead on the implementation of a modern, integrated risk management system.

Conclusion

The Health Board has made strong progress in advancing its risk maturity, with improved risk identification, clearer governance structures, and growing staff engagement. Ongoing initiatives, including the development of training programmes, governance tools, and a new risk management system, will further embed risk management as a core organisational discipline.

These developments are integral to ensuring that risks are managed proactively, transparently, and in a way that supports both patient safety and organisational resilience.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- **TAKE ASSURANCE** on the effectiveness of the Risk Management Framework and the work being undertaken to strengthen and mature the Health Board's management of risk.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. 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 Termau: Glossary of Terms:	Explained within the report
Partion / 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

	<p>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</p>
<p>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</p> <p>https://futuregenerations.wales/about-us/future-generations-act/</p>	<p>Choose an item. Choose an item.</p> <p>Not applicable to this report</p>

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite Threshold		Actions to Reduce Risk to Target	Assurance that the Risk is being managed effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occurring	Impact Of Risk Occurring	Current Risk Score	Risk Level	Risk Appetite Threshold	Within / Outside of Threshold			Likelihood Of The Risk Occurring	Impact Of Risk Occurring	Target Risk Score	Risk Level	Last Reviewed	Next Review
CRR 001	Executive Committee	Service Delivery	Director of Nursing	There is a risk that the Health Board may breach its statutory duties in safeguarding children and adults at risk of harm or abuse.	Due to reduced compliance with mandated level 3 safeguarding training among registered health and care professionals.	This could result in potential harm to individuals and reputational and regulatory consequences for the Health Board.	4	4	16	Extreme	8	N	<ul style="list-style-type: none"> Access to Duty Corporate Safeguarding Team (Monday to Friday, 9-5) Safeguarding guidance available via staff intranet Prioritisation of training for senior staff Systems in place to monitor training compliance Large volume of staff trained to Level 2 Safeguarding Compliance for Levels 1-3 now attainable via ESR Safeguarding Team implementation of Datix for data collection Regular compliance reporting from Divisions to Strategic sub-groups Quarterly compliance reporting to the Safeguarding Strategic Group Ongoing discussions to increase availability of Level 3 training 	Reasonable	2	4	8	Moderate	Aug-25	Sep-25
CRR 002	Executive Committee	Compliance and Safety	Director of Nursing	There is a risk of recurring incidents, Never Events and Complaints..	Due to a failure to effectively implement systems that integrate lessons learned and drive sustained improvements.	This could result in regulatory non-compliance, reduced public confidence, and failure to respond appropriately to patient concerns or complaints.	4	3	12	High	8	N	<ul style="list-style-type: none"> PTR Regulations 2011 and NHS Wales National Policy on PSI Reporting and Management Duty of Candour Statutory Guidance (2023) and Datix Process PSI and PTR intranet resources, Datix Cymru incident guide, and reporting guidance Quality Improvement Strategy and "Speaking Up Safely" initiative National reporting mechanisms (NRI/Early Warning Notifications) Use of Datix system and data submission to Welsh Government AMAT system for action plans and HIW tracking Divisional, complaints, and team meetings for assurance and review Executive Weekly Huddle for escalation and oversight Formal escalation processes at divisional and executive levels Bespoke training: PSI, human factors, coaching, Once for Wales, dashboard, and Datix training Use of patient stories and learning events to drive improvement Engagement with national safety events (e.g. sepsis, deteriorating patient) FURTHER ACTIONS TO BE IMPLEMENTED Short-term controls: dashboards, SOPs, training, standardised processes, data cleanse Medium-term controls: quality improvement and management systems Long-term controls: escalation processes, full training completion, Duty of Candour training, action plan delivery Quality Management Group oversight 	Negative	3	3	9	High	Aug-25	Sep-25
CRR 003	Executive Committee	Compliance and Safety	Director of Nursing	There is a risk that the Health Board may breach its legal responsibilities under the Mental Capacity Act (MCA) 2005, including the potential for unlawful deprivation of liberty.	Due to inadequate internal processes and governance arrangements. This includes inconsistent or inadequate mental capacity assessments, insufficient documentation of best interest decisions, and delays in securing Deprivation of Liberty Safeguards (DoLS) authorisations	This could result in Legal Non-Compliance, Litigation and Regulatory Sanctions, Reputational Damage, Harm to Patients, Staff Accountability and Morale Issues, Delays in Care Delivery	3	4	12	High	8	N	<ul style="list-style-type: none"> Dedicated MCA and DoLS Team Strategic MCA Lead Central Team for DoLS referrals/renewals Expert practitioner and legal access Regional DoLS Consortium Meetings Internal escalation process MCA Forum DoLS Policies/procedures/checklists Mandatory MCA training Internal scrutiny/clinical governance meetings Develop a standardised MCA/DoLS audit tool Introduce peer review for complex MCA cases Consider future DoLS model redesign Improve documentation practices and system prompts Address delays impacting discharge (model redesign) 	Reasonable	2	3	6	Moderate	Aug-25	Nov-25
CRR 004	Executive Committee	Compliance and Safety	Director of Nursing	There is a risk that the Health Board will be unable to meet legal and procedural obligations relating to Coroner inquests	Due to a significant and sustained increase in the volume of cases	This could result in delays in legal representation and inquest preparation, inadequate support to staff involved in inquests, reputational damage to the Health Board, negative impact on families awaiting outcomes, potential breaches of legal requirements.														
CRR 005	Executive Committee	Compliance and Safety	Director of Nursing	There is a risk that in-patients and staff may acquire a transmissible infection	Due to systemic challenges in infection prevention and control (IPC) practices. This includes environmental constraints, inconsistent compliance with IPC standards, and variation in clinical practice.	This could result in avoidable patient harm, breaches of statutory requirements, reputational damage, and increased scrutiny from regulators.	5	4	20	Extreme	8	N		Reasonable	4	4	16	Extreme	Aug-25	Sep-25
CRR 006	Executive Committee	Compliance and Safety	Director of Nursing	There is a risk that the Health Board will be unable to maintain compliance with the statutory requirements of the Nurse Staffing Levels (Wales) Act	Due to ongoing financial pressures, medical workforce remodelling, and a suboptimal skill mix	This could result in a breach of statutory requirements under the NSLWA, increased clinical risk and compromised patient safety, reputational damage and public scrutiny, staff dissatisfaction, burnout, and increased turnover, potential for enforcement action or escalation by Welsh Government or HIW.	4	3	12	High	8	N	<ul style="list-style-type: none"> Compliance with Nurse Staffing Levels (Wales) Act 2016 Statutory nurse staffing level calculations using acuity tools, professional judgment, and patient needs Annual reviews for 25 A areas; bi-annual reviews for 25 B wards Executive Director of Nursing oversight and approval of staffing reviews Annual reports to Board and Welsh Government on compliance and impact Independent reviews and engagement with Chief Nursing Officer (CNO) Twice-daily Safe 2 Start meetings and staffing huddles to manage short-notice deficits Clear escalation pathways for unresolved staffing issues Ongoing recruitment and retention efforts (local, national, international) Lead Nurse for NSA engaged in All Wales NSA Programme Continuous risk monitoring and alignment with workforce strategies Use of acuity tools (e.g., Safe Care) and workforce analytics for data-driven decisions Optimisation of e-rostering to reduce agency dependency Development of workforce and Safe 2 Start dashboards Engagement with patients and staff to promote transparency and learning Targeted recruitment for hard-to-fill areas Streamlined recruitment processes (local, national, international) Bespoke training and support for new and existing nurses Consideration of alternative and MDT workforce models for improved patient outcomes 	Reasonable	3	3	9	High	Aug-25	Nov-25
CRR 007	Executive Committee	Compliance and Safety	Medical Director	There is a risk that the Health Board will not consistently meet the requirements for providing timely and accurate information to the Medical Examiners Service.	Due to insufficient resources to implement, embed, and sustain the service	This could result in delays in issuing death certificates, family stress, reduced quality of information for learning and improvement, non-compliance with statutory or national requirements, and potential reputational and regulatory consequences for the organisation.	3	3	9	High	8	N	<ul style="list-style-type: none"> EAD chasing doctors to complete data and forms. MES information sent to Divisions Reminders issued using the MES Dashboard to monitor compliance rates. (CAD) Service is 	Negative	2	3	6	Low	Aug-25	Nov-25

CRR 008	Executive Committee	Compliance and Safety	Director of Allied Health Professionals	There is a risk that hospital patients will fall, resulting in catastrophic harm (death).	Due to inadequate assessment, prevention and response to management of falls risks.	This may result in increased length of stay, reputational damage, and regulatory scrutiny.	3	4	12	High	8	N	<ul style="list-style-type: none"> Falls Policy for Hospital Adult Inpatients Health & Safety Policy RIDDOR Standard Operating Protocol (SOP) Multifactorial Falls Risk Assessment (MFRA) – national assessment document Enhanced Care Framework Patient Quality, Safety and Outcomes Committee Executive Committee Quality Management Group Health & Safety Committee Falls & Bone Health Strategic Oversight Group Six Goals Programme Board Integrated Discharge Board Hospital Falls Strategic Oversight Panel Patient Quality & Safety Learning and Improvement Forum Divisional QPS Fora DATIX Incident Reporting System Health Board Falls Data Set Learning from Patient Safety Incidents Ward Accreditation <p>FURTHER ACTIONS TO BE IMPLEMENTED</p> <ul style="list-style-type: none"> Improve system-wide compliance with procedures and policies, with measurable parameters aligned to audit criteria. Ensure falls incident-related action plans are specific, measurable, and reported through a robust governance structure. Extend existing audit approaches and data collection to capture process measures aligned with MFRA and care plans. Promote the use of a care bundle for high-risk patients, aligned with RCP Fall Safe and Health Board policies. Implement multi-professional training using blended and practical learning. Engage via an MDT approach to increase confidence in applying policy/procedure changes. Develop and implement a Health Board-wide Falls Communications Plan (audience, message, delivery channel). Empower staff to discuss change ideas through a Falls Network and use of falls champions. Utilise 'Ward Accreditation' to promote MDT engagement and shared accountability. Divisional presentation of audits and reviews to the Falls & Bone Health Committee with quarterly reporting and learning cycles. Adopt safety huddles to discuss falls-related incidents as part of MDT safety culture. Ensure timely onward referrals (e.g., OPAL, Physio), with documented outcomes 	Reasonable	2	4	8	Moderate	Aug-25	Nov-25	
CRR 009	Executive Committee	Compliance and Safety	Director of Allied Health Professionals	There is a risk that the Health Board may fail to comply with health and safety legislation, specifically in relation to manual handling, RIDDOR reporting, fire safety risk assessments, and workplace risk assessments	Due to the inconsistent application of health and safety policies across departments.	This could result in harm to staff, patients, or visitors; legal and regulatory consequences; and reputational damage to the Health Board.			0		8						0				
CRR 010	Executive Committee	Compliance and Safety	Director of Public Health and Strategic Partners	There is a risk diabetes Hybrid loop																	
CRR 011	Executive Committee	Compliance and Safety	Director of Public Health and Strategic Partners	There is a risk that vaccine-preventable diseases will re-emerge.	Due to a sustained decline in routine and seasonal immunisation uptake since the COVID-19 pandemic, particularly in key childhood, adolescent, and adult programmes, and with significant geographical variation in coverage.	This could result in increased incidence of disease, outbreaks with serious health impacts, greater pressure on health services, and reputational and public confidence risks for the Health Board.			0		8							0			
CRR 012	Executive Committee	Compliance and Safety	Director of Public Health and Strategic Partners	There is a risk that the Health Board may fail to comply with its statutory social duties, including those under the Well-being of Future Generations (Wales) Act 2015, and the Socio-economic Duty	Due to inconsistent application across corporate and operational functions.	This could result in non-compliance with legislative requirements, missed opportunities to address inequalities, reduced trust from communities and partners, and reputational and regulatory consequences for the Health Board.			0		8							0			
CRR 013	Executive Committee	Service Delivery	Chief Operating Officer	The Health Board is at risk of failing to achieve the planned care waiting list targets.	Due to the continued increase in referrals that cannot be matched by the current resource available.	This could result in prolonged patient waiting times, poorer health outcomes, increased clinical risk, reduced public confidence, and potential scrutiny or intervention from national bodies.			0		17							0			

CRR 014	Executive Committee	Service Delivery	Chief Operating Officer	The Health Board is at risk of failing to achieve and sustain cancer pathway targets.	Due to the continued increase in referrals that cannot be matched by the current resource available.	This could result in delays to diagnosis and treatment, poorer patient outcomes, increased clinical risk, and reputational and performance-related consequences for the Health Board.			0		17					0			
CRR 015	Executive Committee	Compliance and Safety	Chief Operating Officer	There is significant safety risk to patients who become acutely unwell in the community.	Due to poor system flow impacting timely release of ambulances back into the community.	This could result in delayed emergency response times, increased risk of harm or deterioration for patients, and potential reputational and regulatory consequences for the Health Board.			0		8					0			
CRR 016	Executive Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will fail to support patients to access timely and appropriate care	Due to insufficient NEPTS (Non-Emergency Patient Transport Service) resource to meet daily demand for discharges, transfers, and outpatient appointments.	This could result in delayed care or treatment, increased length of stay, deterioration in patient condition, and potential operational, reputational, and financial impacts for the Health Board.			0		17					0			
CRR 017	Executive Committee		Chief Operating Officer	There is a risk that patients may experience delays in assessment and treatment, and staff may be unable to respond promptly to emergencies or deteriorating patients.	Due to the interim configuration of the Emergency Department during the transition between Phase 1 and Phase 2 of the ED extension results in suboptimal clinical layout, reduced clinical space, and fragmented staff coverage.	This could result in increased clinical risk, compromised patient safety and experience, staff fatigue, and potential reputational and regulatory consequences for the Health Board.			0							0			
CRR 018	Executive Committee	Service Delivery	Director of Strategy, Planning and Partnerships	There is a risk of capital project delays and budget overspend.	Due to increasing contractual disputes with contractors.	This could result in missed project milestones, increased financial pressure, disruption to planned service developments, and reputational and governance concerns for the Health Board.	5	4	20	Extreme	17	Y	<ul style="list-style-type: none"> Active monitoring with Cost Advisor and discussions with Shared Services Negotiation discussions to manage impact to Health Board Capital Project Framework (governance, escalation, sanctions) Clearly Defined Scope, Deliverables & Timelines of project Dispute resolution clause within project contracts Project Risk meetings to allocate who is responsible for risks within the project RPI's – detect early warning signs Scenario Planning Legal and commercial specialists to project teams, Bessons Learnt Exercises and Feedback End-to-End Project tracking Checklist Commercial Meetings Progress Meetings Project Board Discussion 	Reasonable	4	3	12	High	
CRR 019	Executive Committee	Financial Sustainability	Director of Strategy, Planning and Partnerships	There is a risk that the Health Board may face financial pressure and potential loss or reduction of services.	Due to the loss of the Regional Partnership Board (RPB) Regional Integration Fund (RIF) funding, without an identified replacement funding source, which may require the Health Board to financially support services previously funded through RIF.	This could result in service decommissioning, reduced capacity to deliver integrated care, increased strain on core services, and negative impacts on population health outcomes and system partnerships.			0		13					0			
CRR 020	Executive Committee	Transformation & Partnership Working	Director of Strategy, Planning and Partnerships	There is a risk that ineffective or fragmented working relationships across the region will undermine the Health Board's ability to deliver on regional planning opportunities and governance requirements.	Due to misaligned priorities, inconsistent engagement, and a lack of clarity in roles, responsibilities, and decision-making structures across partner Health Boards.	This could result in missed opportunities for service transformation, duplication of effort, inefficient use of resources, and reduced confidence in the Health Board's ability to lead and collaborate effectively at a regional level.			0							0			
CRR 021	Executive Committee	Compliance and Safety	Director of Strategy, Planning and Partnerships	There is a risk that the Health Board may be subject to judicial review.	Due to a failure to comply with NHS (Wales) Act 2006 - Duty to Involve and Engage when making substantial service changes that may significantly affect access, quality, or safety of services.	This could result in legal challenge, delays or reversal of planned service changes, reputational damage, and a loss of public and stakeholder confidence in the Health Board's decision-making processes.			0		8					0			

CRR 022	Executive Committee	Service Delivery	Director of digital	There is a risk that the Health Board may not have a fully integrated, end-to-end digital Radiology solution in place	Due to the Philips solution not being delivered or operational by the planned go-live date of October/November 2025.	This could result in continued reliance on fragmented systems, inefficiencies in radiology workflows, delays in diagnosis and reporting, and a failure to realise the intended benefits of the Radiology Information System and Storage Platform (RISSP) programme, with potential impacts on patient care and Health Board performance.	3	5	15	Extreme	17	Y	<ul style="list-style-type: none"> Additional resource approved for Radiology support Contractual performance management in place (formal letters sent to Philips) Local project plan development to manage correction plans and delivery risks National escalation discussions with Digital leadership to optimise deployment Formal project management methodologies aligned to Health Board policies Regular internal reporting to governance groups and executive committees Fortnightly development meetings to monitor software roadmap progress Additional resource and funding secured or integration development BHCW reviewing national programme board membership to improve decision-making Establishment of Digital, Data & Technology Group Welsh Government governance strengthened via Digital Leadership Board Regular reporting to Chief Executive Team and Welsh Government 	Reasonable	1	1	2	Low	Aug-25	Sep-25		
CRR 023	Executive Committee	Service Delivery	Director of digital	There is a risk that the current inadequate storage arrangements for paper medical records will compromise the security, accessibility, and integrity of patient information during the long-term digitalisation project.	Due to insufficient storage capacity, suboptimal environmental conditions, and fragmented record management processes while awaiting full transition to digital systems.	This could result in breaches of information governance, delays in patient care, increased operational risk, and potential regulatory and reputational consequences for the Health Board.	3	4	12	High	17	Y	<ul style="list-style-type: none"> Regular audits by the Information Governance Unit Bull review of records in St Cadocs Room 034 and Block 3 at Nevill Hall Secure disposal and relocation of obsolete records Best assessment response: relocation plans due to silverfish Business case submitted for digitising Mental Health, Family & Therapies, Primary Care & Community records Internal scanning initiated; outsourcing costs being assessed Request to Core Learning Committee to make Health Records Awareness Sessions mandatory Working group established to survey records management practices Collaboration with nursing education to include record keeping in ward accreditation Ease renewal confirmation for Online House to secure future storage capacity NHS Wales Records Management Code of Practice (2022) Digitised Health Records Services Intranet Health Records Network for Ward Clerks Staff training on storage, security, and confidentiality Risk assessments by Digitised Health Records Service NWSSP audit actions and follow-up plans Ward visits to promote best practice and identify gaps Bi-monthly Health Records Awareness Sessions Incident reporting via Datix and escalation to Information Governance Unit Hybrid records management (paper and digital) Implementation of digital systems: WNCR, WCCIS, ePMA 	Negative	2	2	4	Low	Aug-25	Sep-25		
CRR 024	Executive Committee	Confidence and Trust	Director of digital	There is a risk of patient harm, regulatory non-compliance, or reputational damage.	Due to the inappropriate, unvalidated, or poorly governed use of Artificial Intelligence (AI) tools in clinical and operational settings.	This could result in incorrect clinical decisions, breaches of data protection and ethical standards, erosion of stakeholder trust, and increased scrutiny from regulators and professional bodies.	6	4	12	High	13	Y	<ul style="list-style-type: none"> Artificial Intelligence Use in Clinical Practice Policy in place. Technical controls via security software deployed to Health Board infrastructure. New Digital Service Request Process ensures new digital services go through appropriate governance and assurance prior to operation (patient safety, infrastructure, cyber security, and information governance). Digital Divisional Engagement Meetings where new digital services and requirements are discussed. Microsoft Co-pilot project underway to safely implement the system within the Health Board. Review of AI governance to include clinical and operational digital services. Embedding into New Digital Service Request Process. Board briefing on AI to ensure Executives and Independent Members have additional information on the use of AI in Healthcare and appropriate governance. 	Reasonable	2	2	4	Low	Aug-25	Nov-25		
CRR 025	Executive Committee	Compliance and Safety	Director of Workforce and OD	There is a risk that the Health Board may fail to comply with its statutory social duties including, Social Partnership Duty, Equality Act 2010 (including the Public Sector Equality Duty) and Welsh Language (Wales) Measure 2011	Due to inconsistent application across corporate and operational functions.	This could result in legal and regulatory non-compliance, reduced equity of access and experience for service users, reputational damage, and a loss of public trust in the Health Board's commitment to inclusion and equality.			0		8											
CRR 026	Executive Committee	Service Delivery	Director of Workforce and OD	There is a risk that National Contract Reform and contractual amendments may have a negative impact on the Health Board's ability to deliver services effectively	Due to changes in contract terms and conditions.	This could result in workforce instability, increased operational costs, reduced service flexibility, and challenges in maintaining service continuity and performance standards.			0		17											
CRR 027	Executive Committee	Service Delivery	Director of Workforce and OD	There is a risk to the sustainability of key services, including Occupational Health.	Due to inconsistent application across corporate and operational functions.	This could result in reduced service availability, increased pressure on remaining staff, delays in access to support for the workforce, and potential impacts on staff wellbeing, regulatory compliance, and Health Board performance.			0		17											
CRR 028	Executive Committee	Compliance and Safety	Director of Corporate Governance	There is a risk that the Health Board's ability to operate efficiently, ensure compliance, and provide consistent and safe patient care will be compromised.	Due to Health Board policies and procedures not up-to-date or in place.	This could result in inconsistent practice, increased clinical and operational risk, non-compliance with regulatory and legal requirements, and potential harm to patients and reputational damage to the Health Board.			0		8											
CRR 029	Executive	Confidence and Trust	Director of Corporate	There is a risk that the Health Board does not maintain comprehensive oversight of all aspects	Due to an increased focus on secondary care performance leading to an imbalance of customer	This could result in missed opportunities for early intervention and prevention, unaddressed issues in			0		13											

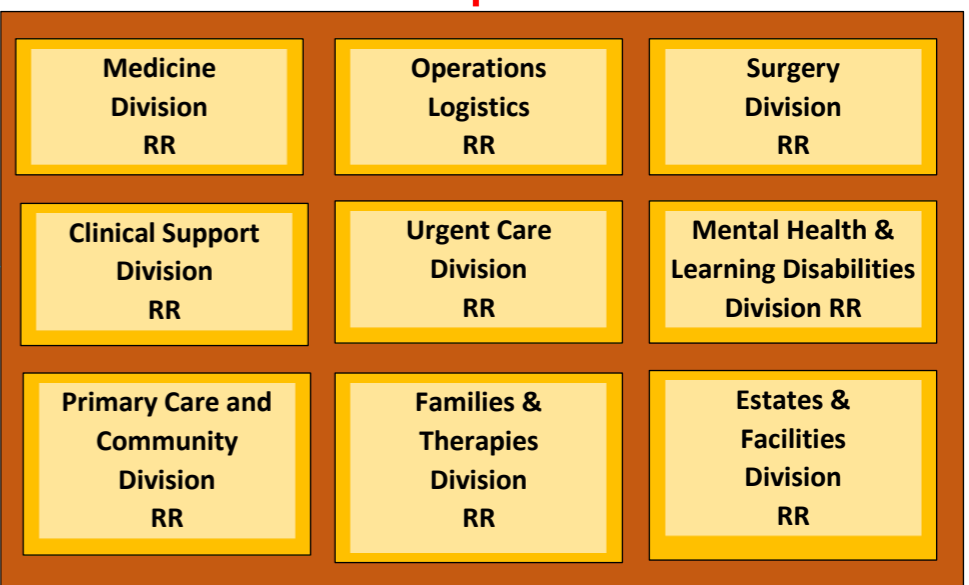
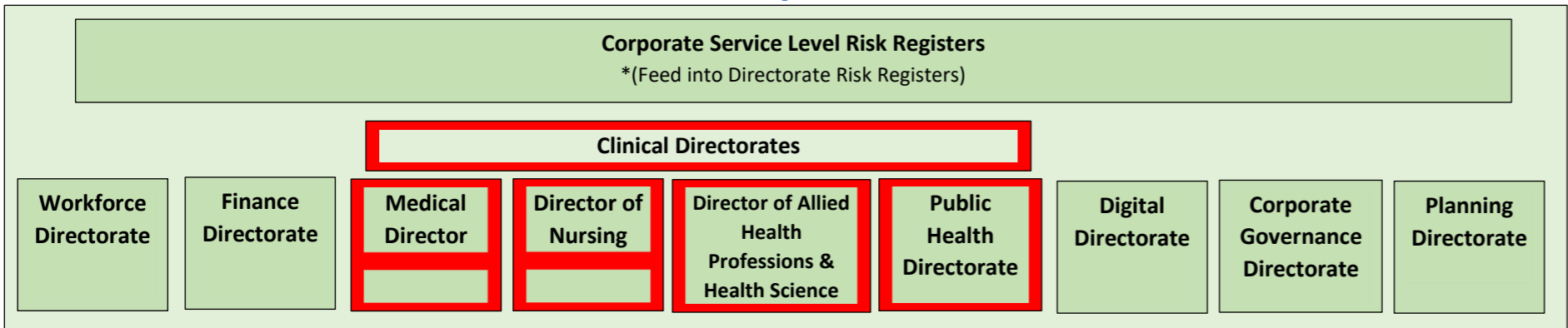
CRR ID	Committee	Business Area	Governance	of the system, from Primary Care to acute services.	performance, leading to an absence of system oversight of performance outcomes.	community and primary care settings, and a failure to deliver integrated, whole-system care.														
CRR 030	Executive Committee	Compliance and Safety	Director of Finance and Procurement	There is a risk that the Health Board will fail to meet the objectives and statutory requirements of the Climate Change Act and the Environment Act in relation to climate adaptation.	Due to insufficient organisational readiness, capacity, and capability to embed adaptation measures across strategic, operational, and capital programmes.	This could result in non-compliance with legislation, increased vulnerability to climate-related risks, missed opportunities for sustainable development, and reputational and financial consequences for the Health Board.			0		8							0		
CRR 031	Executive Committee	Service Delivery	Medical Director and Director of Workforce and OD	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.	This could result in reduced oversight of medical workforce capacity and utilisation, inefficiencies in service planning and delivery, missed opportunities for improvement, and a failure to meet national performance expectations.			0		17							0		

Strategic Risk Register - Board Level
Public Board

Corporate Risk Register - Executive Level
*(Feeds into the Strategic RR)
Executive Committee

Executive Director Risk Register
*(Feed into the Corporate RR)
Senior Management Team Meetings

Chief Operating Officer
*(Feed into the Corporate RR)
Divisional Assurance Meetings



Thematic Risk Registers
*(Overseen by Senior Governance Groups)

Thematic risks should be recorded on the relevant Divisional Risk Register but actively managed at the point where they are manifesting. Thematic risks should be escalated appropriately through the organisational hierarchy, in line with established governance processes.

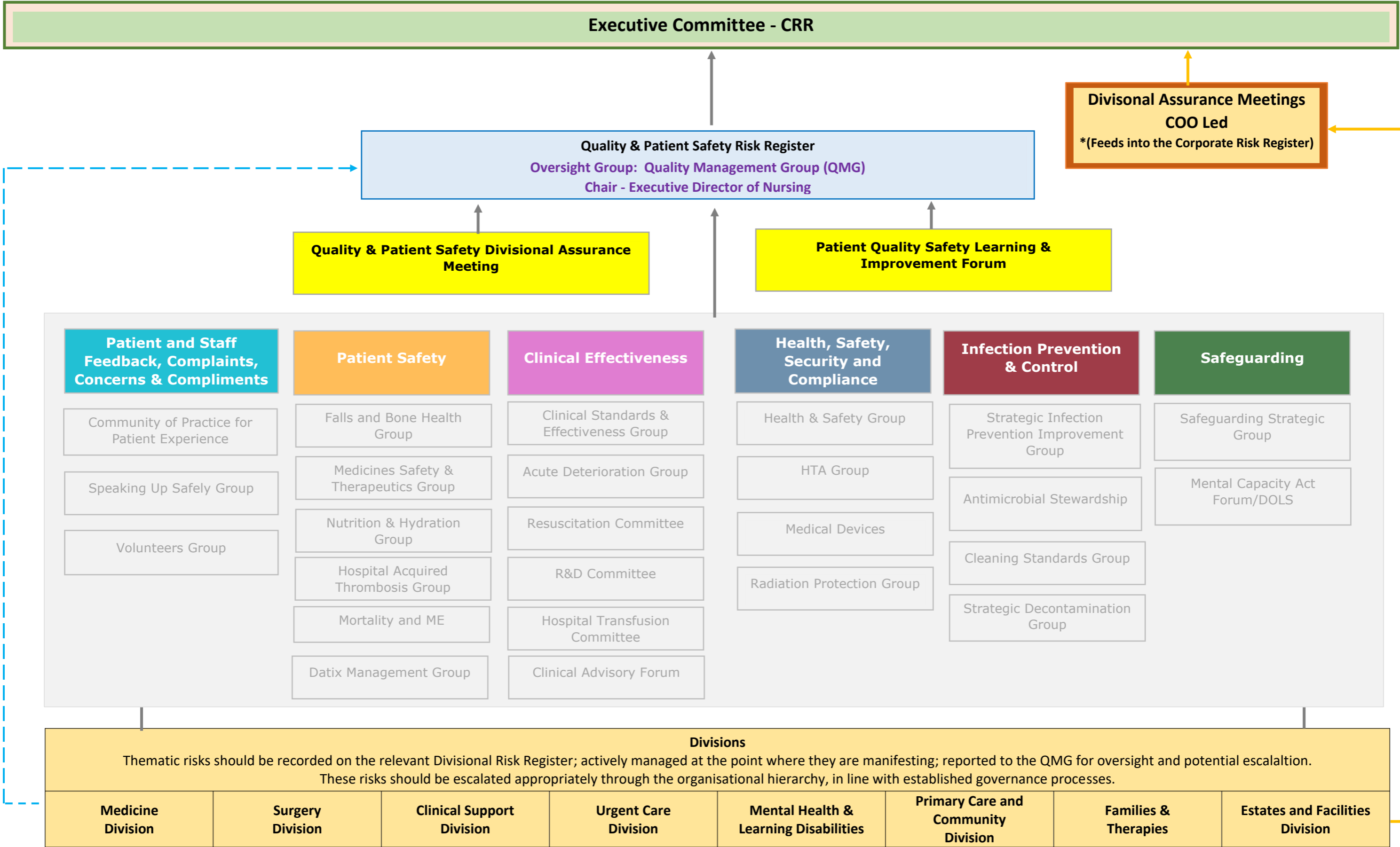


Specific Project Risk Registers

(Risks scored 9 and above – If there is potential of any project impacting on service delivery, consider escalating to the respective Directorate Risk Register for enhanced oversight and management.

Where risks have the potential to arise in other current or future Capital / Digital projects, or require more senior management, escalate to the Capital Group or Digital Service Management Board.

KEY	
	Operational structure
	Corporate structure
	Thematic Risk Register Relationship
	Risk Escalation
	Project Risk Escalation
ABC	Forum where risks discussed
*	Subject to conditions (RM Framework)
RR	Risk Register



Key:

ABC	QPS groups that sit under the QPS risk governance structure. Divisional Representation
	Groups that feed directly into the overarching Quality Management Group (QMG). Divisional Representation
	Duty of Quality Pillars
---	TRR Relationship
→	Organisational QPS Risk Reporting Route
→	Divisional Risk Reporting Route

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 October 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report presents the Audit, Risk and Assurance Committee (the Committee) with an assessment of potential strategic risks that could threaten the delivery of the Board's strategic objectives.

The identification of these risks is undertaken as a means of exploring credible worst-case scenarios, thereby supporting proactive risk management and providing assurance that such risks are being effectively identified, assessed, and managed.

Cefndir / Background

The Strategic Risk Report, last presented to the Committee in June, identified nine principal risks and 21 sub-risks. These risks continue to be actively managed to ensure appropriate mitigation and oversight.

This approach is fully aligned with the Board's Risk Management Framework, strengthening governance and enabling robust scrutiny and assurance of all potential threats to the successful delivery of the 2025–2028 Integrated Medium-Term Plan (IMTP).

Asesiad / Assessment

Strategic Risk Register

In accordance with best practice, all strategic risks have been reviewed within the appropriate timeframe for their respective levels of risk. The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Where it has been determined that the existing preventative controls are insufficient, additional controls have been documented, and actions are currently being taken to address these gaps.

Similarly, the three lines of assurance are evaluated to ascertain the effectiveness and reliability of the controls in place. If gaps in assurance are identified, the adequacy and effectiveness of the control environment are reassessed. Where feasible, proportionate measures are implemented to strengthen controls and close these gaps. However, in some cases, additional controls may not be cost-effective, if the resource cost of implementation outweighs the reduction in risk exposure achieved. In such instances, a risk-based approach is applied, balancing the cost and practicality of further controls against the residual risk and its potential impact.

Changes in Risk Exposure

Since the last update to the Committee in June, the Board at its September meeting received an updated position on its strategic risks and noted changes in two of its strategic risks, outlined below.

SRR 001: There is a risk that the Health Board may be unable to deliver and maintain high-quality, safe, and sustainable services that meet the changing needs of the population.

Sub-risk G, is linked to the Health Board's potential failure to achieve a sustainable financial position and long-term financial plan, has been reviewed by the Director of Finance and Procurement. Following this review, the likelihood of the risk materialising has been increased from 4 (Likely) to 5 (Certain) to reflect the current financial challenges.

SRR 006: There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.

The Director of Digital, who holds accountability for all strategic risks associated with SRR 006, has reviewed sub-risk B and increased its likelihood rating from 3 (Possible) to 4 (Likely). This change reflects growing national concerns regarding the implementation timelines of the Radiology Information Systems Programme (RISP) and the Laboratory Information Management System (LIMS).

Since the meeting of the Board, at the end of September there has been a change in the risk score for **SRR 001D**.

SRR 001D: There is a risk that the Health Board will be unable to deliver and maintain high-quality quality, safe and sustainable services that meet the changing needs of the population, due to the threat of Industrial Action during ongoing disputes and negotiations at a national level

The Director of Workforce and Organisational Development has reviewed the local position in light of emerging national activity and has determined that the likelihood of the risk materialising has increased from a score of 3 (Possible) to 4 (Likely).

This change reflects escalating industrial relations challenges at a national level, including the formal rejection of the 2025/2026 pay offer by Trades Unions and Unison’s notification of its intention to ballot members for industrial action.

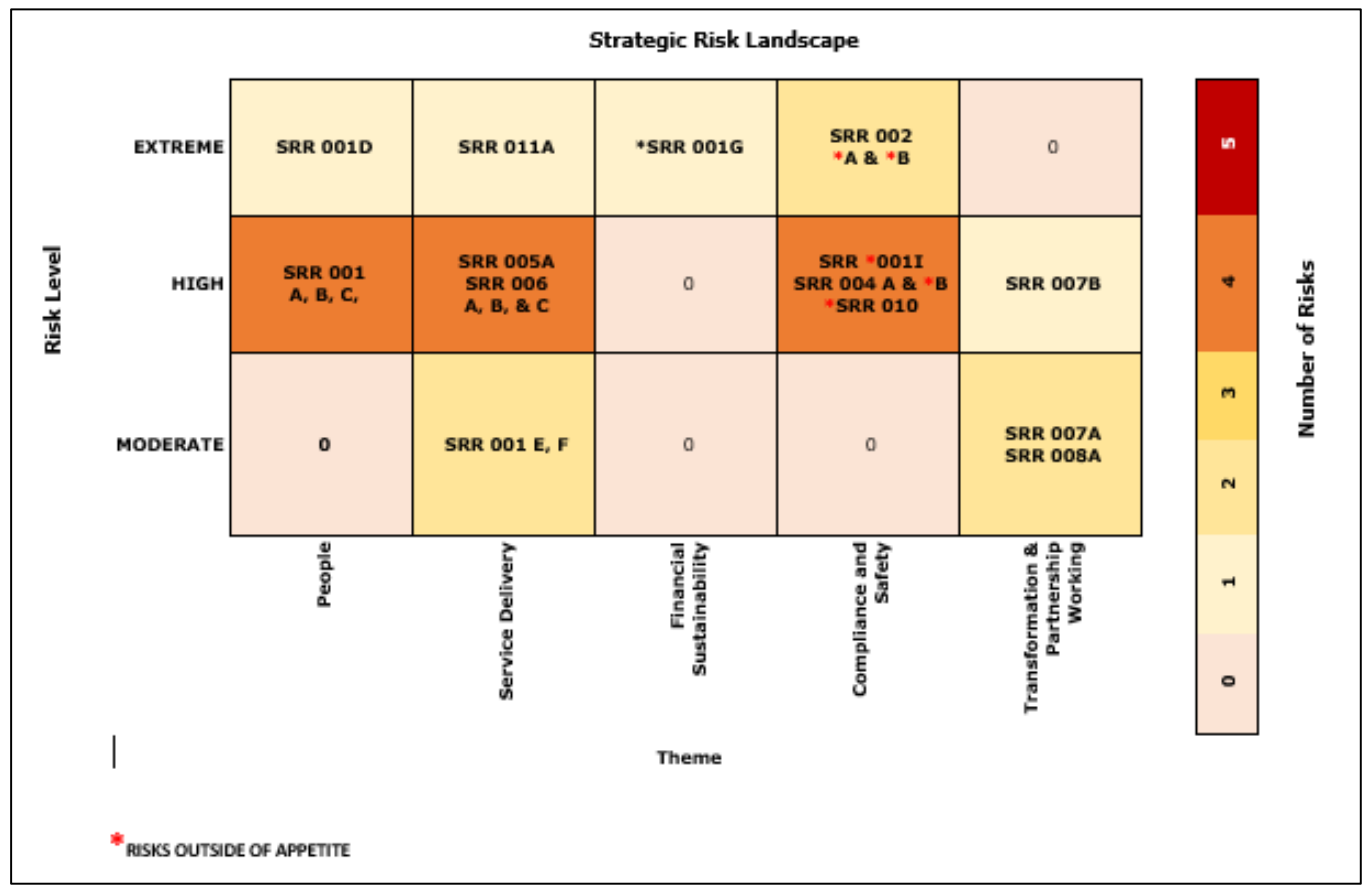
These developments significantly heighten the risk of workforce disruption, which could lead to staffing shortages, delays in service delivery, and increased operational pressures. Industrial action also introduces reputational risks, financial strain from contingency measures, and governance challenges in maintaining stakeholder confidence. Previous NHS disputes suggest that such situations often escalate and prolong, amplifying systemic vulnerability and uncertainty around resolution.

The Health Board acknowledges the uncertainty and challenges posed by the current dispute and remains committed to keeping staff wellbeing and organisational sustainability at the forefront of its approach. These priorities will guide both local and national efforts to resolve the situation effectively.

Risk Exposure and Appetite

Risk Exposure

In terms of the Health Board's current risk exposure to the 21 strategic sub-risks, the Heat Map below illustrates that the majority of strategic risks are concentrated in the central line of the risk matrix. This positioning reflects a high level of risk exposure, reinforcing the need for continued monitoring, robust controls, and proactive mitigation strategies to manage and reduce these risks effectively.



Risk Appetite

The Committee should note that six sub-risks currently exceed the acceptable thresholds for their respective domains. However, each of these risks is under active management. Ongoing assessments are in place to monitor residual risk, ensuring that new threats and vulnerabilities are promptly identified and addressed.

The Table below sets out the suggested management of the risks.

Risk ID	Sub Risk Description	Current Score	Management of the Risk
SRR 001G	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	20	Treat the residual risk, but also Take Opportunities to redesign and strengthen services for long-term sustainability.
SRR 001I	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	12	Treat the residual risk, but also Take the Opportunity to redesign and strengthen services for long-term sustainability.
SRR 002A	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	15	Tolerate the risk until it can be Terminated .
SRR 002B	Due to significant levels of backlog maintenance and structural impairment.	12	TREAT the risk through proactive estate investment and maintenance planning.
SRR 004B	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	12	TREAT the risk by developing, standardising, and testing effective Business Continuity and Critical Incident Response Plans.
SRR 010	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	12	Treat the residual risk, but also Take the Opportunity to improve staff safety culture.

Management of Risks Outside Appetite

To strengthen the Health Board's resilience and ensure alignment with its risk appetite, targeted work is required across three control categories, preventative, detective, and corrective for risks currently outside of appetite in the domains of financial sustainability, compliance, and safety.

In the year ahead, focused monitoring of risks will remain a priority. This ongoing surveillance, combined with strengthened control measures, will be essential in

managing associated risks and ensuring alignment between resources, performance measures, and safety.

Closing Position

The closing position reported to the Committee confirms that the Strategic Risk Register currently includes **nine** high-level strategic risks and **21** sub-risks, with **six** of these sub-risks managed outside of their predefined risk appetite level. These risks continue to be actively managed to ensure appropriate mitigation and oversight.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **NOTE** the Strategic Risk Register and the Risk Assessments for the 21 sub-risks, acknowledging the comprehensive review and ongoing management of these risks;
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;
- **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognising the ongoing efforts to mitigate these risks and bring them within acceptable levels.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives	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
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

**Effaith: (rhaid cwblhau)
Impact: (must be completed)**

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

Risk ID and Description				IMTP Link	Risk Score													
					2	3	4	5	6	8	9	10	12	15	16	20	25	
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialities.	Workforce & Culture					X					●		◇		
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff								×		●		◇			
			c) Due to insufficient and ineffective leadership levels throughout the organisation.						X				●		◇			
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level							X					◇●			
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	System Change					X	●						◇		
	Director of Finance and Procurement		f) Due to unsustainable service models						X				●		◇			
	Director of Strategy, Planning and Partnerships.		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Finance							X					◇	●	
	i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Performance Expectations & Workforce & Culture							X	◇			●					
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	Estates	X										●			
			b) Due to significant levels of backlog maintenance						X	◇			●					
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	System Change					X	●◇								
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.						X	◇			●					
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	System Change								X		●		◇		
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	Digital, Data & Technology						X						●◇		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems						X				●		◇			
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future							X			●		◇			
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	System Change & Regional Plans			X			●						◇		
			b) Due to the impact of fragile services across the regional and supra regional geography				X				●		◇					
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	Quality			X			●						◇		
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	Quality & Workforce & Culture					X	◇			●					
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030).	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected	Green Health										X	●	◇		

Key	Current Score	●
	Target Score	×
	Appetite Threshold	◇

RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 A	There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat (As a result of)	Due to an inability to recruit and retain staff across all disciplines and specialties.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	Patient	Staff	Organisation		
	<ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	<ul style="list-style-type: none"> Non-compliance with safe staffing principles and standards. Increased Workload 	<ul style="list-style-type: none"> Operational Disruptions Quality of Services Reputational Damage Financial strain – use of agency and bank staff 		
Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.					
SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.					
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible)	3 (Possible)	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 October 2025	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 January 2026				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Monitoring Framework to support roll-out of the People Plan. Workforce Dashboard to track activity – recruitment, turnover, sickness absence. Supply and demand tracker (Nursing and HCSW). People Plan tracker to support delivery of actions within the People Plan 2022-25. Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. Management of attendance through All Wales Management Attendance at Work Policy. Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. Nurse Staffing Levels (Wales) Act 201625b/25c. Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. Workforce planning supported by Compendium of new roles to support innovative workforce models. Recruitment KPI's. IMTP (Integrated Medium-Term Plan) Educational Commissioning. Workforce Establishment controls national working group has been instigated. Value and Sustainability Board. Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. Real Living Wage Employer. <ul style="list-style-type: none"> Recruitment Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. Annual programme of Apprentice recruitment. Overseas Nursing (All Wales Recruitment programme). 	<ul style="list-style-type: none"> Recruitment Approval to overrecruit to newly qualified nurses in September 2025 resulting in zero forecasted RN vacancies in rostered areas. Consideration of Lateral Move Scheme to provide flexible internal movement of staff. Approval to overrecruit to newly qualified nurses in March 2026 to maintain zero forecasted RN vacancies in rostered areas and to reduce Variable Pay. Introduction of Rotational Nurse posts in MHL D for newly qualified nurses in March 2026 to test concept. Benefits are more highly skilled workforce, engaged workforce rotating through 4 x 6-month placements in 2 years and reduction of variable pay due to hard to fill areas being included in rotations. Exploring potential of Overseas clinical attachments in other Divisions at both Junior and Senior grades (currently only Medicine) offering NHS experience to IMGs and provides a pipeline of suitable candidates to fill vacancies in future, particularly senior grades. Working closely with HEIW for earlier notification of unfilled and part-time training posts. <ul style="list-style-type: none"> Retention Development of career pathways (e.g., non-clinical to clinical). Implementation of Talent Management and succession planning workshops. NHS Wales Nurse Retention Plan quarterly updates being reviewed, submission update in September 2025. HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover being reviewed monthly. Short project completed with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis currently being undertaken to review findings. <ul style="list-style-type: none"> Variable Pay Reduction Development of action plan based on WHC to support the reduction in bank and agency usage.

- Nursing Workforce Strategy 2023 – 2026
- Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022)
- Partnerships with employability schemes and FE/HE to widen access.
- Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board.
- Working with partners to improve visibility and attraction.
- DBS Policy in place with DBS risk assessment form.
- Introduced centralised HCSW talent pools from September 2023.
- Future Nurse Academy introduced in January 2024.

Retention

- Retention lead appointed with programme action plan in place for the next two years.
- Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR.
- Week of events planned to support retention agenda in 2025. This will include a mixed method of online webinars, videos and retention materials.
- Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.
- Changes in pension regulation and flexible retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked. Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.
- Launch and support of the NHS Wales Staff Survey (October and November 2025).

Variable pay reduction

- Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board.

E- Systems

- Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all 'live' and rolled out within the Health Board.
- E-Rostering is planned to go live shortly following ESR interface testing and following increase in e-job planning compliance, provisionally scheduled for the end of July 2025.

Development of Alternative and New Roles

- Development of alternative and new roles.
- A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care.
- The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management.
- Mental Health Workforce plan development in line with new Models of Care.

Training

- The HEIW Education & Training Plan 2025/26 continues the investment in education and training in Wales that has been increasing over past years.
- The 2025/26 education training plan demonstrated increases in a number of medical training places in medical, surgical, diagnostics and mental health specialities. This is to support areas of high vacancies, population health predictions and Welsh Government Priorities. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing (adult, health visiting, practice. Training numbers in Therapies and Health Care Science programmes will remain static at previous year's numbers.
- HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.

E- Systems

- Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas.
- Roll out of medical rostering will resume in October 2025. This will help to predict junior doctor gaps and look for alternative ways to fill.
- Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision.
- E-Job Planning compliance has increased to 59.2% as of 01 September 2025.
- Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles.

Development of alternative and new roles

- Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP.
- Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards.
- Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal.
- Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology.
- Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity.
- Increasing consultant therapy and nurse practitioners.
- RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce with placements from September 2027.
- Development of new roles and career pathways to support hard to fill roles in Health Visiting.
- Re-design of the Health Board's work experience programme with 246 applicants since March 2024 and 75 placements confirmed
- Development of Medical & Dental Recruitment & Retention Strategy 2025 – 2030.
- Looking to further widen access by partnering with DWP to offer 12-week unpaid placements to the unemployed with a view to offering training, support and guaranteed interviews – further promoting ABUHB as an employer of choice at entry level roles. This programme attracts £1000* per candidate and there is a maximum of 50 candidates we can support per year (*as at July 2025).
- Regional planning supporting a number of strategic workforce plans (Orthopaedics, Endoscopy, Women's Health Units, Vascular).

Workforce Supply and Demand Modelling

- 10-year draft predictions undertaken for future workforce requirements based on previous trends and training pipelines.
- HEIW leading several workforce initiatives to improve supply and demand modelling.

Training

- HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy.
- Workforce planning training prospectus of local and online training launched May 2025 and HEIW Workforce Planning Hub launched June 2025.
- Development opportunity being scoped for Business support staff.
- Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR.
- Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire.
- Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies.
- A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.
- 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.
- Launch of Admin Together staff network (now at 100 members) supporting administrative staff to connect, develop and address organisational challenges. Continued support of all staff networks.

<ul style="list-style-type: none"> Ongoing investment in the Primary and Community Care Academy Network will be a key enabler to delivering innovation and transformation through the Strategic Workforce Plan for Primary Care and the Strategic Programme for Primary Care. Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active. K102 bridging model now being offered to support HCSW pathways into registered nursing. Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year. Delivery of workforce planning training. <p>Vacancy Numbers and establishment control</p> <ul style="list-style-type: none"> Quarterly reporting of vacancy numbers to WG as of 30 June 2025 was 442 WTE, a significant decrease of 220 WTE since March 2025. Development of ESR establishment control model commenced. Local delivery action plan has been agreed by the Executive Committee with expected 90% roll out completed by 31 October 2025. <p>Staff attendance</p> <ul style="list-style-type: none"> Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. “Hot spot” areas identified and plans in place to support. 	
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Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
<ul style="list-style-type: none"> Workforce reports to the Nurse Strategic Workforce Group. Monthly sickness monitoring reports. Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. Medical Staffing Co-ordinator review of medical rotas. Cross site operational calls. 	<ul style="list-style-type: none"> Occupational Health and Wellbeing dashboards report KPIs. Recruitment KPIs Medical & Dental and Student Streamlining fill rate reports 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
<ul style="list-style-type: none"> Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. Measurements of Wellbeing through the ABUHB 	<ul style="list-style-type: none"> (Aneurin Bevan University Health Board) Staff Survey Routine Reporting against nurse staffing levels. Variable Pay Programme Board reporting to Value and Sustainability Board 	<ul style="list-style-type: none"> Governance processes risk management input (register, risk assessment)
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
<ul style="list-style-type: none"> Internal Audit Reviews 2023 -24 Long Term Sickness Absence Management (Q4) Flexible Working (Q4) External quarterly vacancy reporting to WG National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative. 	<ul style="list-style-type: none"> External reporting on Nursing Staffing Levels National Acuity Audits (Nursing) Workforce planning external audit action plan 2024 and Structured Assessment Response August 2025 Resident Doctor Contract Reform 	<ul style="list-style-type: none"> Latest local survey saw a reduction in staff wellbeing Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> <u>Guidance</u>		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
POSITIVE		

RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 B	There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat (As a result of)	Due to a deterioration in, and a failure to improve, the well-being of staff.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff <ul style="list-style-type: none"> High absence levels, with some sustained long periods Non-compliance with safe staffing principles and standards 	Organisation <ul style="list-style-type: none"> Reputational damage to the health board as an employer Work-related claims Financial Implications 	Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 October 2025	Risk rating	= 12 (High)	= 9 (High)	
Next Review (Quarterly based on risk score)	01 January 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
General <ul style="list-style-type: none"> Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority Strategic Equality Plan Rest and Facilities Charter – monitoring and compliance Staff related policies National Staff Survey and Health Board Employee Experience Survey External Employee Assistance Programme Speaking up Safely Action Plan Race/LGBT groups Wellbeing resources Staff diversity networks Regular Schwartz rounds arranged across the Health Board Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own Close links with the Arts in Health programme Chaplaincy service for staff Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. 	General <ul style="list-style-type: none"> Increase wellbeing initiatives, including long term strategic programmes within large departments (e.g., Maternity) Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders) Take a data-based approach to improve our approach to Respect and Resolution processes, and supporting resources Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues Trained mediators so there is team and organisational resilience and network Enhanced our financial well-being offer Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has consistently resulted in a 60-70% reduction in investigations and a wide range of other organisational benefits over 3 years. The next phase of this programme will involve transferring the benefits to Respect and Resolution processes. Implement, develop and embed the Speaking up Safely process in line with the Welsh Government Framework We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB 'Safe atmospheres' training has been piloted to support the ongoing psychological safely focused work taking place in theatres and linked to 'never events' and team debriefing Working with trade union and national partners to improve attendance at work and prevent absence through a variety of initiatives including Wellbeing Passport, alternative roles and health promotion. Occupational Health. <ul style="list-style-type: none"> Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. Current Demand and Capacity review completed. Regional occupational health partnership working being explored with Cardiff and Vale and also Cwm Taff, Phase 1 collaborative physician procurement process underway.

<ul style="list-style-type: none"> The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB An externally commissioned SUS hotline An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative <p>Occupational Health</p> <ul style="list-style-type: none"> Additional occupational health resources secured to reduce waiting times Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19 Support equality and diversity of workforce A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024 Band 5 EDI Officer appointed and commenced in post at the end of March 2024 Inclusive Leadership sessions embedded in the Leading People Programme Reverse Mentorship Programme launched February 2024 <p>Other</p> <ul style="list-style-type: none"> Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC Reducing fatigue poster developed 	<ul style="list-style-type: none"> Submission of response to All Wales KPI delivery and ongoing data analysis review in place Support equality and diversity of workforce Review of staff diversity networks Review of National Staff survey to understand variations within diverse workforce demographic profile Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing <p>Staff Survey Action Plan</p> <ul style="list-style-type: none"> Findings from the staff survey 2024/25 indicate improvements with culture and diversity An ABUHB action plan is in development to address staff engagement, work related stress and to improve retention of staff Planning for 2025 staff survey underway to improve compliance and value of outcomes
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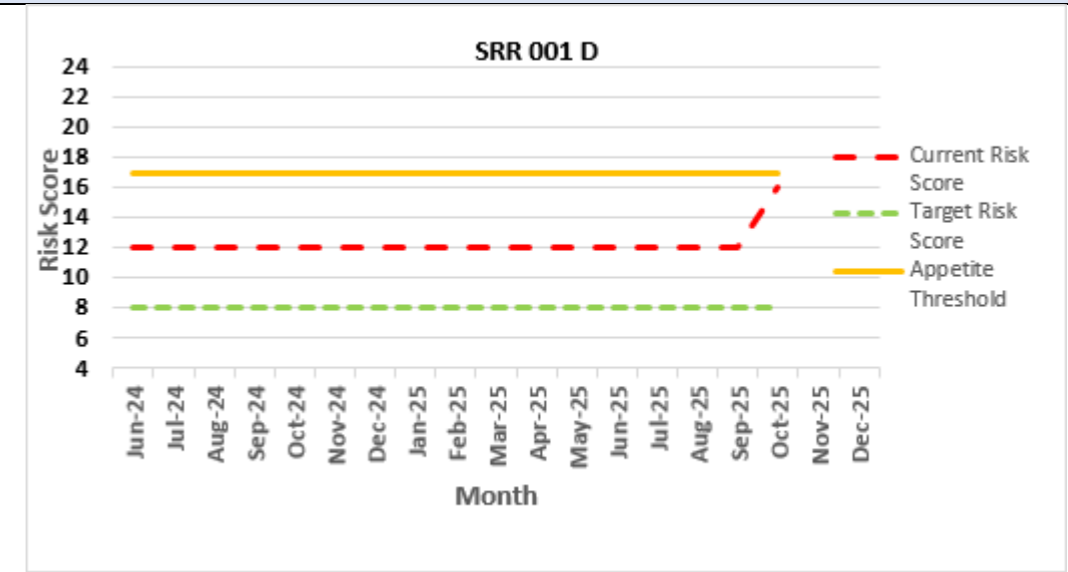
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
<ul style="list-style-type: none"> Dashboard reporting Reporting to monitor the rollout of the People Plan 22-25 Reporting to monitor of demand on wellbeing services 	<ul style="list-style-type: none"> Understand if support is reaching all staff 	<ul style="list-style-type: none"> Meetings with Divisions ongoing to ensure all areas are aware of what's available.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
<ul style="list-style-type: none"> People and Culture Committee reports (People Plan 22-25) Local wellbeing surveys LNC – reporting of compliance of BMA Rest and Facilities 		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
<ul style="list-style-type: none"> National workforce surveys Monitoring and compliance of BMA Rest and Facilities via NHS Employers Staff Welfare Charter Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance 	<ul style="list-style-type: none"> Latest local survey saw a reduction in staff wellbeing 	<ul style="list-style-type: none"> Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
POSITIVE		

RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 C	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat (As a result of)	Due to insufficient and ineffective leadership levels throughout the organisation			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings; 	<p>Staff</p> <ul style="list-style-type: none"> Adverse impacts on staff recruitment and retention 	<p>Organisation</p> <ul style="list-style-type: none"> Failure to deliver health board priorities, required improvements and achieve sustainability; Poor levels of accountability and delivery; Reputational damage to the health board as an employer; 	<p>Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.</p> <p>SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.</p>	
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible)	3 (Possible)	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 October 2025	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 January 2026				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Talent and Succession Planning framework published Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. Monitoring Frameworks with HEIW Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. HEIW schemes 1 x HEIW funded graduate management trainee successfully appointed August 2025 following additional recruitment process. Develop Leadership Capabilities Leadership journey and programmes mapped, and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and managers, clinical directors, directorate managers (DMx), senior nurses and multi-disciplinary teams. Considering very senior leader programme. Learning masterclasses have been designed and developed for the organisation addressing key themes such as giving feedback, developing team and having courageous conversations. Leading People Programme (started cohort 9 May 2025), CDx cohort 5 starting November 2025. 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda. 	<p>Talent and Succession Planning</p> <ul style="list-style-type: none"> Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development workshops being rolled across the Health Board, open for all leaders to attend. Designated Talent and Management succession planning resources available on ABUHB intranet. <p>Development leadership capabilities</p> <ul style="list-style-type: none"> Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. Continued commitment to NHS graduate schemes. Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. Working with HEIW to inform a national development programme for managers Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England). Review of current leadership journey and training with planning starting to develop a very senior leadership development programme in 2025/26 Specific leadership and culture work starting in MHLD division with methods being developed to scale across the Health Board in 2026.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> WOD Divisional reporting Evaluation of internal leadership programmes and regular review of our internal offer 			
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028. 			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> Internal Audit Review Talent and Succession Board 			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	POSITIVE

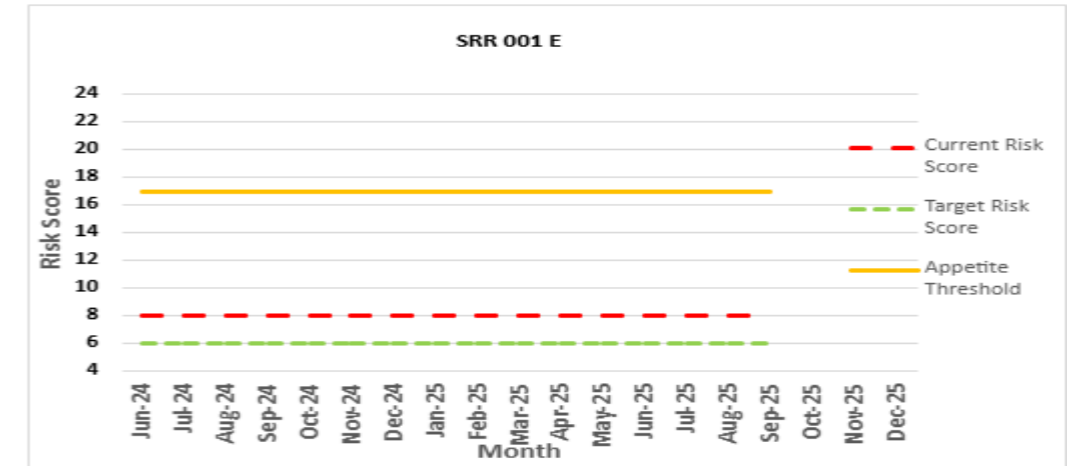
RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 D	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat (As a result of)	Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings 	<p>Staff</p> <ul style="list-style-type: none"> Non-compliance with safe staffing principles and standards 	<p>Organisation</p> <ul style="list-style-type: none"> Litigation & Financial Penalties Reputational damage to the health board and loss of public confidence 	Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					<p>SUMMARY</p> <p>The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.</p>
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	People & Culture Committee	Likelihood	4 (Likely)	2 (unlikely)	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 October 2025	Risk rating	= 16 (Extreme)	= 8 (Moderate)	
Next Review (Monthly based on risk score)	01 November 2025				



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> All Wales Industrial Action Planning Group. Local Health Board planning arrangements. Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and CODE OF PRACTICE Industrial Action Ballots and Notice to Employers. Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. Effective derogation processes including Christmas Day cover definition. Local Negotiating Committee (LNC). Services Business continuity plans in place. Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. Command and control structure and leads established. Derogation test completed. Executive and Senior Manager leads established links with national planning cells. All Wales training sessions provide by legal and risk to support industrial action. Reducing impact on patients - Support for early supported discharge prior to industrial action. Picketing guidance supported and agreed. Workforce Peer Networks – WOD's and DEWOD's. 	<ul style="list-style-type: none"> Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. Issue of WHC AFC non pay elements of collective agreement 2022-24. Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). Communication plans- public, stakeholders and partners. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. Consideration of further additional national legal advice. Early notification of consultative ballot outcomes via NHS Employers/WG. Local negotiation and response to grievances related to band 2/band 3 job descriptions for HCSWs. Programme structure in place for band 2/band 3 assessment subject to national approval. Awareness of national TU ballot responses regarding pay dispute – early notification ahead of any strike action ballots for planning purposes. Resident Doctor contract reform planning structure in place in conjunction with Medical Director.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Local Staff re-deployments assessment Divisional engagement and service planning arrangements in place Local Negotiating Committee (LNC) Trade Union Partnership meetings Established processes and tools used for previous industrial action. 		Further industrial action	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Reporting to Executive team Business Continuity groups Command and control structure in place to be implemented as required 			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> All Wales IA group and Welsh Government planning group. Debriefing session planned to reflect and capture learning for any potential future action Resident Doctor Contract Reform Band 2/3 Implementation Framework – DRAFT, subject to Cabinet Secretary review/approval 			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

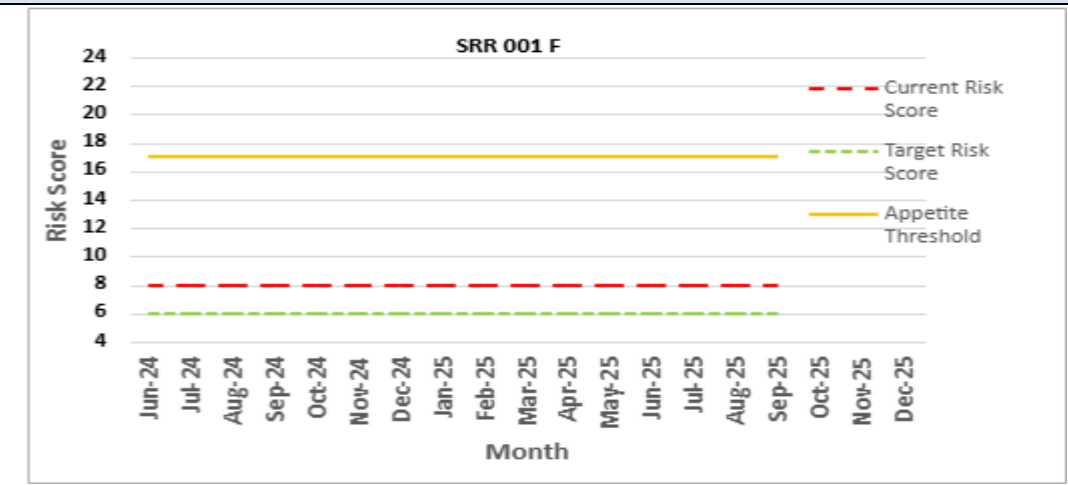
RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic/ Corporate Risk SRR 001 E	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Threat (As a result of)	Due to inadequate strategic plans which respond to population health and socio-economic needs.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Increased patient acuity levels Worsening of health inequalities Worsening of health outcomes 	Staff	Organisation <ul style="list-style-type: none"> Failure to train teams in multi-morbidity management Failure to comply with the Wellbeing of Future Generations Act (Wales) Reputational damage and loss of public confidence Increased demand 	Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six monthly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included))
<ul style="list-style-type: none"> Health Board IMTP and associated KPIs Public Health Wales surveillance data QlikSense – performance dashboard Population Needs Assessment and Area Plan Marmot Region Programme 	<ul style="list-style-type: none"> Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> • QlikSense – performance information • SFN – performance information 		<ul style="list-style-type: none"> • Effectiveness of the plans in delivering improvements 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee 	<ul style="list-style-type: none"> • Regional Planning reporting to Population Health, Planning and Partnerships Committee 		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit Reviews 2023-24</p> <ul style="list-style-type: none"> • IMTP Planning (Q1) Outcome – Reasonable Assurance <p>Internal Audit Reviews 2024-25</p> <ul style="list-style-type: none"> • Internal Audit Partnership Arrangements – Limited Assurance 		<ul style="list-style-type: none"> • Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk SRR 001 F	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Threat (As a result of)	Due to unsustainable Service Models			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Increased demand Increased patient acuity levels Worsening of health inequalities Worsening of health outcomes 	Staff N/A	Organisation <ul style="list-style-type: none"> Failure to train teams in multi-morbidity management Failure to comply with the Wellbeing of Future Generations Act (Wales) Reputational damage and loss of public confidence 	Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six monthly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> The Health Board's Integrated Medium-Term Plan (IMPT) and associated KPIs Strategic Programmes in place Public Health Wales surveillance data – Covid, flu and other communicable diseases. QlikSense – performance information. Population needs assessment and area plan development by the RPB. Southeast Wales Plan for fragile services. 	<ul style="list-style-type: none"> Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Public Health Wales surveillance data – COVID, flu and other communicable diseases. QlikSense – performance information 		<ul style="list-style-type: none"> Evidence of individual arrangements in place to deliver service plans. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> IMTP delivery and outcomes reporting to Board. RPB reporting to Board and Population Health, Planning and Partnerships Committee. Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. 	<ul style="list-style-type: none"> Regional Planning reporting to Population Health, Planning and Partnerships Committee. Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. 		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit Reviews 2023-24</p> <ul style="list-style-type: none"> IMTP planning Q1. Outcome – Reasonable Assurance. <p>Internal Audit Reviews 2024-25</p> <ul style="list-style-type: none"> IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance Partnership Arrangements. Outcome – Limited Assurance 	<ul style="list-style-type: none"> Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan 	<ul style="list-style-type: none"> Implementation of the management responses to close off recommendations 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	FINANCIAL SUSTAINABILITY																																																																																				
LINK TO IMTP	SECTION 4: ENABLER - FINANCE																																																																																				
Strategic - SRR 001 G	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public																																																																																
Threat <i>(As a result of)</i>	Due to the failure to deliver a sustainable financial position and longer-term financial plan.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.																																																																																	
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;">Organisation</p> <ul style="list-style-type: none"> Breach of statutory duty to breakeven over 3 years. Instigation of NHS Wales Escalation & Intervention Arrangements. Non-delivery of Health Board priorities, required improvements, and achieving longer-term sustainability. Prioritisation and possible disinvestment in service delivery. Reputational damage and loss of public confidence. 			Risk Appetite Threshold – Score 17 and Below Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.																																																																																	
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Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	<table border="1"> <caption>SRR 001G Risk Score Data</caption> <thead> <tr> <th>Month</th> <th>Current Risk Score</th> <th>Target Risk Score</th> <th>Appetite Threshold</th> </tr> </thead> <tbody> <tr><td>Jun-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Jul-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Aug-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Sep-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Oct-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Nov-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Dec-24</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Jan-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Feb-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Mar-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Apr-25</td><td>16</td><td>8</td><td>17</td></tr> <tr><td>May-25</td><td>16</td><td>8</td><td>17</td></tr> <tr><td>Jun-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Jul-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Aug-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Sep-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Oct-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Nov-25</td><td>20</td><td>8</td><td>17</td></tr> <tr><td>Dec-25</td><td>20</td><td>8</td><td>17</td></tr> </tbody> </table>	Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-24	20	8	17	Jul-24	20	8	17	Aug-24	20	8	17	Sep-24	20	8	17	Oct-24	20	8	17	Nov-24	20	8	17	Dec-24	20	8	17	Jan-25	20	8	17	Feb-25	20	8	17	Mar-25	20	8	17	Apr-25	16	8	17	May-25	16	8	17	Jun-25	20	8	17	Jul-25	20	8	17	Aug-25	20	8	17	Sep-25	20	8	17	Oct-25	20	8	17	Nov-25	20	8	17	Dec-25	20	8	17
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<ul style="list-style-type: none"> • IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance. • Budget holder financial recovery deep dive meetings, • Enhanced forecasting and planning processes 	<ul style="list-style-type: none"> • Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.
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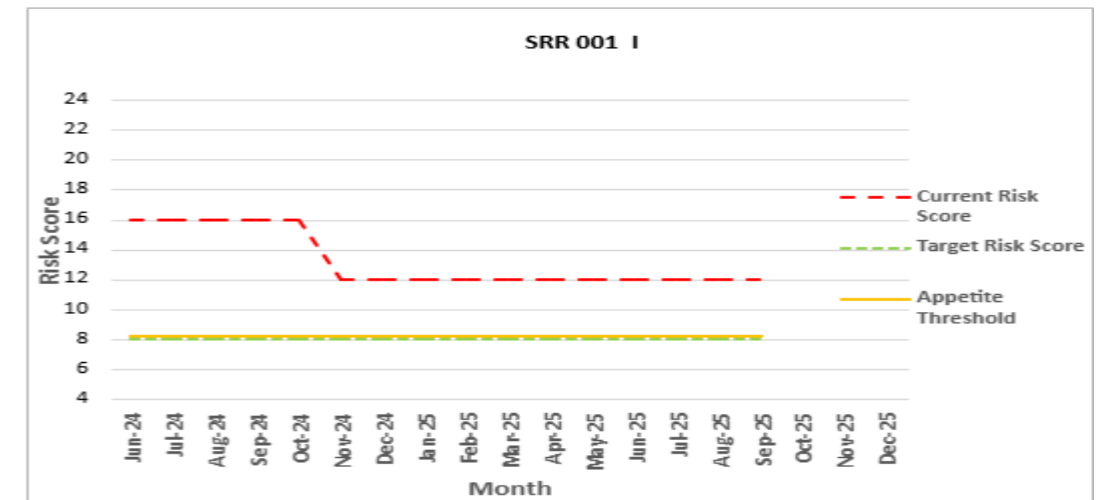
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
<ul style="list-style-type: none"> • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance 	None	<ul style="list-style-type: none"> • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
<ul style="list-style-type: none"> • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee 	<ul style="list-style-type: none"> • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. 	None
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
<ul style="list-style-type: none"> • 2025/26 – 27/28 IMTP plans focussed on ‘living within’ budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years. 		

<p>Internal Audit</p> <ul style="list-style-type: none"> Annual Report 2024/25 Financial Sustainability – Reasonable Assurance Sept 2025 2025/26 - Audit Reviews <p>External Audit Reports</p> <ul style="list-style-type: none"> 2024 -25 – Annual Report 2025/26 - Audit Reviews 	<p>Welsh Government</p> <ul style="list-style-type: none"> Financial assessment and review reports to Welsh Government – monthly Enhanced monitoring T.I. meetings with Welsh Government monthly IMTP plan to WG end of March 2025 	<ul style="list-style-type: none"> Recommendations from audits 	<ul style="list-style-type: none"> Implement management actions to complete the recommendations from audit reports
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Assurance Rating (Overall Assessment of controls and assurances) [Guidance](#)

Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE
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RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS		SECTION 4: ENABLERS – WORKFORCE & CULTURE	
Strategic Risk SRR 001 I	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.			Publication Status Public
Threat (As a result of)	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unintended Patient Harm. Negative Public/Patient Experience. 	Staff <ul style="list-style-type: none"> Reduced Staff Morale leading to potential absence from work. 	Organisation <ul style="list-style-type: none"> Loss of patient/public trust and confidence. Scrutiny from external organisations. Adverse publicity. Punitive Actions. Financial implications. 	Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. SUMMARY The current risk level is OUTSIDE of target and the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Finance and Performance Committee.	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	19 April 2024.	Impact	4 (Major)	4 (Major)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 8 (Moderate)
Next Review (Quarterly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Performance Management and Assurance Framework Executive Accountability letters Divisional Directors Accountability letters Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off Reporting through to Finance and Performance Committee via Executives Specific areas of focus are discussed at Value and Sustainability Board System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. External scrutiny via Welsh Government and NHS Executive Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support 	<ul style="list-style-type: none"> 6-month review of Performance Management and Assurance Alignment of internal mechanisms to national escalation Focused agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. Standardised Divisional Assurance Templates (pre-populated) Commission external reviews to support improvements where required. Appropriate Business Partnering Support and analytical support Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> DMTs in place for all Divisions Divisional oversight arrangements – monthly/fortnightly meetings Divisional plans in place and focussed agendas Cross Divisional meeting monthly – progress the wider system way of working. 	<ul style="list-style-type: none"> System Leadership Team for awareness and updates 12-month Performance Management Framework review in the Autumn 	<ul style="list-style-type: none"> Outcome if the review will determine if further action is required 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Established reporting to the Executive Committee Established reporting to the Finance and Performance and Patient, Quality and Safety Committee Established reporting to the Board Routine reporting through the IQPD process 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> Internal Audit 2024/25 Plan Directorate Review - Mental Health and Learning Disabilities (Q2) Divisional Governance Arrangements (Q2) HIW Inspections Llais for feedback 	<ul style="list-style-type: none"> Internal Audit 2024/25 Plan Findings and recommendations from the Divisional Governance Arrangements (Q2) Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2) 	<ul style="list-style-type: none"> Implementation of the management responses set out in the final Internal Audit Reports 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES				
Strategic Risk SRR 002 A	There is a risk that there will be significant failure of the Health Boards Estates.			Publication Status	Public
Threat (As a result of)	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			Risk Appetite Level – MINIMUM Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Harm or injury to patients Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff <ul style="list-style-type: none"> Harm or injury to staff 	Organisation <ul style="list-style-type: none"> Litigation & Financial Penalties Loss of estate 	Risk Appetite Threshold – Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	Likelihood	3 (Possible) x	1 (Rare) x	
Initial Date of Assessment	01 June 2023	Impact	5 (Catastrophic)	2 (Minor)	
Last Reviewed	01 October 2025	Risk rating	= 15 (Extreme)	= 2 (Low)	
Next Review (Monthly based on risk score)	01 November 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (currently ongoing for June and July with report expected in August 2025) Actions from previous reports including specific actions relating to 'skylights' in progress albeit some will require more substantial work -which is being scoped. Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance Remediation work to areas of high-risk areas undertaken Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. Ongoing engagement with expert surveyor Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props have been reviewed by H&S team and feedback provided to departments Links with NHS England and other Health Boards in Wales for shared learning. Regular dialogue with Welsh Government and Shared Services Estates. Management Action Plan agreed following Internal Audit including the development of a Management Strategy and submitted to the ABUHB Health and Safety 'Committee' in March 2025 	<ul style="list-style-type: none"> Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues Management Strategy and the Management Plan are completed and was approved at the Health & Safety Committee in April

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Monthly checks in place for the props albeit fortnightly checks in new prop locations in OPD 2 department Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) Review of existing arrangements in place supported by external body 	<ul style="list-style-type: none"> Ongoing management of the issues. 	N/A	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. Outcome of H&S risk assessment in place and reviewed May 2025. H&S team will review (subject to risk score) every 3 months. Formal reporting to the Board/Committees in place Formal update to the PPHPC in July and SOC being developed, led by Planning team 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board. 	<ul style="list-style-type: none"> Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan 	<ul style="list-style-type: none"> Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implemented <p>Internal Audit 2024/25 Plan</p> <ul style="list-style-type: none"> Implementation of the management responses to close off recommendations been concluded. 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES				
Strategic Risk SRR 002 B	There is a risk that there will be significant failure of the Health Boards Estates.			Publication Status	Public
Threat (As a result of)	Due to significant levels of backlog maintenance and structural impairment.			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Harm or injury to patients. Adverse impacts on the delivery of care to patients across acute and non-acute settings. 	Staff <ul style="list-style-type: none"> Harm or injury to staff. 	Organisation <ul style="list-style-type: none"> Non-compliance with health and safety legislation. Litigation and financial penalties. Loss of estate 	Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 August 2025	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 November 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included))
<ul style="list-style-type: none"> Health Board Estates Rationalisation Strategy Health Board Estates Strategy Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. Divisional Risk Register Multiple policies and SOPs published and communicated to staff. A robust internal training programme in place covering all aspects of estate management including food hygiene. Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) Asbestos reinspection programme (over the next 3 years) Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants A clear approach to compliance monitoring and escalation of AE reports has been implemented 	<ul style="list-style-type: none"> Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. Drive clinical service engagement in compliance meetings where engagement is low. Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2025/26 Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All Wales Targeted Estates Fund (TEF) Elements of St Woolos Hospital estate being closed as part of the Board agreement to rationalise the site and remove use of old and poor estate.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Divisional reporting of Statutory and Mandatory training of staff Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. 	<ul style="list-style-type: none"> If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration. 	<ul style="list-style-type: none"> Performance reporting 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit Reviews 2023- 24</p> <ul style="list-style-type: none"> Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee <p>Internal Audit Plan 2024-25</p> <ul style="list-style-type: none"> Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARA 	<ul style="list-style-type: none"> Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level 	<ul style="list-style-type: none"> Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan 	<p>Internal Audit 2024/25 Plan</p> <ul style="list-style-type: none"> Implementation of the management responses to close off recommendations
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

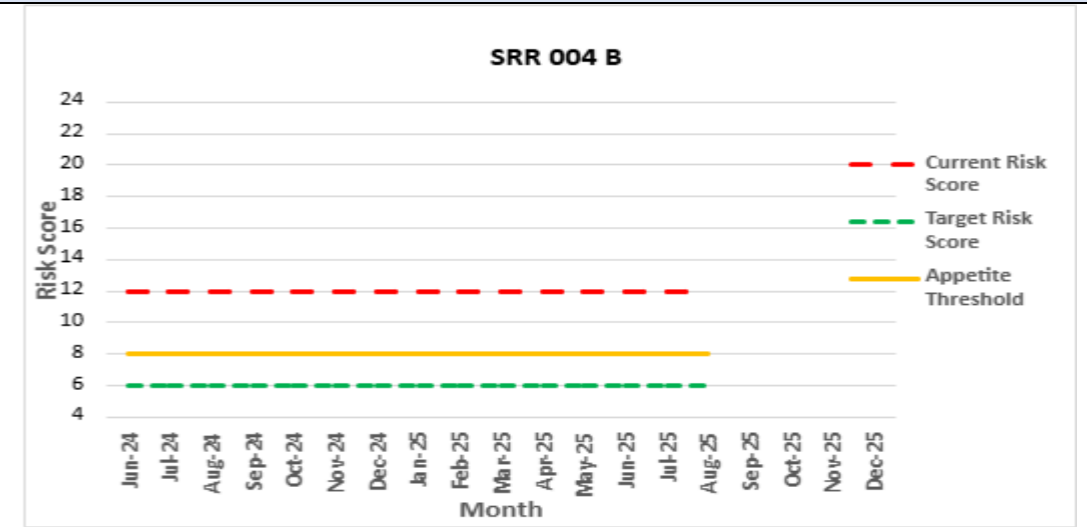
RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk SRR 004 A	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident			Publication Status Public
Threat (As a result of)	Due to emergency planning arrangements at both the corporate and operational levels lacking the necessary robustness to ensure an effective response.			
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Adverse impacts on delivery of care to patients across acute and non-acute settings Harm or injury to patients 	Staff <ul style="list-style-type: none"> Inability to respond to a major incident to meet needs of those affected Harm or injury to staff 	Organisation <ul style="list-style-type: none"> Health Board breaches statutory duties under the Civil Contingencies Act 2004 Litigation & Financial Penalties Reputational damage and loss of public confidence 	Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 May 2025	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six-monthly based on risk score)	01 November 2025			

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Local/Divisional action cards are in place in key areas Training undertaken service-specific relating to local response. Major incident exercise 'Euclid' undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning Internal strategic on call training Executive Team attending 2-day strategic training. Loggist training is provided and accessed regularly New all Wales logbooks are in place for use Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) Joint Planning and Training with LRF and across Wales. Ongoing Participation in exercises UK, Wales, LRF and HB. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner 	<ul style="list-style-type: none"> Continue to deliver training programmes to support staff preparedness to respond to an incident. Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. BCPs in place across all services. Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP's across key operational areas. National pandemic exercise Pegasus Autumn 2025 Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

<ul style="list-style-type: none"> • LRF Pandemic Solaris undertaken 	
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Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> • Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls. 	<ul style="list-style-type: none"> • All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs. 	<ul style="list-style-type: none"> • Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness 	<ul style="list-style-type: none"> • EPRR Thematic Risk Register 	<ul style="list-style-type: none"> • Develop an EPRR 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Review(s) <ul style="list-style-type: none"> • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - Reasonable Assurance • Outcome and feedback from national exercises 	<ul style="list-style-type: none"> • Identification of recommendations to ensure the Health Board is prepared and has the capabilities to respond effectively. 	<ul style="list-style-type: none"> • Implementation of the recommendations and subsequent management responses. 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk SRR 004 B	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to Business Continuity incidents.			Publication Status Public
Threat (As a result of)	<ul style="list-style-type: none"> Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident 			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Harm or injury to patients Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff <ul style="list-style-type: none"> Staff absence (injury, wellbeing) Harm or injury to staff 	Organisation <ul style="list-style-type: none"> Operational flow if services fail to prepare BCPs against the 5 key themes Loss of infrastructure; Financial implications due to staff absence Health Board breaches statutory duties under the Civil Contingencies Act 2004; Litigation & Financial Penalties; Reputational damage and loss of public confidence 	Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Likely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 August 2025	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 November 2025			

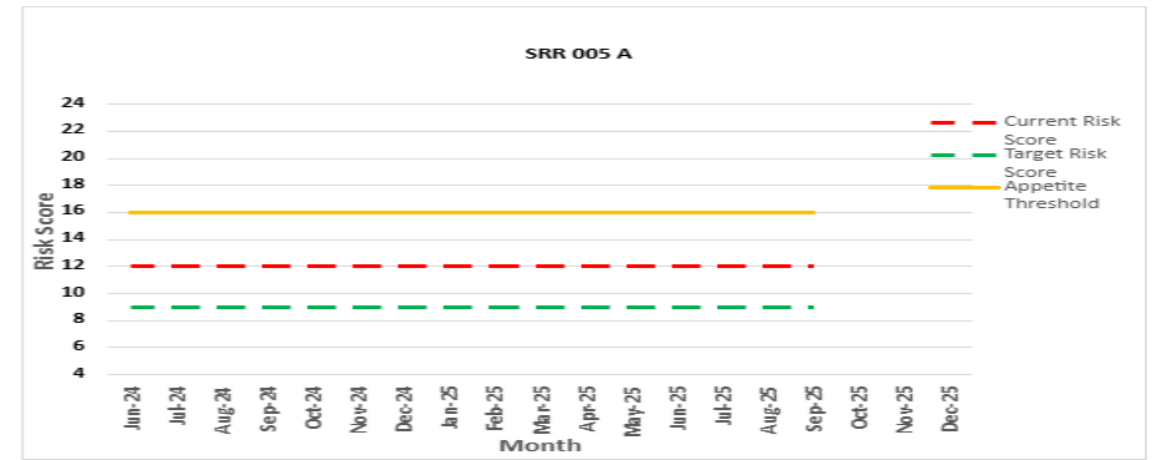


Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> BC Policy BC Response Guidance BC Template & guidance (reviewed and updated April 2025) Divisional, Directorate & Service BC Plans across a number of key operational areas BC Exercise BC debrief learning. HB and LRF Plans. 3C (Command/Control, Communication) structure in place to respond to incidents. 1-2-1 training with Divisional BC leads and delivering BC workshops for services. EPRR Group Established. Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. Awareness raising of the requirement for BC across the Health Board through various training programmes Infectious Diseases plan Joint plan with PH in response to infectious diseases and public health incidence response overall Internal strategic on call training Executive Team attending 2-day strategic training. Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) Joint Planning and Training with LRF and across Wales. Ongoing Participation in exercises UK, Wales, LRF and HB. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update 	<ul style="list-style-type: none"> Ongoing support to develop business continuity plans. Continued engagement with Divisions, Directorates, and service areas to embed contingency planning into the culture of the organisation, Conduct BIAs, develop plans, train staff, test & exercise, and review plans to mitigate the risks and threats to service delivery. Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. Continue to engage with the communication team to improve incident cascade during an event to ensure a Health Board wide awareness in a timely manner. Each Division to identify on their risk register any outstanding business continuity plans against the 5 key themes for their areas and escalate any identified risks to the HB risk group for review. Development of a business continuity dashboard that enables divisions & directorates to manage, RAG rate and provide assurance of their BC planning arrangements. Joint working with partners – Exercise Pegasus Pull together a task and finish group to review and plan for the BC recommendations from the Ex Mighty Oak exercise debrief. Develop an off the shelf BC exercise for divisions, directorates & services. Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP's across key operational areas.

<p>knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).</p> <ul style="list-style-type: none"> • Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team. • Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans are in place. • A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk. • The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical. • Joint working with LRF partners – Exercise Solaris 	
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Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> • Plans and action cards in place and up to date. • Div/Service BC risk registers • Service BC training records • Departmental debrief following an incident to inform learning and enhance controls. • Debrief with key stakeholders following an incident to inform learning and enhance controls. 	<ul style="list-style-type: none"> • All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs. 	<ul style="list-style-type: none"> • Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness • 	<ul style="list-style-type: none"> • EPRR Thematic Risk Register 	<ul style="list-style-type: none"> • Develop an EPRR 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance</p> <ul style="list-style-type: none"> • Outcome and feedback from national exercise 	<ul style="list-style-type: none"> • Identification of recommendations to ensure the Health Board is prepared and has the capabilities to respond effectively. 	<ul style="list-style-type: none"> • Implementation of the recommendations and subsequent management responses. 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

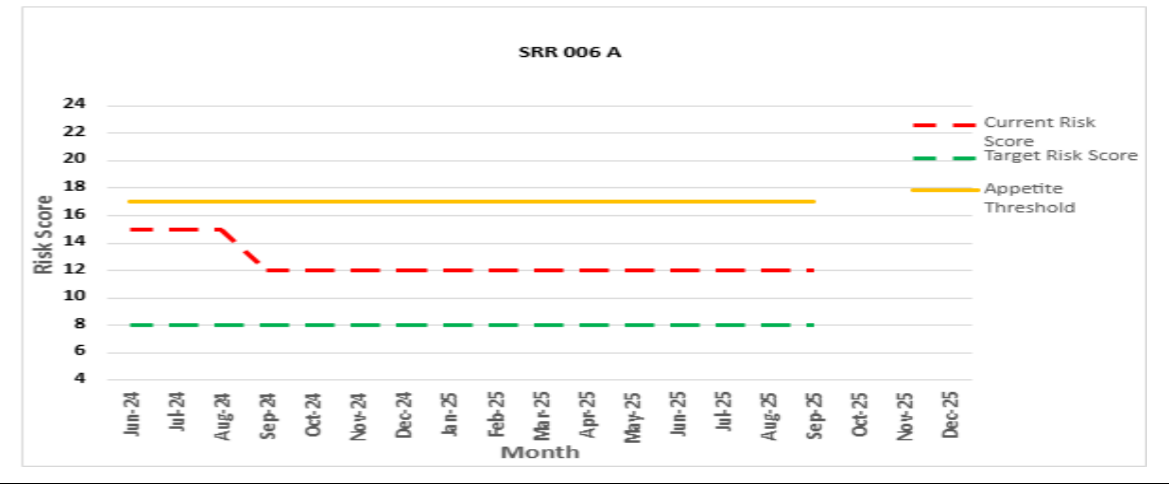
RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk SRR 005 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system			Publication Status Public
Threat (As a result of)	Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Avoidable deaths and significant harm. Delayed discharges from acute and non-acute settings resulting in deteriorating patients. Delays in releasing ambulances from hospital sites back into the community. 	Staff <ul style="list-style-type: none"> Increased workload Fatigue & burnout 	Organisation <ul style="list-style-type: none"> Litigation & Financial Penalties Reputational damage and loss of public confidence 	Risk Appetite Threshold – OPEN SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 September 2025	Risk rating	= 12 (High)	= 9 (High)
Next Review (Quarterly based on risk score)	01 December 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range?) (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Escalation Policy. Performance and Accountability Framework Operational Framework Major incident Procedures Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. Enhanced monitoring in place for U&EC Range of performance measures/metrics in place Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description and guide for where extra capacity can be accessed to ensure patient flow is maintained. Planned care recovery meetings with the NHS execs. Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. WG – IQPD meetings to review areas of focus 	<ul style="list-style-type: none"> New developments and pathways coming online into FY25/26 New expanded transfer lounge o New ED extension and reconfiguration Additional ED consultants coming onboard Safety Flow agenda delivering wider developments and improvements

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. Performance report against measures/metrics 	<ul style="list-style-type: none"> Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. The impact of the Performance and Accountability framework in improving patient flow 	<ul style="list-style-type: none"> Close monitoring and reporting of the frameworks in practice to support learning and improvements. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Divisional Assurance reviews. Performance against measures/metrics reported to the Executive Committee 	<ul style="list-style-type: none"> Effectiveness of the Operational Framework 	<ul style="list-style-type: none"> The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services. 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit Reviews</p> <ul style="list-style-type: none"> Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. External inspections/visits. - 	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 A	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status Public
Threat <i>(As a result of)</i>	Due to the full or partial failure of existing digital infrastructure and systems.			Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact <i>(Consequences of the threat)</i>	<p>Patient</p> <ul style="list-style-type: none"> Unintended harm or Injury to Patients. 	<p>Staff</p> <ul style="list-style-type: none"> Unintended harm or injury to staff 	<p>Organisation</p> <ul style="list-style-type: none"> Data Breaches Litigation and Financial Penalties. Reputational damage and loss of public confidence. 	<p>Risk Appetite Threshold – Score 17 and Below</p> <p>Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.</p> <p>SUMMARY</p> <p>The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.</p>
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 8 (Moderate)
Next Review <i>(Quarterly based on risk score)</i>	01 October 2025			

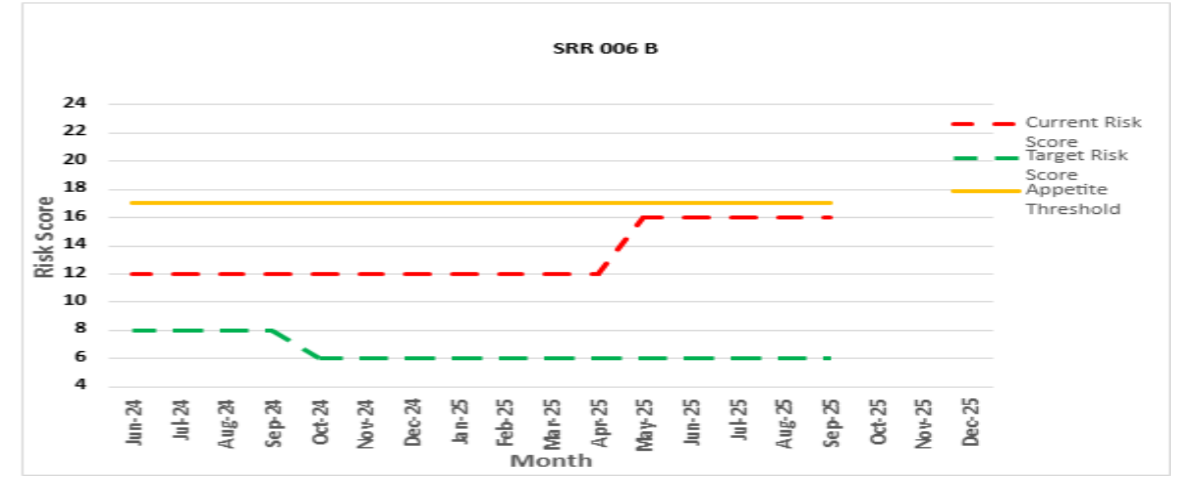


<p align="center">Current Key Controls</p> <p><i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i></p>	<p align="center">Plans to Improve Control</p> <p>What further controls are required to reduce the risk exposure to within a tolerable range? <i>(Short, Medium, and Long-Term Plans need to be included)</i></p>
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<ul style="list-style-type: none"> Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. Governance group terms of reference agreed. Meetings started in November 2023. Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. ·Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023. 	<ul style="list-style-type: none"> Cyber Resilience Audit (CRU) undertaken in June 2025 showed an overall improvement is assessment. Some key recommendations have been identified which will be progressed and monitored via regular meetings with CRU and reported to Information Governance Group. Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. Updated audit from Cyber Resilience Unit to be undertake in Q2 2025. Internal Audit review on Shadow IT scheduled for 2025/2026. Improvements in mandatory training compliance for Information Governance and Cyber Security. Health Board involvement in national cyber response exercise in September 2025.
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Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. Single directorate risk registers now in place. 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> N/A 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. Annual Senior Information Risk Owner report. 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> N/A 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 Oversight from NHS Wales Cyber Resilience Unit. 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> N/A 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

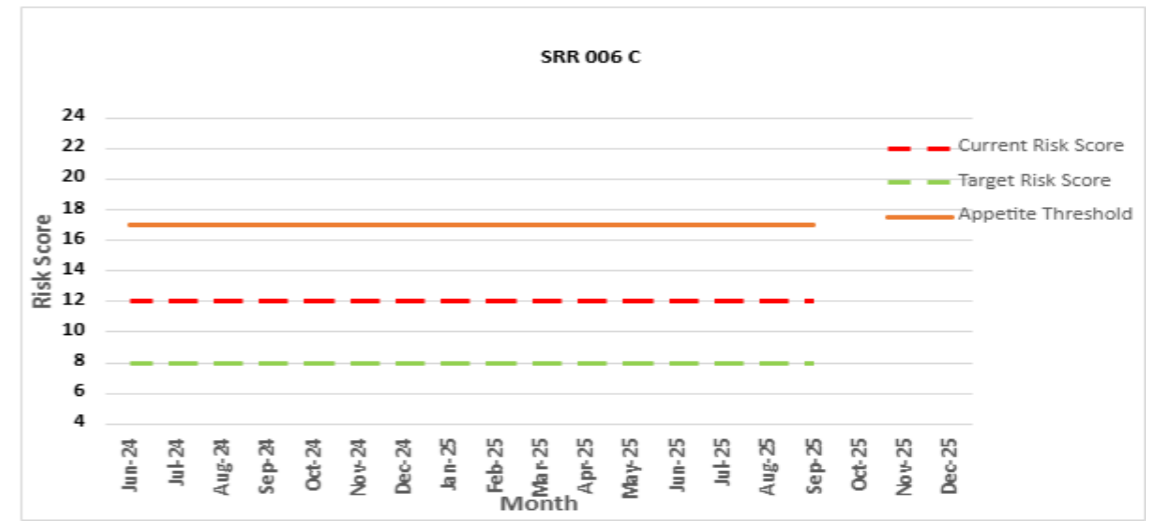
RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 B	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status	Public
Threat (As a result of)	Due to an adverse impact on service delivery in the implementation of new digital systems.			Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unintended harm or Injury to Patients. Adverse impacts on delivery of care to patients across acute and non-acute settings. 	Staff <ul style="list-style-type: none"> Unintended harm or injury to staff 	Organisation <ul style="list-style-type: none"> Data Breaches Litigation and Financial Penalties. Reputational damage and loss of public confidence. 	Risk Appetite Threshold – Score 17 and Below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	4 (Major) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 September 2025	Risk rating	= 16 (Extreme)	= 6 (Moderate)	
Next Review (Monthly based on risk score)	01 October 2025				



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. Business change team in place to support services in improvement of clinical and administrative processes. Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. Projects support backfilling of clinical time where required. Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects 	<ul style="list-style-type: none"> Additional governance being put in place with the Digital, Data and Technology Group which will report to the Finance & Performance Committee. Terms of reference developed, and meeting will be put in place during Q2 2025. Digital benefits Board development session planned for 2025. Digital transformation development programme to be provided to the Board in 2025/2026. Welsh Government strengthening national governance with the introduction of a DDaT Leadership Board and supporting groups. Regular reporting now in place to Chief Executive Management Team and Welsh Government DDaT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP. Local project tolerance levels changed to zero for both RISP and LIMS to ensure immediate escalation processes are enacted for risks or issues impacting delivery / timelines.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> ○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board's Risk Framework 		<ul style="list-style-type: none"> • Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee. 	<ul style="list-style-type: none"> • Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Welsh Government implementing stronger national governance for national project and programmes
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • Regular Reporting to the Finance & Performance Committee 		<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Not Applicable
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2023/24 <ul style="list-style-type: none"> • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance 	Internal Audit 2024/25 <ul style="list-style-type: none"> • Implementation of the Welsh Intensive Care System – future of programme to be decided 	<ul style="list-style-type: none"> • Recommendations identified through audit work 	<ul style="list-style-type: none"> • Recommendations identified through audit work
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

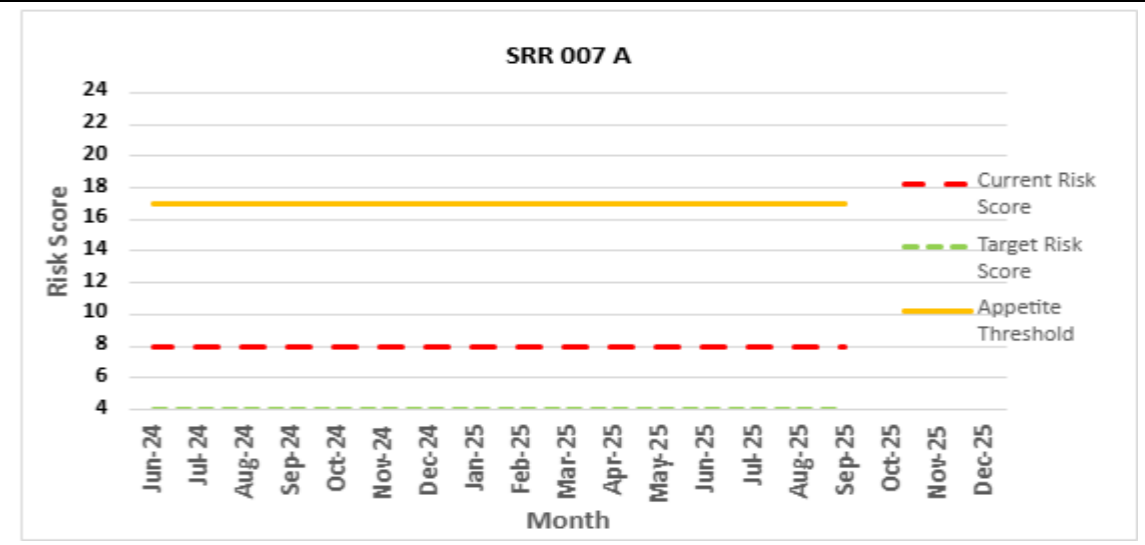
RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 C	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status Public
Threat (As a result of)	Due to failure to develop digital solutions that are sustainable and fir for the future.			Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unintended harm or injury to patients. Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff <ul style="list-style-type: none"> Unintended harm or injury to staff. 	Organisation <ul style="list-style-type: none"> Data breaches Litigation & Financial Penalties Reputational damage and loss of public confidence 	Risk Appetite Threshold – Score 17 and Below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.
	SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.			
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 8 (Moderate)
Next Review (Quarterly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> New Digital Service Request process in place which provides governance in several key areas: Automation of request process via 'Seren' the ICT Portal Information Governance – ensuring new services have appropriate controls to keep patient information safe. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. Patient Safety – ensuring services do not introduce any patient safety risks. Records – ensuring new systems comply with the requirements of records management. Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. Business change function which ensures implemented systems are effective and deliver the benefits required. Formal framework in place for the adoption of new digital services and best practice guidance followed. Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process New Digital Request processes include fortnightly senior leadership scrutiny of requests, New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards Annual operational plan completed and aligned with IMTP Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints. 	<ul style="list-style-type: none"> Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, Portfolio optimisation to ensure the resources of the service are aligned to key priorities New Digital Request quarterly reporting to DDAT Group New governance structures to be put in place further to directorate restructuring Development of product management approach to delivery of core software applications and extending use of agile processes to ICT Development of digital strategies including Digital Transformation Strategy linked to ABUHB 2035 – the new Health Board 10 year strategy and associated component strategies and plans including Electronic Health & Care Record and Infrastructure strategy.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Quarterly reporting to DDAT Group 	<ul style="list-style-type: none"> If the NDSR process delivers anticipated improvements The outcome of the EDRMS audit 	<ul style="list-style-type: none"> Monitor the performance of the NDSR process Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Regular Reporting to the Finance & Performance Committee 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Not Applicable 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit 2023/24</p> <ul style="list-style-type: none"> LINC Programme– Outcome Reasonable assurance Network Infrastructure (VPN) - Outcome Reasonable assurance <p>Internal Audit 2024/25</p> <ul style="list-style-type: none"> Electronic document and records management solution - planned for Q4 	<ul style="list-style-type: none"> Recommendations identified through audit work 	<ul style="list-style-type: none"> Regular Reporting to the Finance & Performance Committee 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

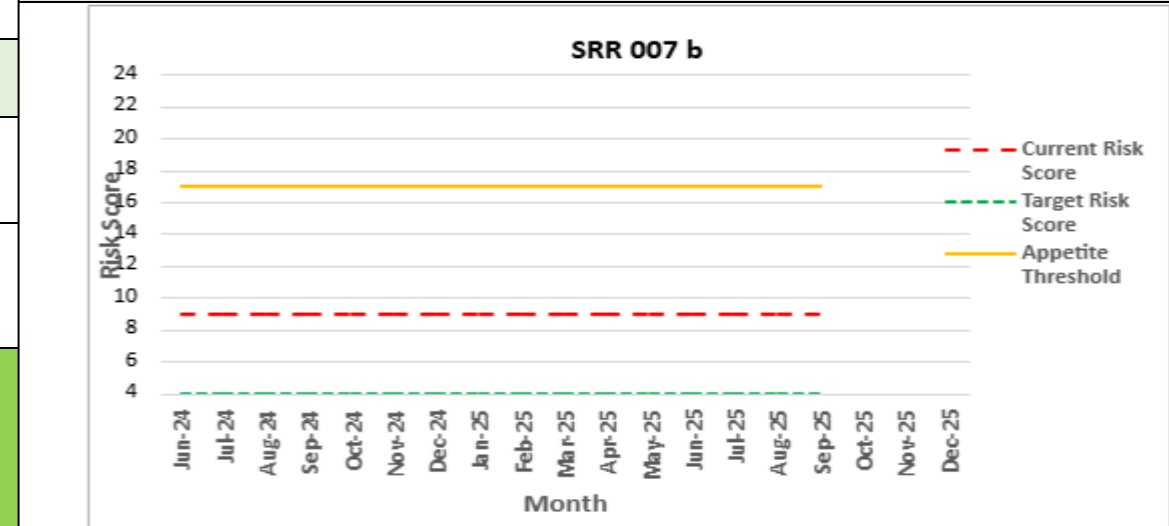
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		SECTION 4: ENABLERS - REGIONAL PLANS	
Strategic Risk: SRR 007A	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status: Public
Threat (As a result of)	Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	<p>Patient</p> <ul style="list-style-type: none"> Unmet patient need resulting in harm 	<p>Staff</p> <p>N/A</p>	<p>Organisation</p> <ul style="list-style-type: none"> Ineffective use of combined resource Delayed decision making Adverse impacts on delivery of care to patients across acute and non-acute settings Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence 	Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				<p>SUMMARY</p> <p>The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.</p>
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 April 2025	Risk rating	= 8 (Moderate)	= 4 (Moderate)
Next Review (Six Months based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<p>The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including:</p> <ul style="list-style-type: none"> The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams 	<ul style="list-style-type: none"> Governance review of Regional Partnership Board undertaken in August 2023. Renewed Strategy for strategic partnership Capital in place and revised governance processes. New Long-Term Strategy for Health Board to focus on Partnership approach.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> PMO reporting to the Director of Strategy, Planning and Partnerships. Regional Leadership Group Reporting 	<ul style="list-style-type: none"> Systematic reporting of outcomes Systematic evaluation of schemes Governance of financial control arrangements 	<ul style="list-style-type: none"> Implementation plan to be developed following RPB governance review. Health Board strategy development approach to focus on partnership approach 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Assurance reporting to the Population Health, Partnerships, and Planning Committee. Assurance reporting to the Board. 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Plan 2024/25 <ul style="list-style-type: none"> RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 Partnership Arrangements Review (Q1) Deferred 	<ul style="list-style-type: none"> Recommendations identified in the Limited Assurance RPB Governance Review 	<ul style="list-style-type: none"> Implementation of the management responses to close off recommendations 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

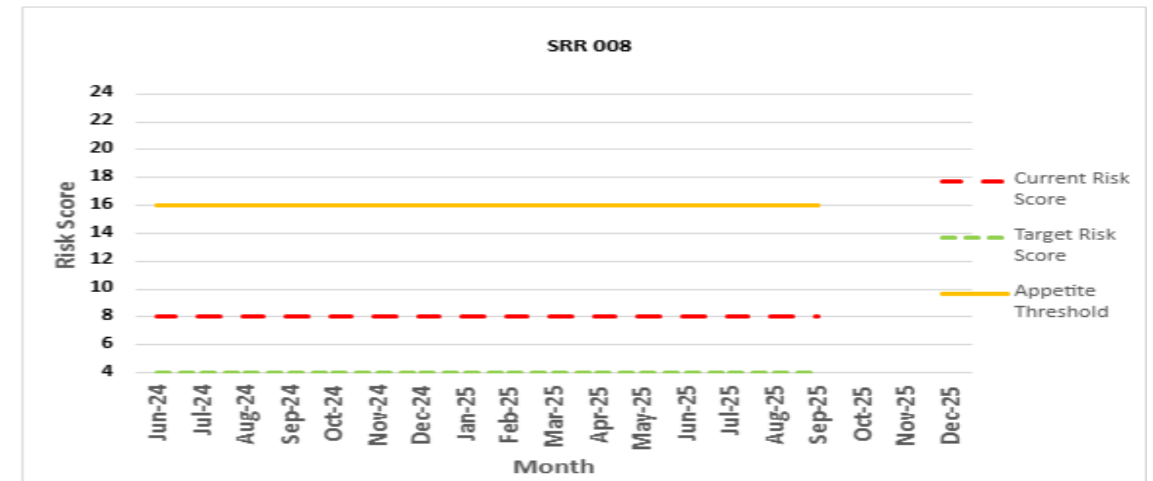
RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		SECTION 4: ENABLERS – REGIONAL PLANS	
Strategic/ Corporate Risk SRR 007 B	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Threat (As a result of)	Due to the impact of fragile services across the regional and supra regional geography			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unmet patient need resulting in harm Adverse impacts on delivery of care to patients across acute and non-acute settings 	Staff N/A	Organisation <ul style="list-style-type: none"> Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence Ineffective use of combined resources Delayed decision making 	Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
Lead Director	Director of Strategy Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)	2 (Minor)
Last Reviewed	01 July 2025	Risk rating	= 9 (High)	= 4 (Low)
Next Review (Quarterly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. The south east Wales health boards agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. Workstreams are underpinned by a Memorandum of Understanding between the participating health boards, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks. 	<p>Additional direction and guidance have been received from Welsh Government, placing greater emphasis on the role of regional planning to achieve sustainable longer-term positions for a range of services where fragilities currently exist. The principal actions are:-</p> <ul style="list-style-type: none"> Requirement to develop a portfolio of documents to inform and drive the forthcoming development of a regional diagnostic and treatment centre at Llantrisant Health Park (LHP). These will include a clear outline strategy, comprehensive demand & capacity modelling for proposed LHP services, future development opportunities and programme governance arrangements Direction for the participating health boards to establish a Joint Regional Committee in quarter 3 of 2025/26, to exercise the facilitation and oversight of regional planning and drive effective collaboration and regional working. <p>The health boards are progressing the above on a collaborative basis. There remains an absolute commitment to delivering on the existing regional programmes of work, and following 're-baselining' work during 2024/25, there is a continued regional consensus on objectives, outcomes, and planning assumptions.</p>

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Service Divisions reporting to the Chief Operational Officer 	<ul style="list-style-type: none"> Alignment and effectiveness of partners to deliver integrated services 		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Assurance reporting to the Population Health, Partnerships, and Planning Committee. Assurance reporting to the Board. Regular touchpoint meetings of all key players to review progress and issues arising 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
LINK TO IMTP	SECTION 4: ENABLER - QUALITY			
Strategic Risk SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.			Publication Status Public
Threat (As a result of)	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	Patient <ul style="list-style-type: none"> Unmet patient needs resulting in patient harm. Ineffective use of combined resources Delayed decision making Adverse impacts on delivery of care to patients across acute and non-acute settings Negative experience of care Distress and frustration. Carer stress. 	Staff <ul style="list-style-type: none"> Staff dissatisfaction Frustration Increased absence. Loss of confidence. 	Organisation <ul style="list-style-type: none"> Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence 	Risk Appetite Threshold – OPEN SCORE 17 and Below All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 August 2025	Risk rating	= 8 (Moderate)	= 4 (Low)
Next Review (Six monthly based on risk score)	01 February 2026			

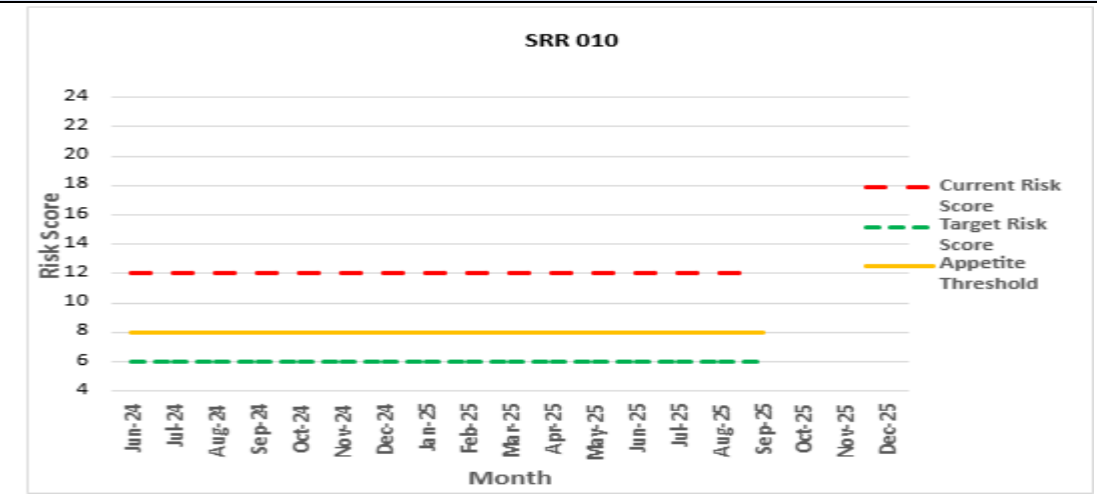


Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
<ul style="list-style-type: none"> Corporate Engagement Team Patient Experience and Involvement Strategy- organisational ownership Person Centred Care (PCC) Surveys and National surveys via CIVICA PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. PLO service at GUH Introduction of PALS Service (Oct 23) Volunteer Patient Experience Feedback Collaboration to recruit community listeners to support Dementia Awareness Digital patient stories to support listening and learning. Patient Experience and Involvement Strategy DATIX Oversight of Medical Examiner reports to determine patient experience actions Public Engagement- Big Conversation Bereavement held 20th March 2024 People Participation Panel ED in Progress Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. 	<ul style="list-style-type: none"> Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. 5 National Maternity Surveys to launch via SMS 1st Sept 2025 National directives around new national surveys that need to be managed additional to internal roll out programme – National People's Experience Survey live 1st May 2025 and default survey for majority of live areas. Volunteer feedback to be reviewed to identify themes. Development of End of Life and Bereavement models in progress and improve bereavement offer to meet Bereavement Standards. Resources being scoped. Community of Practice for Patient Experience and People Participation Panels now agreed and to be progressed. Dementia community hubs in each borough of Gwent will enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent.

- Dementia Person centred Care team dedicated e mail address.
- Dementia Information and signposting through webpages.
- Patient feedback on the agenda for each of the dementia workstream meetings.
- Dementia - QR code for feedback at each training event and session.
- Dementia Thematic review from CIVICA team requested to inform actions and improvements in care.
- Dementia - Multi agency partnership workstreams measuring impact of service.
- Graces places set up in Newport, Caerphilly and Monmouthshire to support bereaved people

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. • Bereavement survey built with CIVICA – Nov 2024 • CIVICA SMS launched 3rd March 2025 across ED and MIU'S 	<ul style="list-style-type: none"> • Currently there is limited SMS provision to increase the number of surveys. <ul style="list-style-type: none"> • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects. 	<ul style="list-style-type: none"> • SMS provision for patient experience feedback launched in ED and all MIU's in February 2025. • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. • Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module 	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<ul style="list-style-type: none"> • Bi-monthly LLais Reports • HIW inspections • Advocacy reports 	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

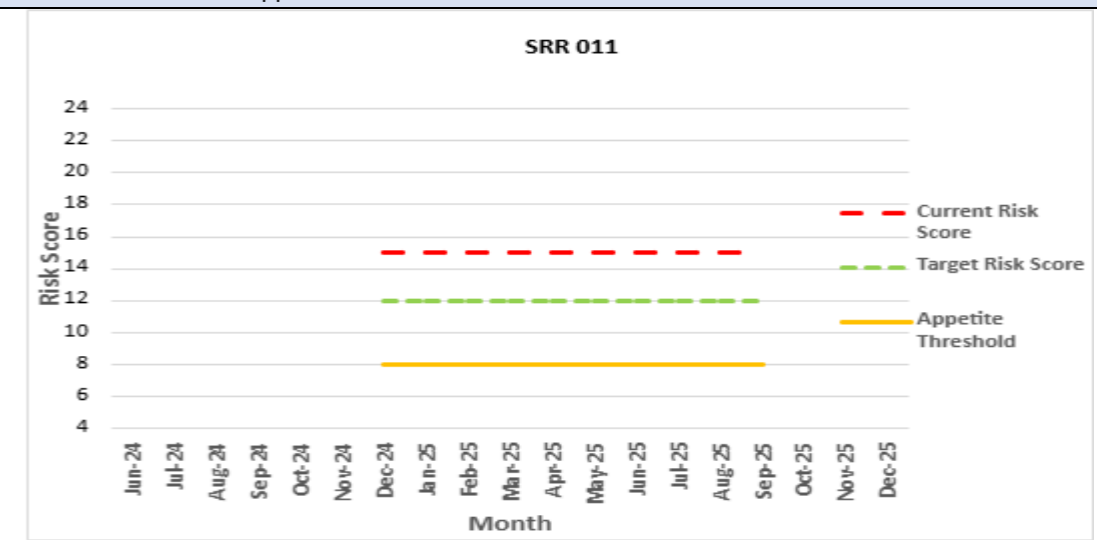
RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP SECTION 4: ENABLER	QUALITY			WORKFORCE & CULTURE
Strategic Risk: SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974			Publication Status: Public
Threat <i>(As a result of)</i>	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements			Risk Appetite Level – MINIMAL Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.
Impact <i>(Consequences of the threat)</i>	Patient <ul style="list-style-type: none"> Unintended physical harm to patients Psychological trauma 	Staff <ul style="list-style-type: none"> Unintended physical harm to staff Psychological trauma Increased levels of staff sickness 	Organisation <ul style="list-style-type: none"> Punitive actions from the Health and Safety Executive (HSE) Loss of estates due to unsafe environments Financial implications Adverse publicity Reputational damage. 	Risk Appetite Threshold – SCORE OF 8 or Below Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls. SUMMARY The current risk level is OUTSIDE of target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Allied Health Professions and Health Science	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 Aug 2025	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review <i>(Quarterly based on risk score)</i>	01 Nov 2025			



Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
<ul style="list-style-type: none"> Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. Health and Safety Policies and Procedures Dedicated Health and Safety site on ABPULSE Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) Partial Programme of Health and Safety Monitoring (Active & Reactive) Corporate and Directorate Health and Safety Risk Register established. Board Training /development (Completed 24 April 2024) Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. Health and Safety Governance and reporting arrangements (Health and Safety Committee) 	<ul style="list-style-type: none"> Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) Consultation and communication with the workforce regarding compliance with the Act New ways of working with Divisions to ensure accountability for health and safety is recognised. Implement key performance indicators to monitor health and safety compliance. Review the governance arrangements for the Health & Safety Committee Health and Safety Policies and Procedures to be reviewed. Onboard further Manual Handling trainers – across the organisation to improve compliance. Scope for training non-Health Board staff Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards	<ul style="list-style-type: none"> • Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions • Consistent adherence and application of policies 	<ul style="list-style-type: none"> • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> • Established monitoring of H&S at the Executive Committee • Corporate H&S Team report risk and assurance to the Health and Safety Group • Health and Safety Annual Report • Health and Safety Improvement Plan • Established monitoring of H&S at the PQSO Committee 	<ul style="list-style-type: none"> • Thematic Risk Register 	<ul style="list-style-type: none"> • Development of a thematic risk register 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
<p>Internal Audit 2024/25 Plan</p> <ul style="list-style-type: none"> • Health and Safety Internal Audit – Concluded Limited Assurance • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. <p>Health and Safety Executive reviews/inspections.</p>	<ul style="list-style-type: none"> • Recommendations from the 2024/25 Internal Audit 	<ul style="list-style-type: none"> • Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – GREEN HEALTH			
Strategic Risk SRR 011	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) <i>This is common to all Health Bodies across the country.</i>			Publication Status Public
Threat <i>(As a result of)</i>	Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected. <i>(The effect of a failure to meet this target is on the wider environment.)</i>			Risk Appetite Level – OPEN: Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure
Impact <i>(Consequences of the threat)</i>	<p style="text-align: center;"><u>Organisation</u></p> <ul style="list-style-type: none"> Failure to meet the target set on Welsh Health bodies for reducing carbon output Non-delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. Reputational damage and loss of public confidence. Opportunity cost of reduced energy costs 			<p>Risk Appetite Threshold – SCORE 17 AND BELOW.</p> <p>Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.</p> <p>SUMMARY</p> <p>The current risk level is OUTSIDE of target level and WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.</p>
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	5 (Almost Certain) x	4 (Likely) x
Initial Date of Assessment	30 October 2024	Impact	3 (Moderate)	3 (Moderate)
Last Reviewed	01 October 2025	Risk rating	= 15 (Extreme)	= 12 (Moderate)
Next Review <i>(Monthly based on risk score)</i>	01 November 2025			



Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
<ul style="list-style-type: none"> Quarterly review of projects and workstreams at the Decarbonisation Programme Board The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, waste and facilities and estates Regular reporting of financial data available Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. Annual net zero return submitted to Welsh Government Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website SUS Qi training Met office training Carbon literacy training HEIW 4 modules on carbon reduction and net zero ESR Spread & Scale academy training sessions 	<ul style="list-style-type: none"> Project structure regularly reviewed should action be needed. Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
<ul style="list-style-type: none"> Regular meetings of the subgroups to discuss position, monitor and new ideas Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	<ul style="list-style-type: none"> Detailed level metrics and measures are limited due to data capture equipment. 	<ul style="list-style-type: none"> All opportunities for funding will be optimised Training opportunities will be maximised. 	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
<ul style="list-style-type: none"> Six monthly updates to the Board Executive Committee (Clinical Futures Board) updates – Quarterly Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised Training opportunities will be maximised. 	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Report in July 24. <ul style="list-style-type: none"> Received “limited assurance” but not because of controls – the issues were largely around funding limitations. External Audit Reports 2023 -24 Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	<ul style="list-style-type: none"> Funding for a comprehensive ABUHB decarbonisation strategy is not available. 	<ul style="list-style-type: none"> As above - REFIT invest to Save capital opportunities being progressed. 	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	NEGATIVE

Speaking up Safely

Final Internal Audit Brief

Aneurin Bevan University Health Board

Introduction

The NHS Wales Speaking Up Safely Framework (WHC/2023/036), issued by Welsh Government in September 2023, states that *'this is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised'*.

Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce, as well as helping to improve the population's experience of healthcare.

The revised process was introduced in Aneurin Bevan University Health Board ('the Health Board') in December 2024, this provided a more structured, detailed and consistent approach. It aims to provide a more transparent, accessible and structured way for staff to raise concerns while ensuring compliance with the NHS Wales Speaking Up Safely Framework (the 'Framework').

The review will provide an updated position on the prior audit completed, issued in April 2025, that provided limited assurance.

Scope, Risks & Approach

Scope	<p>To ensure the newly implemented Speaking Up Safely process fully incorporates the requirements of the All-Wales Speaking Up Safely Framework issued by the Welsh Government.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> 1. Clear processes, embedding the Section 6 Framework requirements and consequently, relevant Section 3 Principles, are in place and communicated to staff, with a focus on the following: <ol style="list-style-type: none"> a. Section 3.10: any matter raised will be reviewed thoroughly, promptly and confidentially, and where appropriate (i.e. not for anonymous concerns) the individual raising a concern will receive appropriate feedback; b. Section 6b: Resources have been identified, and progress has been made to secure these to support the development of the speaking up safely approach and culture; c. Section 6c & h: a review and escalation route is in place to ensure there is regular reporting and monitoring to responsible Committees and stakeholders; d. Section 6d: Ensure that clear and easy to follow processes are in place to allow individuals to raise concerns (included anonymously). The NHS Wales procedure for staff to raise concerns is a necessary minimum standard, but is not in itself sufficient for facilitating and supporting a Speak up Safely culture; e. Section 6i & j: Protected characteristics are monitored, and individuals are offered the opportunity to offer feedback. Lessons are learned from the process; and f. Section 6l & m: Progress is made in the development of training for staff to raise awareness of the principles of Speaking Up Safely.
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Associated risks	<ul style="list-style-type: none"> The Framework is not embedded within the Health Board or effectively communicated. Insufficient resource is in place to ensure the Framework requirements are met. The Principles of the Framework are not adhered to, adversely impacting the raising of concerns by staff, including staff morale. Disclosures are not reviewed in accordance with the Framework in a timely manner. Clinical care may be adversely impacted. 												
Limitations to scope	The review will not comment on those policies and procedures that cover the reporting and management of personal grievances and complaints.												
Approach	<p>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.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.</p> <p>Assurance opinions and action plan risk ratings</p>												
Link to Health & Care Quality Standards	<p>This review may contribute towards assurance over the following Health & Care Quality Standards:</p> <table border="1"> <thead> <tr> <th>Quality Domains</th> <th>Quality Enablers</th> </tr> </thead> <tbody> <tr> <td>Safe</td> <td>Leadership</td> </tr> <tr> <td>Effective</td> <td>Workforce</td> </tr> <tr> <td>Efficient</td> <td>Culture</td> </tr> <tr> <td>Equitable</td> <td></td> </tr> <tr> <td>Patient Centred</td> <td></td> </tr> </tbody> </table>	Quality Domains	Quality Enablers	Safe	Leadership	Effective	Workforce	Efficient	Culture	Equitable		Patient Centred	
Quality Domains	Quality Enablers												
Safe	Leadership												
Effective	Workforce												
Efficient	Culture												
Equitable													
Patient Centred													

Contacts & Timings

Client contacts	<p>Sarah Simmonds Peter Brown Adrian Neal</p>	<p>Director of Workforce & OD Assistant Director of Workforce & OD Consultant, Employee Wellbeing</p>
Audit & Assurance contacts	<p>Stephen Chaney Eifion Jones Rhian Gard</p>	<p>Head of Internal Audit Deputy Head of Internal Audit Audit Manager</p>
Indicative timings	<p>Fieldwork Debrief meeting Audit Committee</p>	<p>October 2025 November 2025 December 2025</p>
Brief agreement	<p>Sarah Simmonds, Director of Workforce & OD 24.09.25</p>	



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

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Aneurin Bevan University Health Board (the Health Board) and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Royal Gwent Hospital Centralised Decontamination Unit

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) to progress the development of the Centralised Decontamination Unit at the Royal Gwent Hospital. This audit has been commissioned in accordance with the agreed 2025/26 internal audit plan.

Cleaning and decontamination of scopes is currently undertaken at several locations within Royal Gwent Hospital. The £4.714 million project seeks to address the inadequate and non-compliant facilities located within Endoscopy, Urology and Urology Theatres i.e. inadequate segregation between dirty and clean areas, significant space restrictions and non-compliance with recommended ventilation standards (WHTM 03/01 and WHTM 01/06).

Welsh Government approval to the BJC was provided in November 2024.

This will be the only audit of the project.

Scope, Risks & Approach

Scope	<p>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.</p> <p>Accordingly, the scope and remit of the current audit will include:</p> <ul style="list-style-type: none"> • Project Performance: An assessment of performance against key project objectives (e.g. time, cost, benefits, critical success factors etc.). • Project Governance and management: Assurance that appropriate governance, management and reporting arrangements are in place for the current project phase. • Contractual arrangements: To obtain assurance that parties contracted to the Health Board have been appropriately appointed (e.g. external advisers, main contractor, other) and in accordance with national and local procurement requirements including the timely completion of appropriate contractual documentation. • Valuation and Payments – Assurance that adequate processes and procedures are in place to ensure that the contractor is correctly reimbursed in accordance with the contract. • Change Management – A robust change management process is defined and applied ensuring the impact of changes on time and cost are adequately controlled. • Other issues: that may impact the assurance provided, including performance against project objectives (e.g., time, cost, quality, benefit, critical success factors).
Associated risks	<ul style="list-style-type: none"> • Projects are not effectively managed; • Project over-runs on time and/ or cost; and

	<ul style="list-style-type: none"> Failure to achieve the required quality or anticipated benefits.
Approach	<p>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.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government, or any other parties pertinent to the review.</p> <p>Assurance opinions and action plan risk ratings</p>
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)
	Jamie Marchant	Director of Estates & Facilities (Senior Responsible Officer)
	Hannah Capel	Assistant Director of Strategic Capital (Project Director)
	Lorraine Morgan	Programme Manager, Strategic Capital & Estates
	Kelly Jones	Head of Capital Finance
	Danielle Jackson	Risk & Assurance Officer
	Vimal Upadhyay	Finance Manager, Capital
	Rani Dash	Director of Corporate Governance
Audit Assurance contacts &	Huw Richards	Deputy Director, Specialist Services Unit
	Murray Gard	Audit Manager
Indicative timings	Fieldwork	Q2 2025
	Debrief meeting	August 2025
	Audit Committee	September 2025
Brief agreement	Management agreement to the audit brief was provided on 17 th June 2025.	



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Public Health

Final Advisory Review Brief

Aneurin Bevan University Health Board



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

This advisory review of Public Health will be completed in line with 2025/26 Internal Audit Plan. As an advisory review, an audit assurance/ opinion will not be provided, instead matters identified will be reported for management consideration.

Since 2023, the Gwent Public Health team has been part of the Aneurin Bevan University Health Board ('the Health Board'), having previously been a part of Public Health Wales. Their main aim of the team is to "build a Healthier, Fairer, Safer and Stronger Gwent for all".

In 2024/25, a Joint Strategic Assessment was produced outlining a wide-ranging set of indicators relating to health and wellbeing, providing evidence of challenges and opportunities across Gwent. In addition, the Director of Public Health produced the 'We are Gwent' – to highlight health issues and to outline what can be done to improve health in the Gwent region.

Nationally, Public Health Wales works alongside health boards/ trusts, local authorities, and third-sector organisations. Coordination across these bodies can be challenging, especially when addressing cross-cutting issues like mental health, substance misuse, and prevention.

Scope, Risks & Approach

<p>Scope</p>	<p>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 Wellbeing of Future Generations (Wales) Act 2015, whilst recognising the responsibilities of Public Health Wales.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> 1. Local public health strategies are adequately defined (e.g. via the Integrated Medium-Term Plan) and align with the national actions/ priorities (e.g. the Wellbeing of Future Generations (Wales) Act 2015). 2. A dove-tailed approach is in place to ensure that local and national approaches are co-ordinated – this will include identifying financial/ resourcing requirements and prioritising initiatives. 3. Review the adequacy of monitoring and reporting for all local/ national public health initiatives – including assessing the achievement of original objectives, critical success factors and key benefits.
<p>Associated risks</p>	<ul style="list-style-type: none"> • Lack of alignment between local public health initiatives and the IMTP leading to ineffective delivery of strategic objectives. Failure to comply with the Well-Being of Future Generations (Wales) Act 2015 • Inadequate governance and oversight structures to monitor progress and performance of public health initiatives. • Reputational risk
<p>Limitations to scope</p>	<p>As this is an advisory review, no assurance rating will be provided.</p>
<p>Approach</p>	<p>As an advisory review, advice and recommendations will be provided to facilitate change and improvement.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.</p>

	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
	Person centred Safe Effective	Learning, research & improvement Whole systems approach Culture

Contacts & Timings

Client contacts	Tracy Daszkiewicz Shareen Ali Simon Hodsdon	Executive Director of Public Health and Strategic Partnerships Head of Public Health (Health Protection) Head of Public Health (Health Improvement)
Audit & Assurance contacts	Stephen Chaney Eifion Jones Rhian Gard	Head of Internal Audit Deputy Head of Internal Audit Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	August / September 2025 September 2025 October 2025
Brief agreement	Tracy Daszkiewicz, Executive Director of Public Health and Strategic Partnerships 30.07.2025	



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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 September and October 2025, 4 standing items on the Forward Work Programme have been deferred until December 2025 to enable more comprehensive and meaningful reporting.

- Audit Recommendations Tracking Q3 Report.
- Receive a Mid-Year update in respect of Post-Payment Verification Activity
- Mid-year Report on the delivery of the Clinical Audit Plan
- Receive the 2025 Structured Assessment

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

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
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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	D√Q2	√Q2	√Q3
Annual Review of Risk Management Framework	An	DofCG	√						
Report on Risk Management Maturity	BI	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
Committee Risk & Assurance Report	SI	DofCG	√		√	√	√	√	
Financial Governance and Control									
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	√	
Report of Losses and Special Payments (<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	-	-	-	-	-	-	√
Receive the Counter Fraud Annual Report	An	HofCF		√					

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
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					D√	√	
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					D√	√	
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	√						
Receive the draft external auditor's opinion on the quality account	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 2025 Structured Assessment	An	AW					D√	√	
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	14	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