Audit, Risk and Assurance Committee
Main Meeting

Tue 16 December 2025, 14:00 - 16:30

Agenda

1. PRELIMINARY MATTERS

1.0 ARAC 20251021 Agenda - final.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 21 October 2025

Attached *Chair*

ARAC 20251216 1.4 20251021 Main Meeting Minutes - Chair Approved.pdf (9 pages)

1.5. Committee Action Log and Matters Arising

Attached *Chair*

ARAC 20251216 1.5 20251021 Action Log - Chair Approved.pdf (6 pages)

1.5.1. Update on the the Health and Safety governance structure and policy implementation

Oral *Director of Allied Health Professions and Health Sciences*

2. Items for APPROVAL/RATIFICATION/DECISION

2.1. To Approve Reviewed and Updated Financial Control Procedures.

Attached *Director of Finance and procurement*

ARAC 20251216 2.1 Finance Governance Report - 16.12.2025.pdf (7 pages)

2.2. To Receive the Audit Recommendation Tracking report and Approve closing position.

Attached *Director of Corporate Governance*

ARAC 20251216 2.2 Internal_External Audit Recommendations Cover Report.pdf (10 pages)
ARAC 20251216 2.2a Appendix A Completed Audit Recommendations.pdf (19 pages)
ARAC 20251216 2.2b Appendix B Revised Deadline Requests.pdf (5 pages)
ARAC 20251216 2.2c Appendix C Recommendations Exceeding Threshold.pdf (3 pages)

3. ITEMS FOR DISCUSSION

3.1. To Receive Internal Audit Progress Report

Attached *Head of Internal Audit*

ARAC 20251216 3.1 ABUHB Dec 2025 Audit Committee Progress Report FINAL.pdf (9 pages)

3.2. To Receive Internal Audit Review Reports

Attached *Head of Internal Audit*

- Standing Orders Compliance
- Welsh Intensive Care Information System
- Business Continuity Plan
- Cyber Security
- RGH Central Decontamination Unit
- Public Health

ARAC 20251216 3.2a ABU-2526-02 Standing Orders Compliance Final Internal Audit Report.pdf (6 pages)
ARAC 20251216 3.2b ABU-2526-24 WICIS Final Internal Audit Report.pdf (6 pages)
ARAC 20251216 3.2c ABU 2526 06 BCP Final Internal Audit Report client issue.pdf (12 pages)
ARAC 20251216 3.2d ABU-2526-22 Cyber Security - Final Report for Client.pdf (14 pages)
AARAC 20251216 3.2e BU-SSU-2526-25 RGH Central Decontamination Unit - Final Internal Audit Report v2.pdf (14 pages)
ARAC 20251216 3.2f ABUHB 2526-13 FINAL Public Health Advisory Report for Client.pdf (9 pages)

3.3. To Receive External Audit Progress Report 2025-26

Attached *Audit Wales*

ARAC 20251216 3.3 3997A2024 Audit Risk and Assurance Committee Update - December 2025.pdf (10 pages)

3.4. To Receive the 2025 Structured Assessment

Attached *Audit Wales*

ARAC 20251216 3.4 ABUHB Structured Assessment 2025 Final.pdf (37 pages)
ARAC 20251216 3.4a ABUHB Structured Assessment 2025 Management Response_Final.pdf (6 pages)

3.5. To Receive the Audit Wales 2026-27 Audit Fees Consultation

Attached *Audit Wales*

ARAC 20251216 3.5 AC528 - Letter on fee consultation.pdf (8 pages)

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

Attached *Director of Finance and Procurement*

ARAC 20251216 3.6 Single Tender Action Report - 01.09.2025 - 31.10.2025 (002).pdf (4 pages)

3.7. To Receive a Quarterly Report on Counter Fraud Activity

Attached *Director of Finance and Procurement*

ARAC 20251216 3.7 ARAC Counter Fraud Progress Report DEC 25 (002).pdf (31 pages)

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

Attached *Director of Finance and Procurement*

ARAC 20251216 3.8 PPV Mid Year ARAC Report 25-26.pdf (4 pages)
ARAC 20251216 3.8a ABuHB Mid-year PPV Report 2025-2026.pdf (1 pages)
ARAC 20251216 3.8b ABuHB Mid-year PPV Report 2025-2026.pdf (1 pages)

3.9. Committee Risk & Assurance Report

Attached *Director of Corporate Governance*

- ARAC_20251216_3.9 Strategic Risk & Assurance Report.pdf (6 pages)
- ARAC 20251216 3.9 Appendix A Strategic Risk Dashboard & Assessments.pdf (45 pages)

4. Director of Corporate Governance

4.1. Director of Corporate Governance

Attached *Head of Internal Audit*

- Capital Projects: Service Readiness
- CAMHS Directorate Review
- Occupational Health

- ARAC 20251216 4.1a ABUHB 2526 07 Capital Projects Service Readiness Final audit brief.pdf (3 pages)
- ARAC 20251216 4.1b ABUHB 2526 09 CAMHS Directorate Review Final Audit Brief.pdf (3 pages)
- ARAC 20251216 4.1c ABUHB 2526-18 Occupational Health Internal Audit Final Brief for Client.pdf (4 pages)

4.2. Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

- ARAC 20251216 4.2 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- ARAC 20251216 4.2a Appendix A ARA 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: Monday 12th January 2026 10:00-11:00

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA	
Date and Time	**Tuesday 16th December 2025 at 14:00**
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 21 October 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
1.5.1	Update on the the Health and Safety governance structure and policy implementation	Oral	Director of Allied Health Professions and Health Sciences
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve Reviewed and Updated Financial Control Procedures.	Attached	Director of Finance and procurement
2.2	To Receive the Audit Recommendation Tracking report and Approve closing position.	Attached	Director of Corporate Governance
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 • Standing Orders Compliance • Welsh Intensive Care Information System • Business Continuity Plan • Cyber Security	Attached	

	• RGH Central Decontamination Unit • Public Health		
3.3	To Receive External Audit Progress Report 2025-26	Attached	Audit Wales
3.4	To Receive the 2025 Structured Assessment	Attached	
3.5	To Receive the Audit Wales 2026-27 Audit Fees Consultation	Attached	
3.6	To Receive Report of the use of Single Tender Action	Attached	Director of Finance and Procurement
3.7	To Receive a Quarterly Report on Counter Fraud Activity	Attached	
3.8	Receive a Mid-Year update in respect of Post-Payment Verification Activity	Attached	
3.9	Committee Risk & Assurance Report	Attached	Director of Corporate Governance
4	**ITEMS FOR INFORMATION**		
4.1	To Receive Internal Audit briefs of audits underway • Capital Projects: Service Readiness • CAMHS Directorate Review • Occupational Health	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: Monday 12th January 2026 10:00-11:00		

Motion to Exclude Members of the Public and the Press

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:
"*Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".*
Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

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

DATE OF MEETING	Tuesday 21 October 2025
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member Dafydd Vaughan - Independent Member Neil Patrick - Independent Member (*Left 10:00*) Helen Sweetland – Independent Member
IN ATTENDANCE	Rani Dash - Director of Corporate Governance Rob Holcombe - Director of Finance and Procurement Rob Jones - Assistant Finance Director Lucy Windsor – Head of Corporate Risk and Assurance Stephen Chaney - Senior Auditor, Internal Audit, NWSSP Sara Utley - Performance Audit Lead, Audit Wales Julie Rees - Audit Wales Finance Audit Lead, Audit Wales Gareth Lavington – Head of Counter Fraud Urvisha Perez – Audit Lead, Audit Wales (*Item 3.4*) Leanne Watkins – Cheif Operating Officer (*Item 3.4*) Danielle Jackson - Secretariat
OBSERVING	None to note
APOLOGIES	None to note

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Minute Reference	Preliminary Matters
ARAC 2110/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 2110/02	**Apologies for Absence** Apologies were noted.
ARAC 2110/03	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 2110/04	**Minutes of the previous meeting** The minutes of the meeting held on the 18 September 2025 were agreed as a true and accurate record.
ARAC 2110/05	**Committee Action Log** The Committee reviewed the Action Log and highlighted several items for clarity and scheduling: **ARAC 1802/05 Clinical Audit:** The Committee reiterated that assurance had been rejected as there was no approved local clinical audit plan. An update report was scheduled for the December meeting. **ARAC 2005/05 Records Management:** An update had been expected in December following discussion at the Executive Committee; however, this discussion had not yet taken place. Scheduling remained to be confirmed pending Executive Committee consideration. **ARAC 1809/10 Discharge Planning:** The Committee expressed disappointment that the assurance report had been deferred to December but noted that a comprehensive report covering the wider discharge context and associated audit recommendations would be presented. **ARAC 2110/05 Job Planning**: The Chair emphasised that the Committee sought assurance on barriers and mitigations rather than completion percentages alone and requested input from divisions experiencing difficulties. Rani Dash (RD), Director of Corporate Governance, confirmed that the People & Culture Committee was responsible for oversight of Job Planning and raised concern that Committee roles were becoming blurred, undermining the clarity of remit and resulting in duplication of effort. RD agreed to explore streamlined reporting, including the potential for an integrated assurance report and feedback of relevant learning to the Committee. **ACTION: Director of Corporate Governance**

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	The Committee **AGREED** that completed actions could be removed from the Action Log.
	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 2110/06	**Financial Governance Report** Rob Jones (RJ), Assistant Finance Director, presented the Financial Governance Report and confirmed that all Financial Control Procedures were in date, with none requiring approval during the reporting period. There had been no purchases or write-offs exceeding £100k during the reporting period. Banking arrangements continued through the Government Banking Service, with NatWest as the provider. The contract was noted as due for retender in 2033, although this was unlikely before 2037. The Health Board did not operate separate bank accounts but used a Barclaycard for specific online purchases. RJ reassured the Committee that the arrangements remained efficient and represented best value for money. The Committee **NOTED** the report.
	ITEMS FOR DISCUSSION
ARAC 2110/07	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report. The Committee noted that good progress had been made against the plan, supported by improved engagement following the introduction of the new audit process and management action framework. Several audits were at draft or finalisation stage, with a significant volume of work scheduled for Quarters 3 and 4. Key audits highlighted for Quarter 4 included: • Clinical Audit • Falls Management • Discharge Planning (follow-up review) The Committee was informed that the discharge planning audit would revisit findings from 2022–2023, with an expectation of sustained improvement and implementation of previous recommendations. The Committee **NOTED** the report for assurance.

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ARAC 2110/08	**To Receive Internal Audit Review Reports** Stephen Chaney (SC), Head of Internal Audit, presented the Safeguarding Audit Report, which provided reasonable assurance. The audit had assessed safeguarding policies, procedures and compliance with legislation. The report acknowledged that additional controls had been introduced in response to increased safeguarding allegations and found these to be robust. The most significant concern had been low compliance with mandatory Level 3 safeguarding training for senior staff, with sessions often oversubscribed and experiencing high withdrawal rates. The safeguarding team had been exploring alternative delivery methods, including virtual options, to improve uptake. The Committee **NOTED** the report.
ARAC 2110/09	**To Receive External Audit Progress Report 2025-26** Sara Utley (SU), Performance Audit Lead, presented the External Audit Update Report, supported by Julie Rees (JR), Finance Audit Lead. The Committee was informed that: • The Eye Care Services report had been finalised, • Fieldwork was ongoing for the Digital Systems • Structured Assessment was being drafted and would be shared imminently, • The GP Managed Practice Contract report was undergoing internal clearance, • Scoping work continued for the Estates and Cancer Services review, • The Charitable Funds Audit was scheduled to commence shortly. The Committee **NOTED** the report.
ARAC 2110/10	**Audit Wales Report: Aneurin Bevan University Health Board Eye Care Services** Urvisha Perez (UP), Audit Lead, presented the Eye Care Services report, outlining regional and local findings. Regionally, the Visionary Eye Care approach had set a positive direction, but implementation had been slower than expected, with capacity improvements focused mainly on cataracts and not addressing the overall backlog. Governance decision-making on business cases had also been identified as slow.

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Locally, planning had been fragmented with the long-term direction remaining unclear. Leadership for short-term improvement was evident; however, strengthened Board oversight and risk management were required. Whilst two-year waits had reduced, targets for the eye care measure and waits over one year had not been met. Harm reviews and prioritisation processes were in place but reporting of harms and learning to Committees required improvement.

Leanne Watkins (LWa), Chief Operating Officer, provided context on current operational challenges and ongoing system-wide work across primary and secondary care to balance demand and capacity. She confirmed that workforce constraints from COVID-19 had begun to improve and noted the diagnostic hub investment supporting harm reduction.

Members requested stronger Board-level reporting on harms and an update against the original ophthalmology business case, including delivery and benefits, to be presented to the Finance & Performance Committee. LWa agreed to discuss with the Director of Corporate Governance scheduling a report to the Finance and Performance Committee and agreed to circulate an updated workforce position outside of the meeting.
ACTION: Chief Operating Officer / Director of Corporate Governance

Rani Dash (RD), Director of Corporate Governance, confirmed appropriate Committee routing:

- Finance & Performance Committee for delivery and value for money;
- Partnerships, Population Health & Planning Committee for planning;
- Patient Quality, Safety & Outcomes Committee for harm and quality;
- Audit, Risk & Assurance Committee adequacy of the control environment.

RD agreed to circulate a concise note clarifying Committee roles and to review Terms of Reference alignment.
ACTION: Director of Corporate Governance

The Committee **NOTED** the report.

ARAC 2110/11 **Audit Wales Final Annual Accounts Memorandum**

Julie Rees (JR), Finance Audit Lead, presented the Final Accounts Memorandum noting five recommendations for the 2025/26 accounts cycle had been made, they included:

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	• Two relating to Declarations of Interest (completeness and leavers), • One on working papers to strengthen performance and accountability, • One on disclosure completeness checks, and; • Two focused on IT control improvements. The Committee noted that management responses and timescales were considered appropriate, and that both Internal Audit and External Audit would follow up on implementation. The Committee **NOTED** the report for assurance.
ARAC 2110/12	**To Receive the National Fraud Initiative 2024 - 25** Sara Utley (SU), Performance Audit Lead, provided the Committee with an overview of the National Fraud Initiative (NFI), a UK-wide mandatory data matching exercise designed to detect and prevent fraud across public sector bodies, including NHS organisations. For the 2024–2025 cycle, 7,591 matches had been identified for Aneurin Bevan University Health Board, with 5,855 flagged in key reports, primarily relating to payroll and creditor data. Gareth Lavington (GL), Head of Counter Fraud, confirmed that approximately 400 matches had been prioritised for investigation, with all reviews expected to be completed by March 2026. Members noted concerns about the reliability of fraud risk scores, as confirmed fraud cases had originated from matches with low-risk scores (3% and 6%) rather than those flagged as high risk. SU confirmed that feedback on these limitations would be escalated to the Cabinet Office via Audit Wales. GL agreed to report back to the Committee on the outcomes of the NFI review once completed. **Action: Head of Counter Fraud** The Committee **NOTED** the report for assurance.
ARAC 2110/13	**To Receive Report of the use of Single Tender Action** The Committee received the Single Tender Actions (STA) report, presented by Robert Jones (RJ), Assistant Finance Director. It was noted that the reporting period covered 30 days, during which no single tender actions had been completed. RJ advised that activity was expected to return to usual levels in the next reporting period. The Committee **NOTED** the report.

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ARAC 2110/14	**Report of Losses and Special Payments** Robert Jones (RJ), Assistant Finance Director, presented the Losses and Special Payments report. An increase in clinical negligence and personal injury claims under £25,000 was reported, creating direct financial pressure as they fall below the Welsh Risk Pool threshold to cover. The Committee was advised that penalties for late submission of "lessons learned" reports had also risen, resulting in a dual financial impact: direct penalties and a less favourable allocation of the Welsh Risk Pool surplus. Executives had escalated timeliness expectations and were reviewing internal processes to improve compliance. RJ confirmed that the emerging cost pressure, estimated at around £1m, had been reflected in Month 6 reporting and would be explained to the Board. The Committee **NOTED** the report for assurance.
ARAC 2110/15	**Report on the arrangements for declaring, registering, and handling interests** Rani Dash (RD), Director of Corporate Governance presented the Declarations of Interest report. The report provided assurance on the implementation of the revised policy approved by the Board and outlined progress in embedding the process across the organisation. It was noted that the number of declarations had increased, indicating improved awareness and compliance. However, given the size of the organisation, overall volumes remained low, and further work was required to strengthen uptake, particularly among high-risk staff groups. An implementation plan was presented, detailing actions to improve recording, monitoring, and adherence to policy. The Committee **NOTED** the report for assurance.
ARAC 2110/16	**Risk Management Maturity across the Health Board** Lucy Windsor (LW), Head of Corporate Risk and Assurance, provided an update on the maturity of the Health Board's risk management practices The Committee noted that while the organisation had not yet reached an optimised level of maturity, significant improvements had been achieved. These included: • Strengthened governance structures;

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	• Targeted training; • Improved data integrity; • Establishment of a Corporate Governance Hub, and the; • Development of a Corporate Risk Register comprising 31 high-level operational risks which have the potential to destabilise the Health Board's strategic objectives. It was further noted that additional work was planned to drive continued maturity improvements and that the introduction of measurable targets would support transparency in tracking progress. The Committee **NOTED** the report for assurance.
ARAC 2110/17	**Committee Risk & Assurance Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Risk and Assurance Report. The report outlined recent changes in the Health Board's risk profile, including updates to risks previously reported to the Board. The Committee noted that the risk score for **SRR 001D: Industrial Action** had been increased following endorsement at the recent People and Culture Committee meeting. This change reflected the formal rejection of the 2025/2026 pay offer by Trades Unions and Unison's stated intention to ballot members for industrial action. The Committee **NOTED** the report for assurance.
	ITEMS FOR INFORMATION
ARAC 2110/18	**Internal Audit Briefs** The Committee **NOTED** the nine audits that were due to commence.
ARAC 2110/19	**Committee Programme of Business 2025/26** The Committee **NOTED** the report for information.
	Other Matters
ARAC 1209/22	**Items to be Brought to the Attention of the Board and Other Committees** Audit Wales Eye Care report to be presented to the below committees: • Finance & Performance Committee for delivery and value for money; • Partnerships, Population Health & Planning Committee for planning; • Patient Quality, Safety & Outcomes Committee for harm and quality;

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ARAC 1209/23	**Any Other Urgent Business** • Nothing reported.
ARAC 1209/24	**Date of the next meeting** • Tuesday 16th December 2025 14:00-16:00

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2025	**ARAC 1802/05** 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	16 December 2025	**In Progress** One off meeting being scheduled for January 2026 with committee and relevant executive directors
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 by the Executive Committee to ensure they accurately reflect the	Director of Corporate Governance/Director of Digital and Head of Internal Audit	21 September 2025	**In Progress** Update scheduled to be presented to the Committee in February 2026

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		scope of the recommendations.			
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	12 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	16 December 2025	**In Progress** One off meeting scheduled for January 2026 with committee and relevant executive directors.
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	16 December 2025	**In progress** Exploration meeting took place 09 October 2025, will be incorporated into the next audit tracking report (December 2025).

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
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 Science	16 December 2025	**Completed** Item on the December 2025 agenda
September 2025	**1809/18** Internal Audit Report - EDRMS	Circulate a timeline for server upgrades.	Director of Digital	October 2025	**Completed** Server upgrades are dependent on the required development in Clinical Workstation (CWS), this work is sitting alongside a range of other Health Board priorities which are being surfaced with clinical executives and the executive committee for ratification. Any acceleration of this action is dependent on the approval of the CWS business case which is currently going through the Health Boards governance processes.

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
October 2025	**ARAC 2110/05** Committee Action Log – Job Planning	Explore streamlined reporting, including the potential for an integrated assurance report and feedback of relevant learning to the Committee.	Director of Corporate Governance	16 December 2025	**In Progress** To be discussed alongside presentation of the Job Planning report scheduled for January 2026
October 2025	To Receive the Aneurin Bevan University Health	Circulate an updated workforce position outside of the meeting, particularly regarding consultant staffing levels and broader workforce planning.	Chief Operating Officer	16 December 2025	**Completed** **Significant Reduction in Medical Workforce:** The ophthalmology medical workforce at Aneurin Bevan University Health Board decreased by 30% between March 2021 and March 2025 (from 18 to 12.5 full-time equivalents). This reduction has impacted service capacity and delivery. We are now back up by 10% due to a new cornea consultant starting in September 2025.

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Board Eye Care Report				The other 2 consultant vacancies have also been filled, but due to training will not be in post until August 2026.
		To discuss the scheduling of a report to the Finance and performance committee focusing on progress against the original ophthalmology business case	Chief Operating Officer	16 December 2025	**Completed** Paper scheduled to be presented to the Finance and performance committee in February 2026
		Circulate a concise note clarifying Committee roles	Director of Corporate Governance	16 December 2025	**In Progress** Email to be circulated to relevant members.
		Review Terms of Reference alignment to ensure outputs from		May 2026 Included as part of the	**Not Due**

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		reports are routed through the appropriate Committees		annual review of ToRs	
October 2025	To Receive the National Fraud Initiative (NFI) 2024 - 25	Report back to the Committee on the outcomes of the NFI review once completed.	Head of Counter Fraud	April 2026	**Not Due**

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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:	16 December 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)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

- Note the contents of this report.

Cefndir / Background

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

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

Asesiad / Assessment

1.Financial Control Procedures (FCP)

There are no FCPs to be reviewed at this Committee.

Summary Position on Financial Control Procedures

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

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
Engaging Off Payroll Workers	25/26	Y	Feb-23	02-Feb-26	Scheduled for Feb-26
Patients' Property	25/26	Y	Feb-23	02-Feb-26	Scheduled for Feb-26
Purchasing Cards	25/26	Y	Feb-23	02-Feb-26	Scheduled for 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	28/29	Y	Apr-25	22-Apr-28	
Charitable Funds	28/29	Y	Apr-25	22-Apr-28	
Budgetary Control Policy & Procedure	28/29	Y	Sep-25	18-Sep-28	
Losses and Special Payments	28/29	Y	Sep-25	18-Sep-28	
Stores & Stocks	28/29	Y	Sep-25	18-Sep-28	

2. Technical Accounting Issues

Technical updates

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

Update Note 2 covered the following area:

- **November AME Returns including AME Impairment and DEL Depreciation Impact**

  In response to concerns raised by Audit Wales regarding the valuation of building additions—specifically, that assets brought into use without prior revaluation should not be recorded at a value exceeding the audit materiality threshold on the Statement of Financial Position—the Capital TAG subgroup undertook targeted work to address this issue.

  As a result, Welsh Government issued updated guidance and templates to all organisations. These resources are designed to facilitate timely and accurate non-cash adjustments, ensuring compliance by both Welsh Government and NHS bodies.

  The Capital Finance team have reviewed the updated guidance and submitted the necessary returns in early November. The impact will be limited on the

Health Board, as we have historically only had a small number of schemes that were not valued, in comparison to other organisations.

Update Note 2 covered the following areas:

- **2025/26 Strategic Cash Requests submission date**

Guidance and submission deadline issued to organisations who will be required to submit a request to Welsh Government for Strategic Cash, in line with operational deficit.

The Health Board is currently forecasting an operational deficit for 2025/26 financial year, and therefore we will be submitting a request to Welsh Government for strategic cash in line with the operational deficit.
The deadline for submitting the Accountable Officer letter for this request is 8th December 2025.

- **Annual Movement of Working Balances Cash Exercise**

Guidance and submission deadline issued to organisations that require working capital cash in 2025/26.

The Corporate Finance team continue to review the Health Board's cash position monthly, alongside the Capital Finance team as part of the Monthly Monitoring Returns process. It has been identified that the Health Board is likely to be in a position where working balances cash support may be required in March 2026.

The request, including breakdown between Capital, Capital IFRS 16 and Revenue working balances cash will need to be included in the Accountable Officer letter for Strategic Cash, due on the 8th December.

3. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value	99.7	98.3
	Number	96.6	91.8
Non-NHS	Value	97.6	96.9
	Number	97.6	97.2

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditor invoices within 30 days of delivery of goods/services in October 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 October, as it did in August and September. 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 October 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 October 2025 %	RANK
Non-NHS by Number	**Aneurin Bevan UHB**	**97.6**	**97.2**	**1st**
	Betsi Cadwaladr UHB	97.1	97.0	2nd
	Cardiff & Vale UHB	96.6	96.3	
	Cwm Taf Morgannwg UHB	94.2	95.8	
	Hywel Dda UHB	96.1	96.4	3rd
	Powys tHB	92.1	91.6	
	Swansea Bay UHB	96.7	96.2	

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

Following the Standing Financial Instructions (SFIs) self-assessment report, a number of FCPs have been reviewed to ensure they are up to date.

As part of this process the following FCPs will be updated and presented to the Committee in February, to ensure compliance with the SFIs.

- Procurement
- Grant Funding – this will be a new FCP.

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

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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker Q2 Position
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit Risk and Assurance Committee (the Committee) with a comprehensive overview of the current status of all identified internal and external audit recommendations as at the end of Q2 2025/26 (30 September 2025).

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

Cefndir / Background

This report was last presented to the Committee in September 2025; the report covered the position up to the end of Quarter 1 2025/26 (30 June 2025). At that meeting the Committee approved the following position:

- **59** recommendations completed;
- **38** recommendations with revised timeframes; and,
- **1** recommendation remaining overdue, with no new implementation date.

This resulted in a total of **140 live recommendations** on the Audit Tracker at the end of Q1.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking

Since the previous report to the Committee, which recorded **140** live recommendations on the Tracker, an additional **33** recommendations from reports received at September and October's meeting have been added, totalling **173** live recommendations.

Of the **173** recommendations, **93** required an update (recommendations that had reached their implementation date) at the end of 30 September 2025.

Table 1 below presents a breakdown of the **93** recommendations requiring updates, grouped by Lead Director responsibility.

Table 1

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance & Procurement	Director of Nursing	Medical Director	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Allied Health Professions	Director of Public Health	Total
Number of updates requested	27	2	8	3	26	11	7	6	2	1	93

The position reported in Table 2 reflects updates provided by Lead Directors. Based on this information, the Committee is asked to:

- **Approve** the completion of **74** recommendations;
- **Approve 19** revised implementation deadlines;

Table 2

Lead Director	Chief Operating Officer	Director of Corporate Governance	Director of Digital	Director of Finance and Procurement	Director of Nursing	Medical Director	Director of Strategy, Planning & Partnerships	Director of Workforce	Director of Allied Health Professions	Director of Public Health	Total
Completed	23	1	5	3	19	10	6	5	1	1	74
Revised Deadline	4	1	3	-	7	1	1	1	1	-	19
Overdue	-	-	-	-	-	-	-	-	-	-	-
Total	27	2	8	3	26	11	7	6	2	1	93

The summary data presented in Table 2 is further broken down in Tables 3 and 4, as outlined below:

- **Table 3:** Provides a summary of the **74** recommendations confirmed as completed. (Refer to Appendix A for full details.)

- **Table 4:** Sets out the **19** recommendations with revised deadlines. (Refer to Appendix B for full details

Table 3

Completed Recommendations		
Audit Title	**Assurance Rating**	**Number by Priority Rating**
2020/21 IM&T Control & Risk Assessment	N/A	**1**
2022/23 IT Strategy	Reasonable	**2**
2022/23 Dementia Services	Reasonable	**2**
2022 Tredegar Health and Wellbeing Centre	Limited	**1**
2022/23 Discharge Planning	Limited	**1** **1**
2023/24 IT Infrastructure	Reasonable	**1**
2023/24 Newport East Health and Wellbeing Centre	Reasonable	**2**
2023/24 Review of Workforce Planning Arrangements	Not Rated	**2**
2024/25 Structured Assessment	Not Rated	**2**
2024/25 Financial Sustainability	Reasonable	**2**
2024/25 Performance and Accountability Framework	Reasonable	**6**
2024/25 Embedding of Policies – Speaking up Safely	Limited	**2**
2024/25 Health and Safety	Limited	**1**
2024/25 Waiting List Management	Reasonable	**3**
2024/25 Records Management	Limited	**1**
2024/25 Job Planning	Limited	**6** **4**
2024/25 Energy Management	Reasonable	**1**
2024/25 Health Board Managed Practices - advisory	Not Rated	**11**
2024/25 Health Board Managed Practices	Reasonable	**3**
2025/26 Quality Governance Follow Up	Not Rated	**3**
2025/26 Discharge Planning Progress Update	Not Rated	**16**
High **Medium** **Low**	**Advisory**	**7** **28** **4** **35**
Total		**74**

Table 4

Recommendations with Revised Deadlines							
Audit Year and Title			**Assurance Rating**	**Number by Priority Rating**			
2020 IM&T Control and Risk Assessment			Not Rated	**1**			
2022 Discharge Planning			Limited	**1**			
2023 IT Infrastructure			Reasonable	**1**			
2024 Estates Condition			Limited	**1**			
2024 Structured Assessment			Not Rated	**1**			
2025 Discharge Planning Progress Update			Not Rated	**2**			
2025 Health and Safety			Limited	**1**			
2025 Intelligence Led Organisation			Reasonable	**1**			
2025 Job Planning			Limited	**1**			
2025 Mental Health and Learning Disabilities			Reasonable	**3**			
2025 Quality Governance Follow Up			Not Rated	**1**			
2025 Urgent and Emergency Care: Flow out of Hospital – Gwent Region			Not Rated	**3**			
2025 Urgent and Emergency Care: Arrangements for Managing Demand			Not Rated	**2**			
High	**Medium**	**Low**	**Advisory**	**3**	**5**	**1**	**10**
			TOTAL	**19**			

Following the agreed removal of **74** completed actions and the approval of **19** extension requests, and prior to the addition of recommendations from audits considered at this Committee meeting; **99** recommendations remain live on the tracker.

Of these **99** recommendations, **88** fall within the accepted extension threshold of two deadline revisions. The remaining **11** exceed this threshold, and only **2** of these have requested a further implementation date. This group therefore warrants closer scrutiny and, where appropriate, escalation.

It should also be noted that, in some cases, implementation is dependent on external factors or on the completion of related recommendations. Further detail on these recommendations is provided in Tables 5 and 6 below.

Table 5

Implementation Status	Total number of Recommendations
Within Original Deadline	47
1st Extension	21
2nd Extension	20
Total Number within the Threshold	**88**
3rd Extension	6
4th Extension	3
5th Extension	-
6th Extension	1
7th Extension	1
Total Number Outside the Threshold	**11**
Overall Total	**99**

The **11** recommendations that fall outside the extension threshold are taken from the following reports, refer to Appendix C for full details.

Table 6

Recommendations Outside of Agreed Deadline Extension Threshold			
Audit Year and Title	**Assurance Rating**	**Number by Priority Rating**	**Number of Extensions Requested**
2020/21 IM&T Control & Risk Assessment	Not Rated	**3**	*1 x 6th Extension 2 x 4th Extension
2021/22 Pathology	Reasonable	**1**	3rd Extension
2021/22 IT System Controls (WRIS)	Reasonable	**4**	All on 3rd Extension
2021/22 Facilities - Care After Death	Reasonable	**1**	3rd Extension
2022/23 Records Management	Limited	**1**	7th Extension
2023/24 IT Infrastructure	Reasonable	**1**	*4th Extension
Total		**11**	

*Represents the 2 that have requested a revised implementation date.

Performance

This section outlines the Health Board's performance over time (2022–2025), both at an individual organisational level and in a national context, with regard to the implementation of audit recommendations.

For illustrative purposes, the graphs presented in this report have been drawn from the Internal Audit Performance Dashboard. This dashboard can generate a wide range of

data, allowing users to drill down into Health Board–specific information while also providing valuable benchmarking data across NHS Wales.

The examples included here represent a snapshot of the data currently available. The data has been reconciled up to the end of July 2025. Internal Audit will continue to update the dashboard following each Health Board's Audit Committee meeting to ensure that the data used for benchmarking remains as accurate and comparable as possible.

It is important to note that the dataset does not currently identify the year in which the original audit report was issued. When interpreting overdue recommendations, consideration should therefore be given to factors such as:

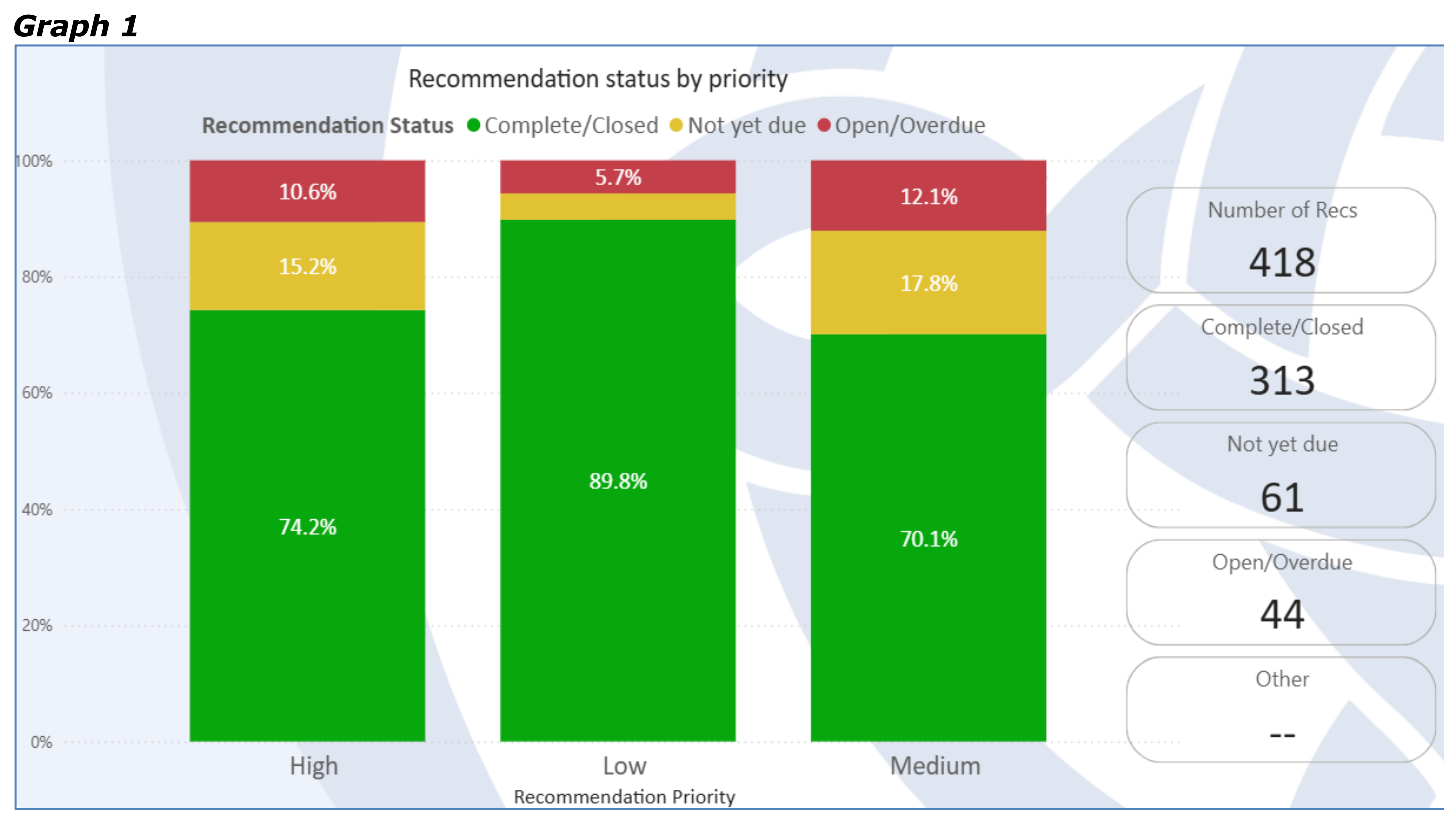
- the length of time a recommendation has been in the system,
- the extent to which it is overdue, and
- any external factors that may have influenced progress.

Understanding these elements will support appropriate interpretation of the overarching data; further drill-down analysis can then provide a more detailed and nuanced view.

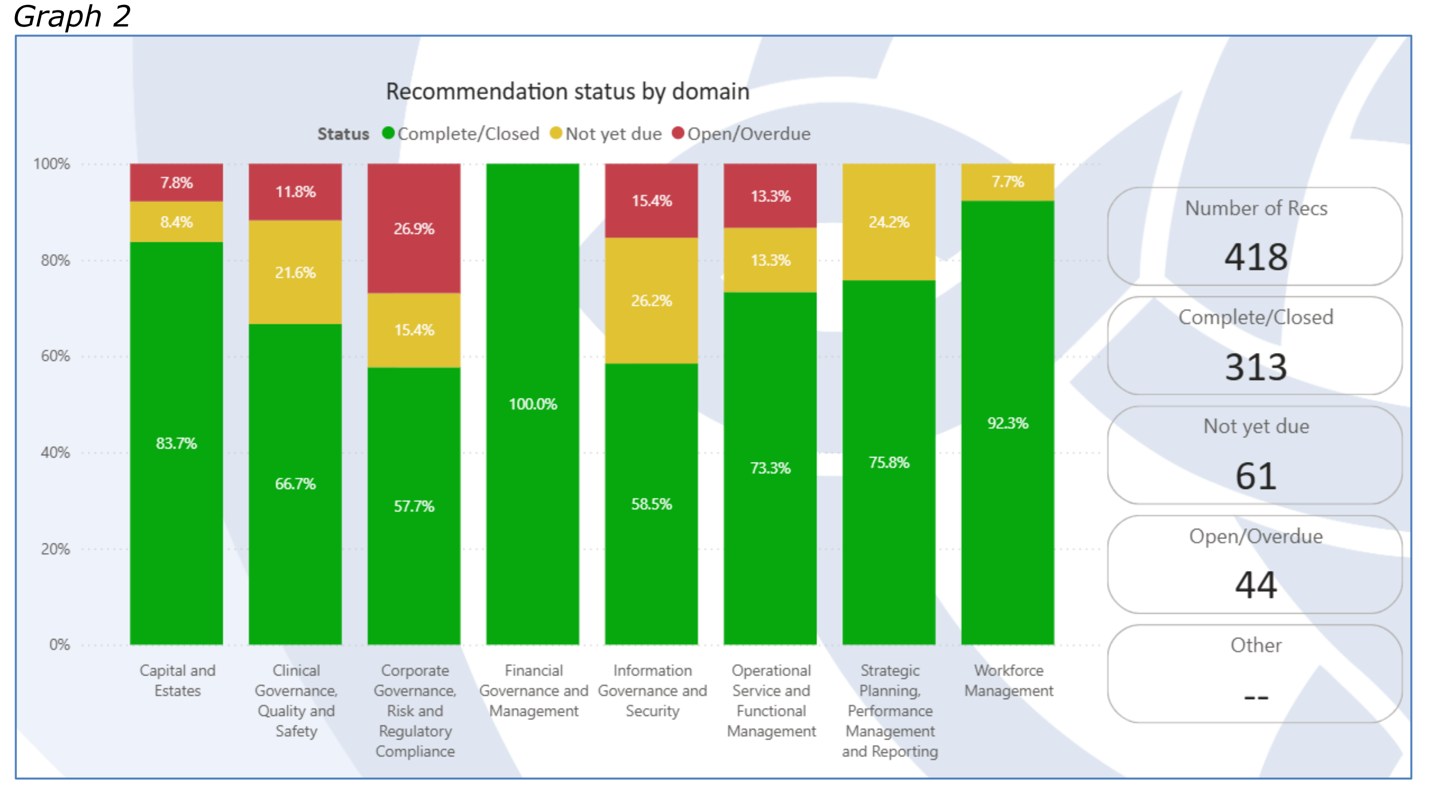
The three graphs included in this section present the Health Board's performance from audit year 2022 to July 2025.

- **Graph 1** presents the position of all recommendations as at the end of July 2025.
- **Graph 2** illustrates the status of risks, mapped against the domains that underpin Internal Audit's programme of work.
- **Graph 3** compares Aneurin Bevan University Health Board's performance with the national position across all Health Boards.

Graph 1



Graph 2



Graph 3

Top graph is ABUHB. Bottom Graph is the combined position of the six other Health Board's.

Recommendation Status

Complete/Closed 74.9%

Not yet due 14.6%

Open/Overdue 10.5%

0% 20% 40% 60% 80%

Percentage of Recommendations

Number of Recs 418

Complete/Closed 313

Not yet due 61

Recommendation Status

Complete/Closed 59.3%

Not yet due 19.9%

Open/Overdue 20.5%

Other 0.2%

0% 20% 40% 60%

Number of Recs 2,592

Complete/Closed 1537

Not yet due 517

Future opportunities
To provide greater assurance around the implementation of recommendations, improvements in quality and safety, governance, and the management of risk, there is a plan to further develop and enhance this report. Future iterations will incorporate trend analysis and performance patterns over time, as the underlying data becomes more mature and can be interrogated in greater depth. This will enable a more comprehensive view of the Health Board's performance, including progress in implementing recommendations, reducing the number of Limited/No Assurance reports, lowering the volume of high-priority recommendations, and addressing recurring recommendations and themes.
Argymhelliad / Recommendation The Audit, Risk & Assurance Committee is asked to: • **NOTE** the completion of **74** recommendations; • **APPROVE 19** revised implementation deadlines; • **NOTE** the ongoing work to strengthen the assurance provided to the Committee regarding the Health Board's management of, and improvements arising from, audit recommendations.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth:	N/A

Evidence Base:	
Rhestr Termau: Glossary of Terms:	Explained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well, Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

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

Appendix 1 Completed Audit Recommendations

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.	Director of Digital	31/12/2021			Completed	Completed	4	"October 25 - Significant progress has been made across clinical asset management, cybersecurity infrastructure, and governance assurance. HALO is actively recording clinical critical assets, functioning as both an asset register and CMDB. This ensures full visibility, lifecycle tracking, and alignment with IT service management standards. The security platform has been deployed at Grange, enabling discovery of shadow medical assets. Full estate-wide implementation will further enhance visibility and security posture across clinical environments. A centralised NDSR process has been established to ensure all clinical IT assets are procured via a single portal. Assets are recorded at point of implementation to maintain register integrity and compliance. The SIEM platform has been successfully deployed, strengthening real-time threat detection and response capabilities. The CRU NIS CAF audit has been completed for 2025. An internal NIS Assurance Group has been formed to oversee implementation of audit recommendations which include critical asset management.The group reports progress to CRU and the IG Sub Group, with escalation to the IG Group and senior governance as required.		Critical assets now identified through the Halo Confirmation Management Database	
2022.15	Internal	IT Strategy	Reasonable	Director of Digital	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	CCIO / CNIO	01/06/2023			Completed	Completed	5	November 2025 - Executive Team presentation on clinical leads presented and discussed at AHP & Health Scientist forum, further discussion with Clinical Executives on 22/10/2025 prior to decision on future model. Recruitment of permanent CXIO is underway with future funding opportunities to be investigated. "August 2025 - No further progress on Business Case development, awaiting review of priority business cases by the Executive Committee""January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. ""October 2024: CNIO JD reviewed and shared with Digital Director and Assistant Director of Nursing for consideration. March '24 - no confimation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Exeuctive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met"		Clinical leads model agreed although funding will need to be sought prior to implementation.	
2022.15	Internal	IT Strategy	Reasonable	Director of Digital	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	CCIO / CNIO	01/06/2023			Completed	Completed	5	November 2025 - Executive Team presentation on clinical leads presented and discussed at AHP & Health Scientist forum, further discussion with Clinical Executives on 22/10/2025 prior to decision on future model. Recruitment of permanent CXIO is underway with future funding opportunities to be investigated. August 2025 - Further work was required on the clinical leads paper following feedback from the Director of Nursing and Director and Director of Allied Health Professions (AHPs) & Health Science. This will now be taken to the Executive Committee in September following further refinement.""April 2025 - Clinical workshop has been completed and paper on clinical engagement is being brough to the Executive Committee in May 2025. Clinical Council now meeting."" ""January 2025 A clinical lead workshop is being held in the first week of February and this will be used to frame the future of clinical engagement and leadership of digital. ""October 2024: Clinial engagament model still not approved. Council being reformed Dec '24. Workshop being undertaken with clinical leads in early November to discuss arrangements going forward. March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of skateholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again		Clinical leads model agreed although funding will need to be sought prior to implementation.	

2022.19	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	Assistant Medical Director for Planning	01/04/2024			Completed	Completed	2	May 2025:New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, survey to staff to evaluate the new process reported into the Safety Flow operational group. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' with completion of a standardised approach Q1 2025/26"January 2025: New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, update at Integrated Discharge Board on 28th January, survey to staff at 3/6 months to evaluate the new process. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' in January/February with completion of a standardised approach end of March 2025 June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document . The SBAR was reviewed May 2024 and new version will be rolled out August 2024		New SBAR process embedded in the Health Board	30/09/2025
2022.19	Internal	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data	Planning Director / Head of Performance	01/10/2023			Completed	Completed	2	April 2025: Senior Nurse for Discharge at RGH and PCC to monitor readmission rates as part of the optimal ward model across three wards at RGH, Medicine, Community and Surgical, identifying reason for readmission aligned to the 50-Day Integrated Care Winter Challenge. Enhanced resource in Corporate Performance team to support analysis of discharge data and information. January 2025: Readmission rates to be monitored as part of the optimal ward model, across three wards at RGH, Medicine, Community and Surgical, identifying reason for readmission aligned to the 50-Day Integrated Care Winter Challenge. Enhanced resource in Corporate Performance team to support analysis of discharge data and information. Optimal ward model to commence 6th January with an evaluation point at end of March 2025 October 2024: The HB currently has the ability to monitor re-admsion rates, categorised as failed discharges, this can be broken down by site, speciality, ward, time and day of the week. June 2024: An initial meeting has been held and a scoping document is being prepared to develop a business case for a new data capture system to enable greater depth of analysis on discharge data and infromation March: There is work ongoing to streamline data analysis, to ensure data is more meaningful and will enable the monitoring of trends. The Executive Director of Nursing and Digital have a meeting to review this in April. Progress will be monitored on an ongoing basis via the Integrated Discharge Board. January 2024: A review of the data and audit requirements for discharge is planned, the systems and processes have been		Analysis of readmission data is problematic, without clinical input at the time of readmission, Health Board systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, this makes any analysis difficult to interpret	30/09/2025
2022.27	Internal	Dementia Services	Reasonable	Director of Nursing	Low	R2	Consideration should be given to digitalise the "this is me" document and use it as a dementia passport document. Also, make it as a live document which could be further used for home care and nursing home settings	This is me is not a mandatory/Once for Wales NHS tool. There are numerous documents/versions of information that would identify a person needs etc. We shall discuss this and other documents at the next Dementia Board and suggest that Workstream 2a and Workstream 3 leads on this recommendation and determine the feasibility of adding this document to the newly developed patient information portal.	Head of Nursing Person Centred Care / Lead Nurse Dementia with Associated Standards Workstream Leads	01/06/2023			Completed	Completed	2	"Update: The All-Wales Dementia Standards of Care national workstream are taking the lead on the development of the Biographical tool digitalisation , which includes the "This Is Me", "Once for Wales" and "My wishes" document and digitalisation. The workstream membership includes representation from each Health Boards, region including Social Care Wales and PHW. When this is agreed the ABUHB Dementia Hospital Steering Group will identify an implementation plan. This is identified in the Dementia Hospital Steering Group action plan. October 2024: There is a national, NHS Biographical Tools task and Finish group who are reviewing the use of the various tools and the development of an App to support. March 2024: The challenge of raising awareness of the benefits of this biographical tool is part of an ongoing programme of improvements through the Meaningful Activities and engagement training delivered monthly from the patient Experience and Involvement team. The national Improvement Cymru team are facilitating an All Wales Biographical tool discussion and implementation group which will help support this message of this tool. Dates unconfirmed as being led by Improvement Cymru. Review September 2024 Nov 2023: Review of the outcomes from the National Audit of Dementia there is a recommendation for a relaunch of information to raise awareness of the diagnostic Code for Dementia on Clinical Workstation (136). The information will be added to the Internal Pulse web pages and shared through ABUHB e mail communication network. "		The audit of the This is me or other biographical tool is now part of the AMaT audit/ one person one day/ WNR. This is part of the memory assessment pathway for post diagnosis and supported by the dementia connectors. The plans for digitalisation of a document is held with National dementia Improvement and Performance team. there are no plans or framework to embed this into WNR. The use of biographical tools is part of the dementia learning and development portfolio and on the intranet/ internet and the meaninful engagement padlet. We have met this target with ABUHB for progression and we have implemented a process for including the use of biographical tools but the use of digitalised version is not a path open to us at this point.	

2022.27	Internal	Dementia Services	Reasonable	Director of Nursing	Low	R4	Consideration should be given to formally monitor (e.g. set KPIs) and report on • patients hospitalised outside of their catchment areas; and • moved from one hospital site to another one over their treatment time.	Workstream 5b (measurement) will consider appropriate KPI's and will extend an invitation to the Patient Flow Team to be members of the workstream	Programme Manager	01/08/2023			Completed	Completed	2	January 2025: There has been little progress on this objective but discussions are taking place within the Goal 1 discharge flow meetings. Patient flow team are invited to the ABUHB Dementia steering group but due to capacity and demands they have been unable to attend.. this will continue to be an action for improvement. March 2024: The Dementia Hospital Steering Group implements the All Wales Dementia Hospital Charter and as such are reviewing the KPI for measurement. The CWS Alert will help us to provide a framework to capture, admission, discharge, hospital moves and incidents. This Alert has been introduced in March 2024 and will be monitored and actions evolve as information is reviewed. The patient flow team have a regular invite to participate in the Dementia Hospital Steering Group. Nov 2023: Work stream 4 is the Hospital Dementia Friendly Charter, patient flow team have been invited to attend this meeting. There is also a audit perameter under the National Audit of Dementia. This will take a focused action as this aim is part if the wider hospitla admission and discharge work.		The national audit of dementia standards and KPI are under review by the Royal College of Physicians. When refreshed it will off each health board refreshed KPI. The dementia steering group workstream 4a includes a target to identify people with dementia on each ward. Using a series of measure, bedside boards, demntia daisy symbols, admission assesment, AMaT audits and CWS coding we are improving our ability to identify and support people with Dementia in our hospitals. Further exploration of the target to identify hospital inpatient moves is being explored in the patient flow/ discharge group as part of Goal 1.	
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R4.2	"A procedure for reviewing alerts and ensuring corrective actions are applied correctly and in a timely fashion should be developed. All staff should adhere to this review process, following a period of communication. "	"ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time."	Head of Ict	31/07/2025			Completed	Completed	0	November 2025 - Single pane of glass for reporting now available.		Solarwinds is our main event management tool and alerts are managed throughs our partners Block/Wavenet. Alerts. Alerts are reviewed with any high-priority issues reported to ABUHB in accordance with the established SLA & SOP. All logged calls are thoroughly investigated and resolved.	
2023.36	Internal	Newport East Health and Wellbeing Centre	Reasonable	Chief Operating Officer	Medium	2.1	"The Health Board should review the current staff training/awareness sessions across the Health Board to assistwith the refugee and asylum seekers agenda. This should be incorporated into training for other vulnerable patient groups, including in conjunction with existing statutory and mandatory training. "	"The Health Board will review existing online training resources available for staff across the Health Board, to include independent contractors, with a view to developing an electronic e-learning session that provides all staff with an understanding of Asylum Seekers and Refugees support, the cultural differences between the UK and individuals home countries, along with the types of barriers they face when accessing services in the UK. Opportunities for this training to be a mandatory awareness session for all Health Board staff and independent contractors will be explored for viability and appropriateness with the Corporate Human Resources and Education and Training teams."	Directorate Manager - Additional Clinical Services	30/09/2025			Completed	Completed	0	The service continues to to review the existing training provided across the health board but due to staffing changes within the Service, there has been limited progress. The service aim to complete this review by quarter 4 2025/26.		A range of training opportunities are now embedded across the health Board including anti racism e learning, a mandatory ESR module which is repeated by all Health Board staff 3 yearly	
2023.37	Internal	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	5.2	The Capital and Estates Board should be advised on the potential impact (and further consequences if additional monies are required) on the discretionary programme, any reduction in other targeted investment priorities and associated risks in the event of additional Welsh government funding not being provided.	The financial position is discussed through the capital and estates group and is also reported and discussed at the Capital Review Meeting with Welsh Government. Financial position is also included as part of the financial reporting	Project Director/capital finance manager	30/11/2024			Completed	Completed	2	May 2025 -Capital and Estates Board are updated as part of the All Wales Capital Update. Project is currently being managed within the current financial budget of the Project. Should there be any additional funding requirement in relation to the oustanding compensation events, this will now be managed through Discretionary. January 2025:Capital and Estates Board are updated as part of the All Wales Capital Update. Project is currently being managed within the current financial budget of the Project. Should there be any additional funding requirement, this will now be managed through Discretionary.		The recommendation to advise the Capital and Estates Board on the potential impact of additional funding requirements has been substantially addressed. Updates are provided through the All-Wales Capital Update, and the project is currently managed within its approved financial budget. In the event of further funding needs arising from outstanding compensation events, these will be managed through the discretionary programme. Financial reporting and discussions occur at the Capital & Estates Group and Capital Review Meetings with Welsh Government.	

2023.05EA	External	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce and OD	N/A	R1.1	"While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models."	The Health Board is currently engaging and will be consulting on a renewed long-term strategy up to 2035 throughout 2024. This will involve developing the strategic outlook to inform and develop workforce planning.		31/12/2024			Completed	Completed	1	In July the new strategy for the Health Board was approved by the Board, Gwent 35: Better Health, Better Care, Better Lives. The strategy signals a step change to our communities in the actions we will take to improve the health of our population achieving equity for all. Its sets the ambition that by 2035 we want everyone to have the chance to live a long, healthy life and improved healthy life expectancy. The Health Board develops its IMTP on an annual bassis and its an essential part of setting the direction. Specific measures for each key area of focus have been developed and these measures are qauntifible and trackable over time. Baseline data for each measure has been established to understand the current state alongside realistic achievable ambitions for each measure over the 10 year period. Monitoring and evaluation progress will be carried out annually and algined to the IMTP and existing plans and actions. The strategy has also identified six key enbling strategies and success measures and each of these will have plans set out. The timeline for when each of these will be shared through Public Boards: People Plan approved September 25. Quality Strategy, approved, Finance Strategy scheduled for January 26, Estate Strategy, March 2026, Digitial Transformation Strategy, Jan 26 and Green Health Strategy - March 2026May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development sesslion on Estates.		The Health Board Strategy and People Plan has been endoresd by the Board	
2023.05EA	External	Review of Workforce Planning Arrangements	Not Rated	Director of Workforce and OD	N/A	R1.2	"While the Health Board has a three-year People Plan, the current approach to strategic workforce planning is not balanced and instead biased towards shorter term transactional workforce solutions. The Health Board's current service model is not sustainable given current demand, and this is affecting the performance and financial position. The Health Board should update its 5 and 10-year planning process, including clinical futures plans and workforce projections to ensure that they appropriately support the implementation of financially sustainable service models."	"The refresh of the People Plan for 2025 will include strategic outlook to 5 and 10-year forecasts based on the work currently undertaken on census, demographics and population needs analysis assumptions. This is addition to development and implementation of National Workforce plans supported by HEIW and Health Board workforce strategies e.g., Nursing, Midwifery, School and Public Health Nursing Workforce Strategy 2023-2026. "		30/05/2025			Completed	Completed	0	The new People Plan 2025- 2030 has been endorsed by the Health Board. Within it sets out a number of actions and measures to support the delivering of its key objectives. Delivery of these will be reportign quarterly to the People and Culture Committee. The Health Board has commenced its future workforce supply and demand modelling for Registered Nursing, Medical and Dental and Health Care Support worker. April 2025 Whilst this action was reporting in the Workforce Planning Audit, it relates to Health Board Service Strategy and workforce planning projections will be informed by the Health Board's long term strategy which is currently in development. Therefore, the timeline has been appropriately adjusted to reflect the long term strategy development."" January 2025: Initial draft is being developed following engagement during 2024. There will be a series of workshops end of Feb/early March to review the document and actions within it. The plan is to publish March/ May pending Board approval."""		5 Year People Plan 2025 - 2030 - approved at September 2025 Board with reference to these recommendations, 5 Year projection for key staff groups and demongraphics core elements of people plan	
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	4.2	Ensuring Single Tender Action reports include total contract values, setting out whether Board or Welsh Government approval was needed, and provide trend analysis of numbers and total values of Single Tender Actions for comparative periods in previous years	Single Tender Action reporting will be updated to include these elements.	Director of Finance and Procurement	31/03/2025			Completed	Completed	0			Single Tender Action Reports are now updated to show these elements.	30/09/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Corporate Governance	N/A	7.1	The Health Board needs to allow sufficient time on Board meeting agendas for the committee chairs to report assurance to the Board and escalate any concerns.	The format of committee chair reports to the Board will be reviewed to ensure clarity on escalation of issues that require the Board's attention whilst balancing the need to ensure the Board does not duplicate the work of its committees.	Director of Corporate Governance	30/09/2025			Completed	Completed	0	November 2025: Committee chairs report templates have been revised to enable clearer escalation of issues from committees to board. Whilst these updates are included in the board's consent agenda, committee chairs should request that matters are brought forward to the main agenda for discussion by then Board where required. Guidance to committee chairs will be prepared to support this.		Revised committee chair templates implemented to provide clearer escalation of issues to Board.	30/09/2025

4693A2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Workforce and OD	N/A	1.1	The Health Board should take steps to improve its arrangements for staff to raise concerns by: updating the procedure for NHS staff to raise concerns so that it is tailored to the Health Board and includes organisation-specific information and contacts.	The NHS Wales Raising Concerns Procedure is a national procedure applicable to all NHS Wales organisations and includes how to raise concerns dependent on the nature (e.g., to line manager, Executive Director). We also have a dedicated SharePoint page accessible to all staff which includes specific information and contact details for staff to raise concerns, including named individuals and champions: Speaking Up Safely. We will strengthen our approach to the Procedure for NHS Staff to Raise Concerns by ensuring it reflects our local context and organisational structure. The procedural document and its supporting appendices will be updated to include the Health Board's name where applicable, identify key individuals within the organisation, and align all	Director of Workforce & Organisational Development	30/07/2025			Completed	Completed	0			The Procedure for NHS staff to Raise Concerns was updated and approved via WOD Policy Group, the Procedure is available via the Intranet	30/09/2025
4693A2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Nursing	N/A	1.2	The Health Board should take steps to improve its arrangements for staff to raise concerns by: monitoring the impact of external support services and accreditation initiatives to ensure that these actions, meet staff needs and are translating into meaningful improvements in staff engagement and patient safety outcomes.	The Health Board will assess the impact of ward / team accreditation through a post implementation evaluation process, this will help determine whether the initiative is improving staff engagement, patient safety outcomes and will help determine areas for improvement.	Director of Nursing	30/09/2025			Completed	Completed	0			Staff Engagement & Recognition: Areas highlighted on the Accreditation Intranet Page Spotlight videos featuring staff to share positive experiences We Said, We Did: Staff survey completed Dec 2024 (MS Forms) Feedback: Need for support & limited time for audits Actions taken: Staff resource page created on intranet → reduces audit duplication Bilingual accreditation posters printed Annual staff evaluations planned	30/09/2025
4693A2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Nursing	N/A	2.1	The Health Board should approve an addendum or update to the current 'Putting Things Right' Policy to reflect the current organisational structure and duty of quality and duty of candour requirements.	The extant 'Putting Things Right' Policy has been updated to reflect the current organisational structure and duty of quality and duty of candour requirements	Director of Nursing	30/09/2025			Completed	Completed	0			Policy updated to include the Duty of Candour	30/09/2025
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.1	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Policy: • The Health Board will review its Discharge Policy in light of the new National Policy published in September 2024. • The Policy will include standard operating procedures (SOP) for Discharge to ensure that there is clarity for staff. • A communication plan for staff, partners and managers will be completed and posters for ward areas will be developed which set out simply the SOPs.	Executive Director of Nursing	31/03/2024			Completed	Completed	1	November 2025: Health Board policy reviewed by Head of Patient Discharge, awaiting sign off by the Clinical Standards and Policy Group• The Health Board discharge policy is currently being reviewed by the Head of Discharge. • The policy will be a practical guide, user friendly that is accessible to staff and aligns with the WG Optimal Hospital Flow Framework. • The policy will include		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.2	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Pathways: • Clinical Workstation 2 (CWS2), which is currently being rolled out across the healthboard has the functionality to assign the correct pathway to each patient: this will integrate with Qlik to ensure daily live capture of patient pathways.	Executive Director of Nursing	30/11/2024			Completed	Completed		" • CWS2 a digital application that records discharge pathways has been rolled out across all sites and wards • Ward based dashboards are currently being developed to display discharge pathways, clinically optimised status and reason for delay • Digital t		CWS2 digital application rolled out across all site, weekly compliance monitoring, monthly submission of data to WG	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.3	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	'Complex List' to be developed into CWS2 with daily data feedbacks, local authority and health staff to have access to the digital system.	Executive Director of Nursing	31/03/2024			Completed	Completed	1	Streamlining of digital discharge tools escalated to Director of Digital scope immediate options for winter to avoid duplication of systems		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.4	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Agreement has been reached to develop an app called 'Ask Annie: this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	Executive Director of Nursing	30/04/2025			Completed	Completed		"• Feasibility study undertaken for the Community Directory of Services/Ask Annie app by private company TPX Impact • RIF application submitted to RPB for funding to progress to phase 2"		Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k, progress interim internal solution aligned to SPoA and discharge planning	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.5	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	A series of workshops are planned to develop a single integrated pathway for Discharge – this will aim to reduce complexity and duplication by creating single access points for discharge services and advice and guidance. This follows a successful piece of work on integrating front door pathways.	Executive Director of Nursing	31/01/2025			Completed	Completed		"• Feasibility study undertaken for the Community Directory of Services/Ask Annie app by private company TPX Impact • RIF application submitted to RPB for funding to progress to phase 2"		Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k, progress interim internal solution aligned to SPoA and discharge planning	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.6	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	An optimal ward project 'Perfect Ward' is planned which will right size the processes, capacity and capability within ward environments to optimise patient flow and discharge.	Executive Director of Nursing	31/03/2025			Completed	Completed	1	November 2025: Continue to roll out the OHFF across all sites, focus on GUH, YYF, NHH and Chepstow Community Hospital		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.7	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Audit and evaluation of the Discharge improvements, plans and pathways will be undertaken post implementation.	Executive Director of Nursing	30/06/2025			Completed	Completed	1	November 2025: Evaluation of optimal ward pilot ongoing aligned to roll out		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.8	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	A patient discharge leaflet will be developed to reinforce the 'what matters' conversation and discharge planning at point of admission.	Executive Director of Nursing	30/04/2025			Completed	Completed				Discharge planning leaflet signed off and shared with Divisional nurses and ward staff	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.9	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	The Health Board and its partners have secured additional funding to pilot the Balancing Rights and Responsibilities Training – the first cohort took place in November 2024 and following evaluation will be embedded within the discharge programme.	Executive Director of Nursing	30/06/2025			Completed	Completed				Initial training complete	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.1	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Further review of the training for new registrants and additional update training will be scoped in the context of the abovetraining and the development of the app.	Executive Director of Nursing	30/04/2025			Completed	Completed	1	Awaiting review and evaluation of the discharge pathway		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	1.11	The Health Board should ensure future and updated tools to support discharge pathways are developed with partners (where relevant), communicated to staff and displayed prominently on wards.	Embedding of the Optimal Hospital Flow Framework across all sites – Red to Green, SAFER, D2RA, Deconditioning	Executive Director of Nursing	30/04/2025			Completed	Completed	1	November 2025: Continue to roll out the OHFF across all sites, focus on GUH, YYF, NHH and Chepstow Community Hospital		Tools supporting discharge (CWS2, OHFF rollout, 'Ask Annie' app, and digital dashboards) have been co-developed with partners and shared with staff through communication and training sessions. Ward visibility has improved with posters and digital tool access.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.1	Ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended;	Roll out renewed guidance to service users.	Chief Operating Officer	31/01/2025			Completed	Completed	0	November 2025: Continue to roll out the OHFF across all sites, focus on GUH, YYF, NHH and Chepstow Community Hospital		All transport policies are on a dedicated Intranet page.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.2	Putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	Utilise current WAST reports available to provide monthly updates on waiting times and themes. Arrange for standing agenda item at Tier 3 Transport Group meeting	Chief Operating Officer	31/01/2025			Completed	Completed	0			Current WAST reports provide the relevant high level data for the Health Board & JCC to monitor delivery to the required standards at local & national level.	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.2	Putting in place a formal mechanism to monitor waiting times for patient transport to enable any themes to be highlighted and challenges to be addressed.	Discharge Lounges to be operational across all sites, to ensure timely patient transport.	Chief Operating Officer	31/03/2025			Completed	Completed	0			Live reporting for discharges & tranfers is in the process of being rolled out operationally by WAST. Names of relevant staff who will require access have been passed to WAST for set up. Transfer Lounge at GUH now undertaking all D&T bookings on behalf of the GUH site; increased visibility & monitoring now enabled.	

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.3	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	The Integrated Discharge Board will be formalised as a Tactical sub-group of the RPB. It is intended and has been agreed that greater transparency in reporting will be developed. A dashboard providing access to waiting times for community assessment and service availability will be included.	Executive Director of Nursing/Chief Operating Officer	30/09/2025			Completed	Completed				IDB continue to monitor performance through performance data	
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.2	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	Agreement has been reached to develop an app called 'Ask Annie': this app will provide access to information on Integrated Discharge Pathways and Services. This app is in the early stages of development.	Executive Director of Nursing/Director of Digital	30/04/2025			Completed	Completed				Community Directory of Services Options appraisal to Integrated Discharge Board, option to progress with TPX Impact £53k, progress interim internal solution aligned to SPoA and discharge planning	
ABUHB-2425-01	Internal Audit	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	1.1	Governance - Savings monitoring meetings We noted that across the 12 months of the 2024/25 financial year, there were several gaps in the monthly meeting regime of VSB meetings: eight Divisional and seven Executive Team meetings took place. We also noted that the VSB lead of the Medicines Management category did not submit a report of savings scheme progress to the meeting of the Executive Team in May 2024.	Agreed Action: V&SB meetings will be held as per the established timetable, there may be circumstances where operational pressures or savings delivery planning may replace these meetings – amendments to meetings are subject to CEO approval. Executive leads will be reminded of their responsibility to provide updated reports. Expected Evidence of Implementation: Correspondence & Minutes of meetings for verification	CEO/DOF	30/09/2025			Completed	Completed	0			"V&SB continues to meet. Review of the financial year confirmed meetings occuring on six occasions over the nine months, with three meetings being re-scheduled: 03 April 2025 28 April 2025 9th May 2025 (CEO approved deferral) 29th May 2025 30th June 2025 (CEO approved deferral) 3rd July 2025 1st September 2025 (CEO approved deferral) 29th September 2025 10th November 2025 1st December (planned next meeting)"	30/09/2025
ABUHB-2425-01	Internal Audit	Financial Sustainability	Reasonable	Director of Finance and Procurement	Medium	2.1	We noted that there was a backlog in the delivery of remedial actions in the VSB action log to address issues threatening savings scheme delivery and that there were a total of six open actions with an average age of seven months, two of which were of 15 months age (September 2023).	Agreed Action: Actions need to be delivered or revised within agreed timescales Expected Evidence of Implementation: Minutes/Action logs reported	DOF	30/09/2025			Completed	Completed	0			V&SB continues to track and monitor actions. The November meeting of the V&SB board included updates on Four actions from Executive meetings which are not yet due. A further three actions from the Divisional V&SB boards were updated of which one item was overdue but underway.	30/09/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	1.1	Framework Document The Performance Management and Accountability Framework was overdue a formal review. The review should consider the findings of this audit and those reported to the Finance & Performance Committee in December 2024.	Agreed Action: The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration going to September Board. Expected Evidence of Implementation: Outcomes of the review, recommendations and redrafted Framework	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			The PMF review is completed, approved by Board 18/09/2025. The changes are being communicated in Q3 with implementation in Q4	30/09/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	2.1	Accountability: Consideration should be given to developing explicit implications of escalation under all three of the performance domains (Quality & Safety, Operational Delivery and Finance), for example linkage to Financial Control Procedures in respect of financial performance.	Agreed Action: All escalations domains to be reviewed and included in the PMF review. Feedback to be drawn from Operational, Corporate, Executive and Board. Expected Evidence of Implementation: Outcomes of the review, recommendations and redrafted Framework	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			2 Additional domains added for Leadership and Corporate Governance, with escalation triggers and assurance metrics agreed following consultation with Operational teams , Executive, Corporate and Board.	30/09/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	3.1	Resource Implications: The current review/ meeting requirements places significant demand on senior staff. This may be reflected in that several executives sent deputies to the mid-year reviews. There is also a significant burden on the Corporate and Divisional teams to manage these arrangements and to produce supporting documents (e.g. slide packs, agendas, notes, accountability letters etc.).	Agreed Action: The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration – this will consider the burden vs benefit of reviews - noting that the requirement for executives to attend is twice a year. Expected Evidence of Implementation: Outcomes of the review, recommendations and redrafted Framework	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			The PMF review is completed, approved by Board 18/09/2025. The changes are being communicated in Q3 with implementation in Q4, the review structure for mid and end of year has been updated with quarterly review removed and corporate moved to an annual review	30/09/2025

ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	4.1	Timings: The Framework document outlines that quarter 4 reviews should be concluded in April of the corresponding year to enable discussion on the delivery plans for the year ahead. It was observed that the end-of-year reviews for 2023/24 were completed between April and June 2024. They are to be completed between May and June 2025 for the 2024/25 year. It was also apparent that the accountability letters were issued later than expected for both Executives and Divisions.	Agreed Action: Timeliness of reviews is noted. End of Year reviews are planned for June – July. Our learning is that April is too early as we do not have the management information (performance or financial Timings of reviews and accountability letters will be considered in the review and refresh of the PMF. The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration. Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted Framework	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			Completed. This is now Business as Usual. It has even been extended to Mid-Year Reviews which take place in October/November.	30/09/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	5.1	Corporate Team Reviews The Performance and Accountability Framework outlines that Corporate Teams Assurance Review Meetings would be held on a six-monthly basis for the following: • Public Health; • Planning; • Digital; • Corporate Governance; • Therapies and Health Science; • Finance; • Medical; • Nursing; and • Workforce & OD. Corporate Team reviews were not conducted in 2024/25. Subject to Board approval, these should be removed as a requirement from the Framework document or should be instated in full as required by the Framework document.	Agreed Action: This recommendation will be considered as part of review. It is important that all elements of the organisation have accountability arrangements and consideration will be of frequency. Corporate Team reviews are scheduled for Q1 and Q2 2025. Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted Framework Evidence of the review an actions.	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			The PMF review is completed, approved by Board 18/09/2025. The changes are being communicated in Q3 with implementation in Q4, the review structure for mid and end of year has been updated with quarterly review removed and corporate moved to an annual review	30/09/2025
ABUHB-2425-05	Internal Audit	Performance and Accountability Framework	Reasonable	Director of Planning, Strategy and Partnerships	Medium	7.1	Timely Committee Reporting: It is important that committees received timely updates on the outcomes of the six-monthly and end of-year reviews. The Finance & Performance Committee are currently receiving reports between four and five months after the period to which they relate.	Agreed Action: There is a challenge with alignment of corporate calendar and reviews. It is accepted that consideration of status post reviews can be more timely and as part of PMF review can include some reporting standards. The PMF is undergoing a full review expected to conclude in Q2 with a revised Framework for consideration, this includes the resourcing load, timeliness and time to administer and implement. Expected Evidence of Implementation: Outcomes of the Review, recommendations and redrafted FrameworkEvidence of the review an actions	Assistant Director Planning & Performance	30/09/2025			Completed	Completed	0			The PMF review is completed, approved by Board 18/09/2025. the review structure for mid and end of year has been updated with quarterly review removed and corporate moved to an annual review to improve timeliness and administration load an points of the year. Production of the reporting to be included in accountability conditions of the relevant departments	30/09/2025

ABUHB-2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce and OD	Medium	2.1	Concern Management System The reliance on manual Excel spreadsheets for recording speaking up safely and HR concerns presented significant risks. Unlike a dedicated database, it required manual data entry, increasing the likelihood of errors, data loss, and inefficiencies. The system lacks automation, security, and robust tracking capabilities, making long-term sustainability and compliance challenging.	Agreed Action: It is noted that the sample contains other employee relations issues which would not be considered via Speaking up Safely Framework. This has been addressed by the new system referred to in this report with consideration of this finding. Management will review options to implement a case management system for both general HR cases and speaking up safely concerns. For Speaking up Safely concerns this may be combined with a new external reporting system which may have this built in capability such as Work in Confidence which is being widely used across HealthBoards. However, it is important to note that Welsh Government are currently exploring a national solution to this for which we await the outcome. Expected Evidence of Implementation:	Assistant Director of Workforce and OD	30/09/2025			Completed	Completed	0	"The current system for staff to raise concerns is to use a Microsft Form which is hosted by an external provider. This form is then sent to the Health Board's Speaking up Safely Guardians. As of December 1st 2025 this system is being removed, and we wil be using a custom built Datix form for staff to raise their concerns. Datix allows for the storage and case management of concerns raised in line with: ISO 27001 (Information Security Management) ISO 7101 (Healthcare Organization Management) ISO 9001:2015 (Quality Management System) and has an approved DPIA. This system will enable full tracking, time stamping and documentation of timeline of notes. "		Datix risk management system to be implemented by the Speaking up Safely process.	30/09/2025
ABUHB-2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce and OD	Medium	5.1	Training The framework states, 'Managers will have training on how to deal with concerns that have been raised', however, there is a lack of sufficient training with existing modules based on NHS England resources and with minimal uptake, and no targeted training for NHS Wales.	Agreed Action: Management will train staff – Provide required speaking up safely training for effective case management. Expected Evidence of Implementation: Evidence of completed and tracked training for speaking up safely.	Assistant Director of Workforce and OD	31/08/2025			Completed	Completed	0	"Training is now available on ESR for speaking up safely for all staff in line with what is available in NHS Engalnd, containing: 000 Speak Up - core training for all workers 000 Listen Up - Training for all Managers 000 Follow Up - For Senior Managers Comms have been circulated to staff via he intranet to raise awareness of the training. The training is not currently mandated for staff - there is currently a National Review of Stat and Mand training ongoing and any additional training to be mandated must be aligned to the outcomes of this report. "		Training now available on ESR for individuals raising their concerns, managers and senior leaders.	30/09/2025
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	Medium	1.1	Overarching Health and Safety Policy The overarching Health and Safety Policy was still in draft and waiting for approval, having originally been drafted in September 2024. The Policy had gone through multiple reviews and scrutiny but has not yet been approved and ratified.	Agreed Action: The Health and Safety Policy has been reviewed and shared with Executive Directors and key stakeholders for comment. Feedback received was constructive and has been used to strengthen the current iteration of the Policy. The policy is scheduled for formal ratification at the Health and Safety Committee on 23rd September 2025.It is scheduled to be presented to the Workforce and Organisational Development (OD) Policy Group in September 2025 to ensure staff engagement. Expected Evidence of Implementation: • Health and Safety Policy • Health and Safety Committee Notes of formal ratification • Published to the staff intranet AB Pulse and Health Board website	Head of Health, Safety and Fire	30/09/2025			Completed	Completed	1			The Health and Safety Policy has been presented and ratified by the Health and Safety Committee	30/09/2025

ABUHB-2425-13	Internal Audit	Waiting List Management	Reasonable	Chief Operating Officer	Medium	1.1	Interim Targets Whilst the overall aspirational targets align with those expected by Welsh Government for similar services, there may be benefit in developing interim targets, to assist in incremental achievement of the overall targets. Particularly noting the current significant variation between targeted and actual waiting list performance. Any targets would need to be appropriately signed off.	Agreed Action: Further internal targets have been considered by the Service and in discussion with the Dietetics and Weight Management Head of Service and Therapies Clinical Director. Internal targets will be closely monitored, in line with the Therapies Performance and Governance Framework, reviewed within service and reported monthly at Accountability and Assurance Meetings. In addition, the service will ensure it stays appraised of any formal National developments in line with national data standards and data assurance process (previously considered in December 2023). Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.	Directorate Manager for Therapy Services	30/09/2025			Completed	Completed	0	"Internal Targets are in place and communicated to the service- New patient 6 weeks target for urgent 14 weeks for routine. October WHC is in keeping with the urgent criteria set by the service for acceptance into level 3 AWMS. AWMS Level 3 routine suspended in September 2025. Local Action log in place - KPI monthly data report incorporates the internal 6 and 14 weeks target. KPI monitored by service and monthly via Acountalility and Assurance meeting with Clinical Director and Directorate manager."		"As per new progress update Embedded practice operationalised and ongoing Implementation plan and target tracking KPI is available on request."	30/09/2025
ABUHB-2425-13	Internal Audit	Waiting List Management	Reasonable	Chief Operating Officer	Medium	2.1	Tracking Improvement Plans Performance was monitored against the overall targets, identifying any gaps as necessary and remedial action. Given that overall targets were extremely ambitious, the resulting observations/ actions were reflective of the gap in performance. Separately, monthly action plans were produced to capture any local initiatives. This document was not fully complete, and the actions documented were not always SMART, making it difficult to quantify the impact of the action. The action plan would also be better maintained as a rolling record, rather than separately produced each month, demonstrating whether items were addressed in a timely manner.	Agreed Action: Develop SMART Actions for all improvement initiatives - rolling record. Develop a live and shared tracker to capture progress of all initiatives including objectives, SMART target, Key Actions, Owner, Deadline and Success Measures. Agree maintenance /responsibilities of tracker updates including escalation progress Agree forum/s to review tracker progress Demonstrate impact and outcomes of Actions Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.	Head of Dietetics and Weight Management Services	30/09/2025			Completed	Completed	0	"Live tracker created. Updated by Business Support Mananger and Professional Manager for AWMS. Overseen by Head of Service. Escalation process in place via Professional Manager to HOS and via service performance meeting Log of Actions for improvement initiatives are discussed routinely. All actions are smart and logged by month. Impact of outcomes and actions detailed in goal acheived section of live tracker."		"As per progress update Embedded practice operationalised and ongoing Copy of Improvement Plan tracker available on request."	30/09/2025
ABUHB-2425-13	Internal Audit	Waiting List Management	Reasonable	Chief Operating Officer	Medium	3.1	Investigation of Issues As part of the audit, key data was interrogated. For example, we queried: • The longest wait KPI reported seemed to relate to the same patient as it increased from 94 to 141 in the period. Management explained that this individual's referral had now been changed to urgent. • The DNA % for the cohort was 15.9% against a target of 5%. Management demonstrated how a number of initiatives had been implemented, with examples of improved rates from a move to self-led groups. Whilst it was reassuring that the above had been investigated/ challenged, this was not captured/ documented within the existing performance management reporting.	Agreed Action: Ensure all key data sets that are investigated, captured and documented using existing performance management reporting. Develop investigative issues log Agree maintenance and responsibilities of log updates including escalation process. Expected Evidence of Implementation: Implementation plan and target tracking matrix updated.	Head of Dietetics and Weight Management Services	30/09/2025			Completed	Completed	0	Investigation issue log created Maintinance via Professional Manager and Business Support Officer at 1:1's and Performance meetings Escalation process in place to HOS		As per progress update Embedded practice operationalised and ongoing Copy of Investigaton log available on request.	30/09/2025

ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	8.1	Access to systems We found that only two out of 18 wards, that we have visited, currently have ward clerks with "write access" to WNCR and were regularly tasked inputting data, such as inpatient notes related to ambulance bookings and assisting with patient discharge records. While there is an expectation that all ward clerks will be required to perform these duties in the future and possess the necessary skills to use WNCR accordingly, it is important to note that only 34 ward clerks received training and were granted access to WNCR in 2024. During our fieldwork, we noted that in the absence of a ward clerk, records management tasks were delegated to a Health Care Assistance (HCA), however, certain tasks remained incomplete, as the HCA did not have the same level of system access as the ward clerk (e.g. access to CWS and WPAS).	Agreed Action: To ensure WNCR training sessions are available to ward clerks. Expected Evidence of Implementation: Training logs.	Chief Nursing Information Officer (CNIO)	31/07/2025			Completed	Completed	0	November 2025: Training is underway, digital nurses have been attending sites and talking to ward sisters to identify training requirements.		Training is now being provided to ward clerks.	30/09/2025
2022.2	Internal	Tredegar Health & Wellbeing Centre 2023	Limited	Chief Operating Officer	Medium	R4	Management should obtain signed lease agreements with relevant parties at the earliest opportunity	Agreed. The provision of signed lease is being actively addressed so that they are in place well before the planned occupation of the building.	Project Director	01/06/2023			Completed	Completed	5	November 22025: "Dentist – Renegotiating the lease has begun after the death of the senior partner. Recommencing negotiations have respected the understandable sensitivities for the dental practice at this time. Some amendments to the lease and some costs (due to removal of items from the lease) and negotiations expected to conclude prior to January 2026 at this time. Pharmacist – has agreed head of terms, but additional negotiations around the opening and closing of the building on going once complete lease will be signed. Glan Yr Afon – Negotiating with the Practice on room usage ongoing and rooms are being monitored for activity. This may lead to reduction in room allocation and as such the lease so this monitoring has to be concluded first. This will run into November and may lead to a redrafting of the lease. If no redrafting required this should conclude in January 2026 but may take longer if the reduced room allocation leads to a redrafted lease/service charge Tredegar – Currently a Managed Practice negotiations stopped."April 2025: The leases are now reduced from 4 to 3 leases but the main sticking point is the service charge, it has now been agreed that the contractors will only pay for their demises. Unfortunately a new risk has come to the surface. The Welsh Risk Pool has questioned if they can indemnify contractors in ABUHB buildings. Both ABUHB W&F and SES supported by legal and Risk are working through the issues with the Welsh Risk Pool, It is estimated an agreement will be in place by the end of April 25.			
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.1	Job Planning compliance As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Agreed Action: Discuss accountability for progress to achieving 90% compliance in the bi-annual Divisional Performance reviews. Ensuring actions to address the compliance are captured in the Executive summary of these meetings. Expected Evidence of Implementation: The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.	Chief Operating Officer	30/09/2025			Completed	Completed	0			Performance issues discussed monthly Divisional Performance meetings. Highlight report and presentation sent to Execs following each meeting.	30/09/2025

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.3	Job Planning compliance As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Agreed Action: Vacant consultant posts will not be replaced until the whole team have an up-to-date job plan. Expected Evidence of Implementation: The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.	Director of Finance and Procurement	30/07/2025			Completed	Completed	0			A robust check of job planning compliance or evidence of definitive plans in place to achieve compliance is undertaken prior to any approval of a consultant post by the Med Dir.	30/09/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.6	Job Planning compliance As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Agreed Action: Accountability arrangements will be strengthened to ensure the Directorate Manager has oversight and is responsible for ensuring job planning takes place within the directorate. Expected Evidence of Implementation: The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.	Chief Operating Officer/Medical Director	31/07/2025			Completed	Completed	0			A letter was sent on 18/06/2025 by the Medical Director to all Divisional and Directorate Management, outlining their responsibilities in the job planning process. ''Accountability arrangements will be strengthened to ensure the Directorate Managers have oversight of progress of compliance and will have responsibility for supporting Clinical Directors to deliver job planning arrangements effectively and to the required standard within the directorate.''	30/09/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	2.1	Quality of approved of job plans Our testing of approved job plans showed: • 10 out of the 20 job plans did not contain personal outcomes for individuals even though this is stipulated in the guidance. The L2P function for recording service outcomes is not currently activated and thus, not being recorded. This position should be reviewed once the compliance position with contracted sessions and personal outcomes has been improved. These aspects need to be improved to ensure contractual obligations are adhered to and they are completed correctly.	Agreed Action: Work with L2P to establish whether the outcome section can be a mandatory field, preventing sign off until such time as this section is completed. Expected Evidence of Implementation: SMART objectives are evident in the operational section of each job plan. Job plans are not signed off until these are complete	Director of Workforce and OD	30/06/2025			Completed	Completed	0	August 2025: L2P is discussing the requirement with their development team. A view will be provided to the Medical Systems team by 24th June.		In line with L2P's standard process, the outcome section change is currently being reviewed with other customers to assess broader applicability, as the system is not developed solely for our use. This consultation phase is still ongoing, and an update is expect 25/11/25. If the proposals are approved, WOD will be able to confirm a development timeline for implementing the changes	30/06/2025

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	3.2	ESR Reconciliation Testing completed of the job plans and L2P found the following inaccuracies when reconciling to ESR: • 5 job plans out of 20 did not reconcile with ESR (4 underpayment and 1 overpayment on ESR) Records need to be correct to ensure actual sessions are being paid and there is no underpayment or overpayment taking place.	Agreed Action: Once all job plans are on the L2P system for a directorate it will be possible for Directorate Managers and BPAs to easily identify job planned session in L2P and compare with ESR. Monthly comparisons for completed job plans will be undertaken within the directorate. Expected Evidence of Implementation: When there is a variation to job planned session, this will be reflected in ESR to ensure Consultants are accurately paid.	Chief Operating Officer/Director of Finance	30/06/2025			Completed	Completed	1	Awaiting 90% compliance with job planning in the system. Review September 2025		Performance issues are discussed at the monthly Divisional Performance meetings. Highlight report and presentation sent to Execs following each meeting. COO signs off at monthly meetings.	30/09/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	3.1	ESR Reconciliation Testing completed of the job plans and L2P found the following inaccuracies when reconciling to ESR: • 5 job plans out of 20 did not reconcile with ESR (4 underpayment and 1 overpayment on ESR) Records need to be correct to ensure actual sessions are being paid and there is no underpayment or overpayment taking place.	Agreed Action: There is already an alert icon in the L2P system that identifies a sessional change in the job plan. Work with L2P to establish whether the current alert can be used to provide a reminder that a change form needs to be completed and submitted to pay roll. It may also be possible to add a link to the Change form. Expected Evidence of Implementation: When there is a variation to job planned session, this will be reflected in ESR to ensure Consultants are accurately paid.	Director of Workforce & OD	30/06/2025			Completed	Completed	0	The additional requirement will be discuss with L2P on 24th June with a view to establishing timeline and any cost implications.		In line with L2P's standard process, the alert change is currently being reviewed with other customers to assess broader applicability, as the system is not developed solely for our use. This consultation phase is still ongoing, and an update is expect 25/11/25. If the proposals are approved, WOD will be able to confirm a development timeline for implementing the changes	30/06/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	4.2	Operational forums The changes in the Medical E-Systems Board, Medical Leaders Group and infrequency and low attendance of the Job Planning Consistency Group has led to a lack of focus on job planning and compliance. These forums are key in ensuring actions are implemented along with risks and issues discussed in an appropriate forum. A possible refresh in these forums along with deep dives, rotational discussions on job planning elements and sharing of good practice within these forums could also assist with improving compliance and engagement.	Agreed Action: The terms of reference for the Job Planning Consistency Group will be reviewed and include identification of when to stand down a meeting and what action to take for persistent non-attendance. Good practice and key issues sections will be included in the agenda going forward. Expected Evidence of Implementation: Change in focus and culture such that job planning is seen as a vehicle to support demand capacity planning and delivering service objectives. Improved compliance.	Medical Director	31/07/2025			Completed	Completed	0			The Terms of Reference for the Job Planning Consistency Group have been updated to include the following: "The chair of the JPCG will be the Deputy Medical Director, who will report to the Medical Director and provide updates where appropriate. Members who cannot attend the JPCG meeting will be expected to contact the Deputy Medical Director and provide their apologies and where possible request an appropriate representative attend. The Deputy Medical Director will reserve the right to stand down a meeting in the event that there are no new items to discuss or there are insufficient representatives attending from the clinical divisions. In the event of repeated non-attendance from the same division the Deputy Medical Director will discuss with the Divisional Director with a view to ensuring appropriate representation going forward.'' There has been a significant improvement in attendance at these meetings, and a 'good practice' item has been added to the agenda and is discussed at each session.	30/09/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	4.1	Operational forums The changes in the Medical E-Systems Board, Medical Leaders Group and infrequency and low attendance of the Job Planning Consistency Group has led to a lack of focus on job planning and compliance. These forums are key in ensuring actions are implemented along with risks and issues discussed in an appropriate forum. A possible refresh in these forums along with deep dives, rotational discussions on job planning elements and sharing of good practice within these forums could also assist with improving compliance and engagement.	Agreed Action: The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with the division of Medicine. Expected Evidence of Implementation: Change in focus and culture such that job planning is seen as a vehicle to support demand capacity planning and delivering service objectives. Improved compliance.	Medical Director	31/07/2025			Completed	Completed	0			Targeted Deep Dive meetings have been conducted with 5/7 directorates identified as below the 90% target of job plan compliance for consultants. These sessions have led to measurable improvements: Mental Health achieved 91% compliance as of August 2025, and Medicine demonstrated a notable increase of 41.6% from Feb 2025 to Oct 2025. In addition, Primary Care reached 100% compliance in August without requiring a Deep Dive meeting. Significant improvement has been made with 12 directorates having achieved consultant job planning compliance rates of 90% or higher, with several attaining full compliance at 100%. As of October 2025, the compliance rate for the Health Board is 58.6%. From October 2025 Dashboard out of 563 consultants: 330 job plans are complete 93 job plans are in progress - 16.5% 38 job plans are not started/expired - 6.7% 52 job plans are non-compliant with reason - 9.2% 41 job plans are awaiting signatures - 7.3%	30/09/2025

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	4.3	Operational forums The changes in the Medical E-Systems Board, Medical Leaders Group and infrequency and low attendance of the Job Planning Consistency Group has led to a lack of focus on job planning and compliance. These forums are key in ensuring actions are implemented along with risks and issues discussed in an appropriate forum. A possible refresh in these forums along with deep dives, rotational discussions on job planning elements and sharing of good practice within these forums could also assist with improving compliance and engagement.	Agreed Action: The Chief Operating Officer and Divisional Directors will escalate strategic issue highlighted through Performance meetings to the Deputy Medical Director. Operational issues will be dealt with within the division. Expected Evidence of Implementation: Change in focus and culture such that job planning is seen as a vehicle to support demand capacity planning and delivering service objectives. Improved compliance.	Chief Operating Officer	31/07/2025			Completed	Completed	0			Performance issues discussed monthly Divisional Performance meetings. Highlight report and presentation sent to Execs following each meeting.	30/09/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	Medium	4.4	Operational forums The changes in the Medical E-Systems Board, Medical Leaders Group and infrequency and low attendance of the Job Planning Consistency Group has led to a lack of focus on job planning and compliance. These forums are key in ensuring actions are implemented along with risks and issues discussed in an appropriate forum. A possible refresh in these forums along with deep dives, rotational discussions on job planning elements and sharing of good practice within these forums could also assist with improving compliance and engagement.	Agreed Action: Regular performance reports will be submitted to Performance Oversight Committee section of the Executive Committee. Expected Evidence of Implementation: Change in focus and culture such that job planning is seen as a vehicle to support demand capacity planning and delivering service objectives. Improved compliance.	Medical Director / Director of Workforce & OD	31/07/2025			Completed	Completed	0			Performance update provided to Executive Team 18th Sept 2025. Workforce Oversight Performance Report presented 16th October 2025.	30/09/2025
ABUHB-2425-27	Internal Audit	Energy Management	Reasonable	Chief Operating Officer	Low	3.1	The Energy Manager should liaise with the Estates team to establish how utility-cost elements of lease charges to third parties are determined, and whether there is benefit to improved engagement at future leases to ensure forecast UHB energy costs are sufficiently incorporated.	AGREED – The Energy Team is now integrated into the Capital Projects & Property Management section; which will facilitate communication and understanding of lease requirements and potential arrangements to recharge utilities if deemed appropriate under the wider lease agreements. Discussions on a case by case basis on potential for submetering will take place with relevant internal and external stakeholders.	Energy Manager	31/03/2025			Completed	Completed	0			In line with management response the Energy Manager formally reports now to the Assistant Head of Capital and Property, so is linked into all discussions around premises. Submetering options will be looked on a case by case basis.	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	1.1	Applicant financial capability checks There was little record retained of the financial checks made on individuals or their businesses to ascertain their capability to finance a medical practice, including financial due diligence and other associated risks (e.g. availability of GPs across the region and the potential resulting impact on service delivery).Consideration should also be given to financial stress/ sensitivity testing, incorporating any lessons learnt from the current exercises. The Health Board should consider the reviews and checks performed by NHS Wales Shared Services Partnership, including for the Medical Performers List and determine if enhancements are required to the process.	Agreed Action: The Division recognises the importance of comprehensive financial due diligence, and whilst acknowledging the usual formal approach was taken in line with NHS Wales Shared Services Partnership checks, including the Medical Performers List checks, accepts that enhanced financial checks could improve robustness. The Division has committed to developing aSOP in respect of the vacant practice process which, in the absence of formal guidance within the WHC, will contain strengthened local financial due diligence processes and risk mitigation strategies in accordance with The Health Services (Provider Selection Regime) (Wales) Regulations 2025. Expected Evidence of Implementation: A comprehensive SOP will be	Head of Primary Care	31/07/2025			Completed	Completed	0	Robust standardised due diligence checklist developed and incorporated into the SOP. The due diligence checklist is comprised of 2 parts, the first including requirements as part of any tender submission (e.g., copies of audited accounts and credit checks) and the second includes elements expected to be in place upon contract commencement (public liabilty insurance, payroll systems etc).		"Final SOP in place to support the management of vacant GP practices, incorporating a robust due diligence checklist and resource forecast template. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	2.1	Binding service levels The GMS regulations 2023 require all services covered by the GMS contract to be included – including any services added through the update of the regulations. Whilst not a requirement of the Welsh Health Circular/ GMS Contracts Regulations, where possible, provider contracts and/or monitoring arrangements should incorporate the material, metrics and commitments made during the bidding process.	Agreed Action: The GMS Contract is a nationally agreed contract and amendments to the core contract are not within Health Board control. Alternative contractual arrangements, such as the Alternative Provider Medical Services contract (APMS), would provide a contracting route to enable Health Boards to contract outside of a standard GMS Contract, but this would provide variation to GP service provision in ABUHB. The Division recognises the importance of ensuring providers adhere to commitments made during the procurement process and as such, will implement a mandatory period of enhanced 4monitoring upon successful contract award where evidence of such compliance will be reviewed. Expected Evidence of Implementation:	Head of Primary Care	31/07/2025			Completed	Completed	0	"Full enhanced monitoring framework developed and included in the SOP, for automatic implementation upon contract commencement for a period of 12 months as a minimum, with the ability to extend if required. The agreement to the enhanced monitoring is required as part of the tender submission for any incoming partnership."		"Final SOP in place to support the management of vacant GP practices, incorporating a robust enhanced monitoring framework. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	3	Applicant business case scoring model The business case scoring model was amended mid-use to bring in a previously unscored element. It is recognised that this did not affect the overall result, as it was applied to all candidates. Scoring models should not be changed during the process to reduce the risk of any potential challenge to the award from unsuccessful parties. Where changes are made, the associated rationale and approvals should be fully documented.	Agreed Action: The Division acknowledges the finding regarding the scoring model, accepting that this did not affect the overall result. The Division recognises the importance of scoring model integrity, a formal approval process will be introduced for any unavoidable scoring adjustments. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to reflect these Regulations. Any future letting will be in accordance with these Regulations and will be managed in conjunction with NHS Wales Shared Services Partnership Procurement. Expected Evidence of Implementation: Amendment of	Head of Primary Care	31/07/2025			Completed	Completed	0	"Vacant Practice Policy updated to reflect 2025 procurement regulations and detailed scoring criteria, set as part of the procurement documentation. Incorporated into the SOP. "		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	4.1	Applicant interview questions Interviews for the Brynmawr practice should have been held with each applicant using the same questions but were not. Whilst the questions fell within similar themes, the individual questions differed significantly in depth/ breadth – making comparison difficult. Conversely, a standardised approach was observed for the letting of the Tredegar practice letting. A standardised approach reduces the risk of challenge to the award from unsuccessful parties.	Agreed Action: The Division acknowledges that whilst themed questioning was used to accommodate different presentation content and avoid duplication, ensuring consistency in structure across all interviews provides fairness and transparency. Recognising the importance of both structured assessment and thematic flexibility, enhancements to interview standardisation will be introduced.	Head of Primary Care	31/07/2025			Completed	Completed	0	"Clear criteria for interview structure incorporated into the revised Vacant Practice Policy, shared as part of the tender documentation. Included in the SOP."		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear interview structure. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	5.1	Applicant interview scoring model: There was a disconnect between interview question responses and interview scores attributed and we were unable to establish a mapping between the interview questions and the themes that were scored.	Agreed Action: Recognising the need for transparent scoring, enhancements will be implemented to strengthen interview frameworks, ensuring clear mapping between responses and scores, to mitigate risks associated with any potential inconsistency. Expected Evidence of Implementation: Supported by procurement and in accordance with PSR, scoring criteria will be developed and explicitly mapped to interview questions, ensuring a direct correlation between responses and evaluation metrics. A structured scoring matrix will be implemented to ensure transparency, consistency, and fairness in assessments. The SOP will include further detail on this.	Head of Primary Care	31/07/2025			Completed	Completed	0	Scoring criteria and matrix included in revised Vacant Practice Policy and SOP. Shared as part of the tender documentation.		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scorign matrix and criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	6.1	Shortened practice launch timetable There was a tight practice launch timetable (contract signed on 15th December 2023 for a contract commence date of 1st January 2024), which may have impacted new service delivery. Whilst the Policy sets out a three month period for the transfer lead in time, the Health Board can also agree to a reduced timetable, dependent upon the circumstances. Likewise, there is a preference to align the transfer to the end of a financial quarter. Therefore, there should be scrutiny over the feasibility of the timetable proposed and / or justification documented.	Agreed Action: The Division has confirmed that the agreed commencement date of the 1 January 2024 in respect of Tredegar Medical Practice was to align with the opening of the new Health and Wellbeing Centre, in order to minimise any disruption to staff and patients as far as possible. This was in full agreement with the incoming partnership. Whilst flexible timelines are sometimes necessary, the Division acknowledges that ensuring feasibility and documenting justifications are crucial to maintaining transparency, mitigating risks, and safeguarding service continuity. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to	Head of Primary Care	31/07/2025			Completed	Completed	0	"Vacant Practice Policy revised to reflect the 2025 procurement regulations and associated timescales. Included in the SOP, along with a Transition plan template, capturing timescales and any adjustments/rationale. Adherence to the 2025 procurement regulations will be ensured through compliance with SOP. "		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and transition plan template. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	2.1	Binding service levels The GMS regulations 2023 require all services covered by the GMS contract to be included – including any services added through the update of the regulations. Whilst not a requirement of the Welsh Health Circular/ GMS Contracts Regulations, where possible, provider contracts and/or monitoring arrangements should incorporate the material, metrics and commitments made during the bidding process.	Agreed Action: The GMS Contract is a nationally agreed contract and amendments to the core contract are not within Health Board control. Alternative contractual arrangements, such as the Alternative Provider Medical Services contract (APMS), would provide a contracting route to enable Health Boards to contract outside of a standard GMS Contract, but this would provide variation to GP service provision in ABUHB. The Division recognises the importance of ensuring providers adhere to commitments made during the procurement process and as such, will implement a mandatory period of enhanced 4monitoring upon successful contract award where evidence of such compliance will be reviewed.	Head of Primary Care	31/07/2025			Completed	Completed	0	"Full enhanced monitoring framework developed and included in the SOP, for automatic implementation upon contract commencement for a period of 12 months as a minimum, with the ability to extend if required. The agreement to the enhanced monitoring is required as part of the tender submission for any incoming partnership."		"Final SOP in place to support the management of vacant GP practices, incorporating a robust enhanced monitoring framework. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	3.1	Applicant business case scoring model The business case scoring model was amended mid-use to bring in a previously unscored element. It is recognised that this did not affect the overall result, as it was applied to all candidates. Scoring models should not be changed during the process to reduce the risk of any potential challenge to the award from unsuccessful parties. Where changes are made, the associated rationale and approvals should be fully documented.	Agreed Action: The Division acknowledges the finding regarding the scoring model, accepting that this did not affect the overall result. The Division recognises the importance of scoring model integrity, a formal approval process will be introduced for any unavoidable scoring adjustments. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to reflect these Regulations. Any future letting will be in accordance with these Regulations and will be managed in conjunction with NHS Wales Shared Services Partnership Procurement. Expected Evidence of Implementation:	Head of Primary Care	31/07/2025			Completed	Completed	0	"Vacant Practice Policy updated to reflect 2025 procurement regulations and detailed scoring criteria, set as part of the procurement documentation. Incorporated into the SOP."		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	4.1	Applicant interview questions Interviews for the Brynmawr practice should have been held with each applicant using the same questions but were not. Whilst the questions fell within similar themes, the individual questions differed significantly in depth/ breadth – making comparison difficult. Conversely, a standardised approach was observed for the letting of the Tredegar practice letting. A standardised approach reduces the risk of challenge to the award from unsuccessful parties.	Agreed Action: The Division acknowledges that whilst themed questioning was used to accommodate different presentation content and avoid duplication, ensuring consistency in structure across all interviews provides fairness and transparency. Recognising the importance of both structured assessment and thematic flexibility, enhancements to interview standardisation will be introduced. Expected Evidence of Implementation: While maintaining thematic flexibility, predefined core questions will be applied uniformly to all candidates and clear guidelines will be established for question variation, ensuring fairness without compromising depth or relevance. These elements will be incorporated into the SOP (MA 1)	Head of Primary Care	31/07/2025			Completed	Completed	0	"Clear criteria for interview structure incorporated into the revised Vacant Practice Policy, shared as part of the tender documentation. Included in the SOP."		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear interview structure. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	5.1	Applicant interview scoring model There was a disconnect between interview question responses and interview scores attributed and we were unable to establish a mapping between the interview questions and the themes that were scored.	Agreed Action: Recognising the need for transparent scoring, enhancements will be implemented to strengthen interview frameworks, ensuring clear mapping between responses and scores, to mitigate risks associated with any potential inconsistency. Expected Evidence of Implementation: Supported by procurement and in accordance with PSR, scoring criteria will be developed and explicitly mapped to interview questions, ensuring a direct correlation between responses and evaluation metrics. A structured scoring matrix will be implemented to ensure transparency, consistency, and fairness in assessments. The SOP will include further detail on this.	Head of Primary Care	31/07/2025			Completed	Completed	0	"Vacant Practice Policy updated to reflect 2025 procurement regulations and detailed scoring criteria, set as part of the procurement documentation. Incorporated into the SOP."		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scorign criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

ABUHB-2425-27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	6.1	Shortened practice launch timetable There was a tight practice launch timetable (contract signed on 15th December 2023 for a contract commence date of 1st January 2024), which may have impacted new service delivery. Whilst the Policy sets out a three month period for the transfer lead in time, the Health Board can also agree to a reduced timetable, dependent upon the circumstances. Likewise, there is a preference to align the transfer to the end of a financial quarter. Therefore, there should be scrutiny over the feasibility of the timetable proposed and / or justification documented.	Agreed Action: The Division has confirmed that the agreed commencement date of the 1 January 2024 in respect of Tredegar Medical Practice was to align with the opening of the new Health and Wellbeing Centre, in order to minimise any disruption to staff and patients as far as possible. This was in full agreement with the incoming partnership. Whilst flexible timelines are sometimes necessary, the Division acknowledges that ensuring feasibility and documenting justifications are crucial to maintaining transparency, mitigating risks, and safeguarding service continuity. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the	Head of Primary Care	31/07/2025			Completed	Completed	0	"Vacant Practice Policy revised to reflect the 2025 procurement regulations and associated timescales. Included in the SOP, along with a Transition plan template, capturing timescales and any adjustments/rationale. Adherence to the 2025 procurement regulations will be ensured through compliance with SOP. "		"Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and transition plan template. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-28	Internal Audit	Health Board Managed Practices	Reasonable	Chief Operating Officer	Medium	1.1	Standard operating procedure for letting a managed practice Whilst there is a vacant practice policy that covers this area, the Health Board did not have a standard operating procedure (SOP) that set out the steps to be followed for the letting of vacant practices. The SOP should provide further clarity on the expected contract letting arrangements of both vacant and Health Board managed practices – complimenting both the Welsh Health Circular and Vacant Practice Policy.	Agreed Action:The Division accept this recommendation regarding the development of Standard Operating Procedure (SOP) for the letting of all vacant practices, including directly managed practices, to complement the existing vacant practice policy. We recognise the importance of having a clearly defined process to ensure consistency, transparency, and compliance with relevant regulations. The Division would support a recommendation to Welsh Government to review the WHC 2006, to update the guidance to incorporate the latest regulations and guidance including The Health Services (Provider Selection Regime) (Wales) Regulations 2025. Expected Evidence of Implementation: Development of SOPA comprehensive SOP will be developed to outline the procedural steps for contract	Head of Primary Care	31/07/2025			Completed	Completed	0	"Comprehensive SOP developed for the management of vacant GMS practices, outlining procedural steps required. SOP considered and agreed by Dvisional Senior Leadership Team. Tested alongisde procurement process and revised as needed to produce final version."		"Final SOP in place to support the management of vacant GP practices via the Vacant Practice Policy. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025
ABUHB-2425-28	Internal Audit	Health Board Managed Practices	Reasonable	Chief Operating Officer	Medium	2.1	Application submission deadlines. The Health Board's Vacant Practice Policy outlines: • Advertisement of Vacant/ Managed practices – by week 5 • Closing date expression of advert – by week 11 We noted an application submission deadline that allowed a shorter interval (three/ four weeks) for applications for the practice lettings rather than the six	Agreed Action: The Division acknowledges the finding regarding the variance in application submission deadlines for vacant practice lettings. While the existing Vacant Practice Policy outlines a recommended time period for applications, some cases have permitted a shorter interval as was the case with Tredegar Health Centre to allow for alignment with the opening of the new Health and Wellbeing Centre in order to minimise disruption for both staff and patients. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to reflect these Regulations. Any future letting will be in accordance with these Regulations and will	Head of Primary Care	31/07/2025			Completed	Completed	0			"Final SOP in place to support the management of vacant GP practices via the Vacant Practice Policy. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

ABUHB-2425-28	Internal Audit	Health Board Managed Practices	Reasonable	Chief Operating Officer	Medium	3.1	Stakeholders absent from interview panel Whilst not required at the interview panel to meet quoracy requirements, the following was noted: • Neighbourhood Care Network representation was missing from the interview panel for the Aberbeeg, Brynmawr, Bryntirion and Blaenavon practice letting. • Both Neighbourhood Care Network Lead and Llais representatives were not in attendance for the Tredegar practice letting.	Agreed Action: The Division acknowledges the audit finding regarding the absence of certain stakeholders from the interview panels for practice lettings. While their attendance was not a requirement to meet quoracy, we recognise the potential value of their participation in ensuring a balanced and comprehensive evaluation process. Whilst we endeavour to ensure full stakeholder participation in interview panels, attendance can be subject to external factors such as availability and unforeseen circumstances, this is particularly evident with organisations outside of the Health Board i.e. Llais. In cases where key stakeholders are unable to attend, the Health Board remains committed to maintaining a fair and objective selection process. Expected Evidence of Implementation:	Head of Primary Care	31/07/2025			Completed	Completed	0	Clear communication plan developed and included in the new SOP.		"Final SOP in place to support the management of vacant GP practices, incorporating a clear communications plan. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)"	30/09/2025

Appendix B Revised Deadline Requests

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
ABUHB-2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	2.1	Monitoring and communicating arrangements Whilst discussion and updates are provided at numerous committees, in addition to the Board. However, there is no detailed specific monitoring / challenge over the delivery (or non-delivery) of actions within the Plan against agreed timeframes and the intended outcomes. In addition, where actions are not delivered on time there is no formal escalation or subsequent tracking over any remediation.	Agreed Action: • We will continue discussions and updates at various committees and the Board, emphasising the need for detailed monitoring and challenge over long-term actions and outcomes – using the performance and accountability framework. • The 90-day improvement plan has evolved into a broader, long-term improvement program, focusing on culture change and workforce development, requiring sustained effort and commitment. These measures will enhance accountability and ensure timely delivery ofinitiatives. Expected Evidence of Implementation: • Monthly Divisional Assurance Review Meetings. • Quarterly Divisional Performance Review Meetings. • Corporate teams – 6 monthly assurance review meetings. • Internal Divisional and corporate team arrangements • Performance meeting including key metrics and delivery against agreed trajectories and forecast.	Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates	30/09/2025	31/12/2026		Overdue	Overdue	1	November 2025:Conntinuous reporting through daily, fortnightly, and monthly meetings and the reinstated MH&LD Committee A range of meetings take place, daily safety flow, weekly patient flow and monthly meetings e.g. DMT, Exec Assurance, Finance, QPSE, wider DMT to include all SLTs within the Division • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. Regular attendance at QPSOG with submission of reporting slides monthly • Improvement plan aligns with Health Board's Quality Strategy and new accountability framework. Expected Evidence of Implementation: All Wales MH Strategy now published, Divisional strategy aligns with the principles. Accountability framework in place via Exec Assurance and Divisional dashboards in place • Monitor against the Performance Management and Accountability Framework (PMF) at Divisional Assurance (DA) meetings, quarterly and mid-year reviews with the wider execs. HB process in place, with meetings in place for MHLD to comply with reporting requirements, feedback and remedial actions addressed with appropriate responses provided • Agreed workplan for the MH&LD Committee and plan for the year – starts April 2025. A forward workplan is now in place • Triangulate inspection and audit data, linking it with the wider QPS team identifying any trends or areas of concerns. Mock HIW inspections in place, AMH will complete wards by September. OA and LD in progress. Action plans in place to address any deficits, themes collated across "			30/09/2025
ABUHB-2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	3.1	Implementation The 90-day action plan was originally scheduled for completion by December 2023. However, as of January 2025, we confirmed three out of the four actions have been fully completed with one action partially complete. Whilst we confirmed that progress has been made against each of the actions, with considerable work completed / underway, the Plan has still not been fully delivered. Overall, we found that the Plan lacked specific delivery milestones and we found multiple live records in use to record status updates. Upon implementation of the Plan, there is value in reviewing the process adopted for the delivery and monitoring of actions to inform future plans. In particular, how accountability for the delivery of actions is maintained.	Agreed Action: • From September 2024, MH&LD transitioned into Phase 2 of the Improvement Plan, focusing on sustaining actions and developing long-term initiatives. • The Triumvirate and senior leadership team are now permanent, with ongoing efforts in culture change and workforce development. • A robust monitoring framework is being implemented, including detailed tracking, regular progress reviews, and formal escalation procedures. This will have oversight by the COO and the QPS Team. • Staff training and development are prioritised to enhance accountability and ensure timely delivery of actions. Expected Evidence of Implementation: • Staff engagement events scheduled. • Participate in National events. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk process. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking	Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates	30/09/2025	31/12/2026		Overdue	Overdue	1	November 2025:: "Many aspects of the Improvement plan are now incorporated as BAU. Division has formal inks to Corporate QPS team with attendance at regular meeting QPS/ Risk management meetings Training team has been realigned to deliver Divisional priorities, line management moved to Divisional Nurse to ensure CTP, WAARN compliance is visible and improving Incident management process enhanced with daily touchpoint meeting to review and direct action for every reported incident. Additional staff training in respect of concise or comprehensive status Staff engaged in national workstreams as directed by the MH strategic programme Mock HIW process used to assess compliance against a range of metrics, action plans in place with updates at Directorate Assurance Regular reporting at IQPD and WG Performance meetings"			30/09/2025
ABUHB-2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	4.1	Intended outcomes We found progress is being made in implementing the 90-day actions; however, not all actions have been fully implemented, preventing us from determining if the Division is achieving the intended outcomes. Completing a post-plan analysis would be beneficial in outlining the necessary steps to embed these actions once they are all fully implemented.	Agreed Action: • Tight oversight on Disability Division for serious incidents and governance. • Improvement plan sustained. • Initiatives in workforce, leadership, performance, risk, and service changes progress. • Reporting to key committees and meetings. • NHS Executive Colleagues' advisory role continues. Expected Evidence of Implementation: • Staff engagement events / staff survey results. • Staff retention. • Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices. • Robust audit and risk processes/plans in place. • Continue regular reporting to committees. • Agreed workplan for the MH&LD Committee and plan for the year. • Triangulate inspection and audit data, linking it with the wider QPS team and escalate when needed. • Continue monthly IQPD reporting. • Continue reporting to JET twice yearly. • Bespoke Board Development sessions, as	Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates	30/09/2025	30/06/2027		Overdue	Overdue	1	November 2025: Improvement for management of serious incidents, now embedded as BAU Division is progressing OCP to revise management structure and ensure alignment to delivery of HB and WG priorities MHA formal quarterly meeting now in place with wider remit, chaired by HB vice chair Cultural change programme commenced June 2025 with a 2 year timescale. Initial priority areas identified Staff vacancies reduced and lower turnover, likely to be fully recruited for nursing early 2026 Positive feedback from HIW inspections, no immediate assurance required on 2025 reports"			30/09/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	High	3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB "kitemark" will be added to reports so this will be clearly visible.	Chief Information Officer	31/07/2025	31/03/2026		Overdue		1	November 2025: The dynamic planning project has delivered a suitable alternative to Lightfoots sfn platform via the NDR.The Head of Information Management and Analytics commenced in post on 3rd November and will be progressing the implementation of the Centre of Excellence as referenced in the Data & Analytics strategy over the coming months.			30/09/2025

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.2	Job Planning compliance As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Agreed Action: The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with Medicine. Expected Evidence of Implementation: The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.	Medical Director	30/07/2025	28/02/2026		Overdue		1	"Targeted Deep Dive meetings have been conducted with 5/7 directorates identified as below the 90% target of job plan compliance for consultants. These sessions have led to measurable improvements: Mental Health achieved 91% compliance as of August 2025, and Medicine demonstrated a notable increase of 41.6% from Feb 2025 to Oct 2025. In addition, Primary Care reached 100% compliance in August without requiring a Deep Dive meeting. Significant improvement has been made with 12 directorates having achieved consultant job planning compliance rates of 90% or higher, with several attaining full compliance at 100%. As of October 2025, the compliance rate for the Health Board is 58.6%. From October 2025 Dashboard out of 563 consultants: 330 job plans are complete 93 job plans are in progress - 16.5% 38 job plans are not started/expired - 6.7% 52 job plans are non-compliant with reason - 9.2% 41 job plans are awaiting signatures - 7.3%"			30/09/2025
4510A2024	External Audit	Structured Assessment 2024	Not Rated	Director of Corporate Governance	N/A	2.1	To enable more effective scrutiny of delivery of corporate plans and strategies, the Health Board should ensure that progress reports are clear and contain performance targets and comparative benchmarks, where possible. Reports should also contain clear progress against established milestones to aid scrutiny of progress.	Work is underway to develop report templates and supporting guidance setting out requirements and standards. Report writing training will also be delivered to senior teams responsible for preparing board and committee papers.	Director of Corporate Governance	30/09/2025	30/04/2026		Overdue		1	November 2025: A brief has been prepared to secure report writing training with procurement paused in light of the financial outlook for 2025/26. In the meantime the Corporate Governance Team will review templates and guidance, aligning with the Board's recently approved long-term strategy.			30/09/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	6.1	The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to assess patients when required.	The Local Authorities and Health Board have undertaken a review of opportunities to embed a Trusted Assessor model against national best practice and local datasets for Pathway of Care Delays linked to assessment codes. Three areas of recommendation have been presented to Integrated Discharge Board to progress. Integrated front door • Embedding of quality conversations that promote positive risk management through the Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces. Review undertaken of assessment code delays from POCD datasets, top areas identified. • Embedding of DST model in the community not hospital to reduce 'joint assessment' delays, December figures reduced dramatically following focus on this.	Director of Nursing	31/03/2025	31/03/2026		Overdue	Overdue	1	The health baord continues working with national and local partners to further develop the trusted assessor model. Currently the most established trusted assessor model is the Home first model. The Home First team works on behalf of all five Gwent local authorities at the front door of the Grange Hospital. The staff in the team work across Gwent using a trusted assessor model. This is facilitated by a single point of access, where health and social care professionals can refer individuals using one contact number, streamlining the process and enabling timely intervention. Within this framework, trusted assessors from social care are empowered to make decisions about care packages, equipment, or onward referrals without the need for further approval, which helps to minimise delays and ensure equitable delivery across the region. Home First have strong relationships with each individual local authority and are empowered to act on their behalf empowering early decision making			30/09/2025
4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	7.1	The Health Board should monitor compliance with its discharge policy to assess the effectiveness and consistency of the application, and whether the intended outcomes are being achieved. This includes adhering to its own policy that an annual programme of learning will be reported to the Patient Quality, Safety and Outcomes Committee.	Data collected via POCD, CWS2 length of stay and discharge work streams will form the cornerstone of improving guidance, shaping the educational programme and focusing resources to improve and evaluate outcomes. Further development of CWS2 to replace the Complex List. Formal dashboard in development and reported to the Integrated Discharge Board. Learning and feedback to be presented at local forums and integrated boards and the patient Quality outcomes committee	Director of Nursing and Director of Digital	31/03/2025	31/03/2026		Overdue		1	the Health Board Discharge policy has been recently simplified as part of the wider review and discharge improvement programme. Key Elements have been identified for increased awareness and education particularly in relation to best interest decisions and patient choice. POCD monthly meetings and scrutiny panels on-going as part of the wider discharge programme under the Integrated Discharge board governance structure.			30/09/2025

4775A2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	9.1	The Health Board should improve record keeping by: 9.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.	Monthly Audits: Ward staff conduct monthly audits of nursing documentation to assess the standard and detail of information recorded in patient records. This includes Admission documents, Risk Assessments, Care Records, and Discharge documents. Ward Accreditation Programme: The completion and detail of information recorded on these documents are included in the Ward Accreditation programme, which ensures that staff are aware of the importance of comprehensive documentation. Electronic WNCR Programme: Discharge Planning documentation is available on the electronic WNCR programme, which facilitates better access and understanding of the importance of documenting comprehensive information. Audit Results: Recent audits have shown room for improvement in documenting estimated discharge dates (EDD) and discharge planning. For example, the	Director of Nursing	30/04/2025	31/03/2026		Overdue	Overdue	1	The Health Board has implemented a ward accreditation programme with bronze, silver and gold levels that can be acheived. This is a recognised process through which wards and teams are assessed and recognised for their quality care and safety standards. The accreditation process aims to improve patient care by ensuring areas meet certain benchmarks such as cleanliness, staff performance, safety protocols, improvement projects and overall patient experience. ABUHB are currently rolling out accreditation across the health board with new teams joining the process every month. Most areas are at the beginning of their accreditation development - we would like to recognise their journey from bronze through to platinum. In addition, roll-out of CWS2 continues aiming to standardize processes around discharge planning pathways as part of the optimal hospital flow framework programme.			30/09/2025
4693A2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Workforce and OD	N/A	4.2	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: monitoring and reporting on completion rates for the Duty of Quality and Duty of Candour e-learning.	Monitoring of all statutory and mandatory training compliance is published on a monthly basis, including Duty of Candour. Duty of Quality will be included once approved by the Core Learning Advisory Committee.	Director of Workforce & Organisational Development	30/07/2025	31/03/2026		Overdue		1	Duty of Candour has been through the Core Learning Committee and the Staff Segment Report completed, which identifies the staff groups requiring this training in ESR. This information has been sent to the Organisational Development Coordinator to move to stage 4 of the process. Duty of Quality to go through Core Learning Advisory Committee for approval.			30/09/2025
4916A2025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	1.1	Risk Management within plans - The Health Board should ensure that in future Six Goals for Urgent and Emergency Care Plans, all identified risks have clear risk owners and that mitigating actions have clear target dates (Exhibit 2).	The Six Goals Programme maintains a centralised risk register and action log; to strengthen our assurance process the register will be reviewed and updated regularly, with escalation routes clearly defined for significant risks. In addition, risk management will be strengthened across the Six Goals for Urgent and Emergency Care Programme, in the following ways: • all identified risks within the Programme will have named owners accountable for ongoing oversight, escalation, and resolution. This will be reflected consistently in the risk register and programme documentation. • each mitigating action will have clear target dates and associated leads. This will ensure timely intervention and provide a basis for tracking progress at Programme Board level. These improvements will be in place ahead of the September 2025 Programme Board meeting. Progress will be monitored by the Programme Team and reported to the Board quarterly to ensure sustained compliance.	Executive Director of Nursing	30/09/2025	31/03/2026		Overdue		1	Risk management will be strengthened across the Six Goals for Urgent and Emergency Care Programme, in the following ways: • all identified risks within the Programme will have named owners accountable for ongoing oversight, escalation, and resolution. This will be reflected consistently in the risk register and programme documentation. • each mitigating action will have clear target dates and associated leads. This will ensure timely intervention and provide a basis for tracking progress at Programme Board level. These improvements will be in place ahead of the September 2025 Programme Board meeting. Progress will be monitored by the Programme Team and reported to the Board quarterly to ensure sustained compliance.			30/09/2025
4916A2025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	9.1	Primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board: To ensure the Health Board has a broad understanding of demand pressures and the interaction of urgent and emergency care services, it should ensure there is primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board (Exhibit 10).	Current board membership includes broad representation from partners such as WAST, Llais, NHS Executive, and Local Authorities. Primary and Community Care (PCC) Division is represented by two Senior Responsible Officers who are part of the PCC divisional leadership team. In addition, primary care clinicians aligned to transformation initiatives are invited to participate.However, we acknowledge that regular clinical commitments can limit attendance and input from practising primary care clinicians. To address this, we will: • extend a standing invitation to all Neighbourhood Care Network (NCN) Leads, ensuring broader clinical representation across the geography; • review scheduling and format of board meetings to improve accessibility for primary care participants; • explore alternative models of engagement. These changes will be implemented by the end of Q2 2025, and the effectiveness of this enhanced representation will be reviewed at the end of the year as part of the Programme Board's annual	Director of Nursing	30/09/2025	31/03/2026		Overdue		1	The Six Goals programme board has been temporarily stepped down during winter months however, following revised winter structures The Six Goals programme board terms of reference will be extended to include the following additional groups. Neighbourhood Care Network (NCN) Leads, ensuring broader clinical representation across the geography; review scheduling and format of board meetings to improve accessibility for primary care participants;			30/09/2025

ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	Medium	3.1	Record of Legislative and Statutory Requirements There was an electronic Health and Safety Legislative & Statutory Register for all relevant requirements, but this was out of date and should be reviewed. The Health and Safety and Fire Work Plan 25-26 (H&S WP 25-26 -079) included a corresponding high priority action (with a target date of 31 May 2025) to address this, but work had not commenced at the time of the audit.	Agreed Action: The Health and Safety Legislative & Statutory Register has been reviewed and updated. The revised register will be presented at the next Health and Safety Committee in September 2025. The Health and Safety Legislative & Statutory Register will be reviewed annually via the Health and Safety Committee to ensure it is appropriately maintained. Health and safety performance has been and will continue to be regularly reported to the Executive Committee. Expected Evidence of Implementation: • Health and Safety Legislative & Statutory Register • Health and Safety Committee Notes of September 2025 meeting	Head of Health, Safety and Fire	30/09/2025	31/12/2025		Overdue		1	The revised Health and Safety Legislative & Statutory Register is on the agenda for the Health and Safety Committee on 10 December 2025 for sign off.			30/09/2025
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	31/03/2026		Overdue	Overdue	6	September 2025 - Digital strategy development now commenced following Board approval of Gwent 2035 strategy. Executive Team presentation completed with further engagement across the Health Board planned.April 2025 - Data & Analytical Strategy approved by the Executive Committee and work on component strategies underway for Health & Care Record, Information Governance / Cyber Security and Technical Infrastructure. The Digital Strategy will be reissued following the publication of the Health Board's 10 year strategy."" ""January 2025 Digital champions across all in-patient areas for WNCR Digital Clinical Council reformed and meeting 5th Dec '24, Reporting to Clincial Advisory Forum At the request of Planning, the development of a new Digital Transformation Strategy for ABUHB will commence once the ABUHB 10 year strategy has been agreed. An OCP has been agreed and will be consulted on in Q4 2024/25 that includes a refreshed strategy, planning and engagement function that will further develop stakeholder engagement at local, regional and nationakl level. """"August 2024: Digital Champions in place through the M365 Team. Business partnering to be reviewed by DDaT Senior Leadership Team"" January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been			
2023.06	Internal	Estates Condition - Jan 2024	Limited	Director of Planning, Strategy and Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	Director of Strategy, Planning and Partnerships	31/03/2024	30/09/2026		Overdue	Overdue	2	November 2025: Work is underway to re-establish estate baseline information in order to then align with strategy. Alongside this the specification for the Facet Survey is being developed in order to procure a company to undertake the surveys on behalf of the Health Board. This work will commence in the new year and is likely to conclude in approx 6-8 months. Following this findings will then be aligned in order to develop the HEalth Boards Estates Strategy.May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development sesslion on Estates. Estates Strategy to follow Organisational Strategy. June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat."			
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R6	Consideration should be given to enhancing the use of SolarWinds to enable full network monitoring and the use of the CatTool	"ABUHB partially accepts this recommendation in so far as the need for full network monitoring is recognised and will be addressed. The specific tool to do this will be decided once the event management review outlined previously has been completed "	Chief Technology Officer	31/07/2025	30/06/2026		Overdue		1	"October 2025 - We are collaborating with our SolarWinds partner to scope a platform upgrade, which will enable the use of additional licensed modules and features. The professional services engagement is included in a capital funding request. Block Solutions is implementing the Axiom monitoring platform as part of our support contract, providing enhanced oversight of hardware lifecycle, licensing, and network status. We are also assessing the integration of Cisco's Thousand Eyes for further monitoring capabilities, subject to cost considerations."April 2025 - No further progress			
2022.19	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.1	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	01/04/2024	31/03/2026		Overdue	Overdue	2	November 2025: CWS technical change requires funding to progress, escalated to interim Medical Director and Director of Data and Digital, business case to PIP and Executive team re further development of CWS to support streamlining of the discharge notification. Progress has been made through improved discharge data capture via the CWS2 rollout and renewed clinical communication. A Task & Finish Group has worked on standardising discharge notification processes	Aligned to time line of CWS business case		30/09/2025

4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Chief Operating Officer	N/A	2.1	Ensuring staff have easy access to relevant transport policies and information and their use is monitored to ensure they are operating as intended;	Discuss potential for live reporting system with the National NEPTS Delivery Action Group and Joint Commissioning Committee	Chief Operating Officer	31/03/2025	31/12/2025		Overdue	Overdue	1	"Live reporting is in the process of being rolled out operationally by WAST. Names of relevant staff who will require access have been passed to WAST for set up. "			
4753A2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.1	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	Further work to improve the flow of information will be addressed through the 'Perfect Ward' project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge.	Executive Director of Nursing	31/03/2025	31/03/2026		Overdue		1	November 2025: Continue to roll out the OHFF across all sites, focus on GUH, YYF, NHH and Chepstow Community Hospital			

Appendix C Recommendations Exceeding Threshold

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Reporting Date
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNIO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	31/03/2026		Overdue	Overdue	6	September 2025 - Digital strategy development now commenced following Board approval of Gwent 2035 strategy. Executive Team presentation completed with further engagement across the Health Board planned.April 2025 - Data & Analytical Strategy approved by the Executive Committee and work on component strategies underway for Health & Care Record, Information Governance / Cyber Security and Technical Infrastructure. The Digital Strategy will be reissued following the publication of the Health Board's 10 year strategy."" ""January 2025 Digital champions across all in-patient areas for WNCR Digital Clinical Council reformed and meeting 5th Dec '24, Reporting to Clincial Advisory Forum At the request of Planning, the development of a new Digital Transformation Strategy for ABUHB will commence once the ABUHB 10 year strategy has been agreed. An OCP has been agreed and will be consulted on in Q4 2024/25 that includes a refreshed strategy, planning and engagement function that will further develop stakeholder engagement at local, regional and nationakl level. """"August 2024: Digital Champions in place through the M365 Team. Business partnering to be reviewed by DDaT Senior Leadership Team"" January 2024: The Digital Champions network for Microsoft 365 has been relaunched and there are plans to further develop this through networking events and lunch and learns. Similar networks are being planned for Analytics and the refreshed Clinical Council. Nov 23: Progress has been			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R13	R13 Critical assets should be identified within the asset and configuration management systems.	Agreed. This in part is due to the devolved nature of informatics.The first step will be presenting the new operating framework's overarching governance recommendations will provide oversight. A strategy, policy and resultant business case will be developed following the Health Board adoption of the reviews recommendations.		31/12/2021	31/07/2025		Overdue	Overdue	4	April 2024 - Implementation of the new security platform has commenced at the Grange University Hospital and configuration of the platform is underway. August 2024: A review of the cyber security plan and Information Asset Register has identified significant work remains to undertstand critical assets across the estate alongside the new security platform mentioned in the April 2024 which has now been funded by Welsh Government. This platform will be in place by March 2025 so this work will now not be completed until July 2025, in the meantime all assets will continue to be protected by our cyber security controls. January 2024: New Cyber Security Assurance Group will be meeting in January 2024 and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. A component of this action plan is the identification of critical assets, further timelines will be developed after the first meeting of the Cyber Security Assurance Group. In addition, the Cyber Resilience Unit will be visiting the Health Board in late January to discuss progress against the Network & Information System Regulations. In April 2024 work will commence on the Health Board's new security platform which will provide visibility of all assets connected to the network which will improve the visibility of critical assets which may not be managed by the directorate. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information			
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.		31/12/2021	31/03/2026	18/09/2025	Overdue	Not Yet Due	4	January 2024: No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year. Aug 2023: Awaiting next HBOTS meeting.			

Internal	2021.05	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise(including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond.Where additional resourcing / facilities arerequired, theseshould be factored into the IMTP process.	To review and updateworkforce plans as appropriate. Workforce is factored into the IMTP		24/02/2022	01/09/2026	08/02/2024	Overdue	Not Yet Due	3	January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.		
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.		30/04/2022	30/04/2026		Overdue	Not Yet Due	3	June 2025 - Same as previous RadIS is no longer being developmed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis.January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.			
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver'slists from the Health Board and action these also.The success of the process will be tracked and evaluated to ensure it is working.		30/04/2022	01/12/2025		Overdue	Not Yet Due	3	June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers. Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard. June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundry electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.			
Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.		31/03/2022	01/12/2025		Overdue	Not Yet Due	3	June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution. March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.		

Internal	2021.12	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.		30/04/2022	01/12/2025		Overdue	Not Yet Due	3	June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH If there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution. Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominently cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUH and a smaller backup in our YAB DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continumity. June 2024- the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the YAB datacentre if there are issues with the GUH datacentre. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report.	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.		
Internal	2021.26	Facilities - Care After Death	Reasonable	Chief Operating Officer	Medium	R3	R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: • remotely accessible across all sites, at all times; • update immediately following any change inputted; • link to key software within the Health Board, to minimise manual data entry; • produce management information / a dashboard and other relevant information (e.g. patient location); • raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings; • a full audit trail including access information and data changes; • support profile levels to facilitate access control; and	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Divisionwill now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.		31/03/2023	31/12/2025	20/05/2025	Overdue	Not Yet Due	3	April 2025: Decision made to procure dedicated mortuary and CAD services software (following comprehensive review of TCLE 2025 functionality) which will meet all the required recommendations set out by the Risk and Assurance Team and the HTA, and fully integrate with PAS in order to mitigate against the risk of transcription errors due to manual entry. System can provide reports and/or be integrated with Qlik. Procurement underway. No timeline yet provided for 'go-live' date.October 2024: CAD team database was on Qlik for intiial period but was removed due to data quality issies and planned recommencement end of Nov 24 beginning Dec 24. TCLE 2025 UAT underway for CAD and Mortuary , no requirment currently for a bespoke database for CAD, Current CAD database will transfer to TCLE upon completion January 2024: Partially completed. This risk has been resolved/removed by some minor changes to the current CAD database and development work that will make the body store details available in Qlik. Awaiting final verification of Qlik data. Estimated date of completion 31/03/24 November 2023 - new software was not procured due to cost implications. Work undertaken to cleanse databse and ensure that relevant fields are completed to enablel reports to be produced through Qlik. Work on reporting is currently underway.	IT Infrastructure Team resouce capacity may delay the implementation.		
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.		31/12/2023	31/10/2025	18/09/2025	Overdue	Not Yet Due	7	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.			
Internal	2023.17	IT Infrastructure	Reasonable	Director of Digital	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.		30/11/2024	31/03/2026	18/09/2024	Overdue	Not Yet Due	4	August 2025 - Work continues but lack of resources within directorate is hindering progress, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.	January 2025 CMDB is now much more mature, with over 54000 assets and may interdependcies recorded allowing a service view to be taken of large elements of infrastructure. Further review to be undertaken in the summer.		

Internal Audit Progress Report

Audit, Risk and Assurance Committee

December 2025

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2025/26 Internal Audit Plans for Aneurin Bevan University Health Board (the 'Health Board') to the December 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 21st October 2025:

AUDIT ASSIGNMENT	ASSURANCE RATING
Standing Orders Compliance	Substantial
Welsh Intensive Care Information System	Substantial
Business Continuity Plan	Reasonable
Cyber Security	Reasonable
RGH Central Decontamination Unity	Reasonable
Public Health	Advisory

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	9
Draft reports	2
Work in Progress	6
Planning	4
Not started	9
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 21st October 2025.

Standing Orders Compliance (substantial assurance)

We sample tested the Health Board's compliance with the Welsh Government's Model Standing Orders and Standing Financial Instructions. Overall, the review concluded **substantial assurance**, indicating strong adherence to governance and financial control requirements. The Health Board has appropriately tailored the Welsh Government template for its governance framework, including Board structures, committees, and meeting cycles. A comprehensive internal review against the Standing Financial Instructions was completed, covering all 95 sub-sections, with eight gaps identified and documented in an action plan.

The only observation relates to inactive advisory groups—the Stakeholder Reference Group and Healthcare Professionals Forum—whose chairs remain vacant, creating a governance gap against the prescribed model.

Welsh Intensive Care Information System (substantial assurance)

The audit reviewed the Health Board's handling of lessons learned from the paused Welsh Intensive Care Information System (WICIS) programme. WICIS aimed to digitise and centralise critical care documentation but was halted due to unresolved risks, usability issues, and technical deficiencies. The Health Board undertook internal and external reviews, identifying failures in clinical safety, governance, supplier engagement, and training. While lessons have been captured in a register and incorporated into other programmes, there is no structured process to ensure these lessons are consistently embedded and monitored. The audit concluded with **substantial assurance**, noting that most risks have been addressed, but improvements are needed in tracking and applying lessons learned.

The Health Board demonstrated strong governance and risk management throughout the programme, escalating concerns and collaborating with national stakeholders to mitigate risks associated with delays. Actions included formal reporting of hazards, usability testing, and strategic engagement with Welsh Government and Digital Health and Care Wales. Although the pause in WICIS means reliance on paper-based processes continues, this has not increased the inherent risk.

Business Continuity Plan (reasonable assurance)

We reviewed the adequacy of business continuity plans (BCPs) (excluding digital / disaster recovery plans) within a sample of service areas across the Health Board. The Health Board, as a Category 1 responder under the Civil Contingencies Act 2004, must maintain robust emergency preparedness and resilience arrangements. The audit confirmed that BCPs exist for the sampled services, including action cards, but we identified gaps in testing, staff awareness, and documentation. None of the three services sampled had tested their BCPs, and action cards lacked clarity on activation triggers, role-specific responsibilities, and secure storage. Whilst we provided **reasonable assurance**, noting that while the framework is sound, improvements are required to ensure plans are practical and effective during disruptions.

Cyber Security (including cyber incident response) (reasonable assurance)

We concluded **reasonable assurance** for this audit, noting active risk management through the Digital Risk Register, with risks managed and closed when appropriate to do so, and emerging improvements via the new Digital Governance Structure. Positive steps include dedicated cyber security agenda items and deployment of tools like Palo Alto, though progress is challenged by resource constraints and competing priorities.

While many NIS Assurance Group actions have been closed, concerns remain around outdated risk entries, a lack of Datix recording, high phishing susceptibility (12% click rate), lower mandatory training compliance (77%), and an untested Cyber Incident Response Plan lacking action cards, external communications, and formal third-party support. The Strategic Risk (SRR 006A) should also be reviewed to reflect its role with digital risks.

RGH Central Decontamination Unit (reasonable assurance)

The internal audit of the Royal Gwent Hospital Central Decontamination Unit project concluded with **reasonable assurance**, noting that governance and financial controls were largely robust, but significant delays and some contractual weaknesses were identified. As of July 2025, the project faced an estimated 15-week delay, primarily due to steel and mechanical/electrical design issues, which impacted procurement and scheduling. Despite this, the forecast outturn cost remained within the approved £4.023m budget, although contingency had reduced sharply to £63,780. Quality assurance processes were in place, and workmanship concerns were minimal. Governance arrangements strengthened during delivery, with the Project Board established later than ideal but now operating effectively. Contractual and valuation processes were generally sound, supported by JCT contract terms and independent verification, while change management controls were assessed as substantial.

Key areas requiring attention include unresolved extension-of-time claims, derogation approvals, and adviser appointment processes. The audit highlighted that some derogations lacked justification and formal sign-off, and adviser appointments under the Shared Business Services framework showed gaps in insurance verification and KPI application. Additionally, we identified the absence of a Project Bank Account or documented exemption.

Finally, whilst valuation and payment processes were strong, and change management was well-controlled, project performance and contractual arrangements received limited assurance due to delays and procurement weaknesses.

Public Health (advisory)

The advisory review assessed whether the Health Board has effective controls to meet public health objectives aligned with its Integrated Medium-Term Plan (IMTP) and the Wellbeing of Future Generations (Wales) Act 2015. Since integrating the Public Health Team from Public Health Wales in 2023, the Health Board has made progress in embedding public health initiatives locally, becoming the first Marmot Region in Wales, addressing health inequalities through collaborative approaches.

Positive achievements include an alignment of local strategies with national priorities, a 2025/26 work plan, and regular leadership forums. However, the review suggested areas for improvement, such as demonstrating how work plans contribute to IMTP objectives, strengthening governance arrangements, addressing a £560,000 underspend, and introducing a robust performance management framework with clear indicators and targets.

Further considerations include enhancing strategic planning by bridging annual work plans with medium and long-term objectives, explicitly embedding the Future Generations Act principles in future plans. Governance inconsistencies across leadership and project forums, lack of formal risk registers, and absence of structured performance monitoring were noted as risks to oversight and accountability. A more coordinated approach is recommended to link local and national initiatives, prioritise resources, and establish clear evaluation mechanisms. While the review did not assign assurance ratings, it offers practical options for management to strengthen internal controls and ensure sustainable delivery of public health objectives.

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	Substantial	Final Report
3. Strategic Risk and Assurance		Planning for Q4
4. Subject Access Requests		Draft Report
5. Benefits Realisation (excluding digital)		Planning for Q3
6. Business Continuity Plan	Reasonable	Final Report
7. Capital Projects: Service Readiness		Work in Progress
8. Falls Management		Deferment to Q4
9. Directorate Review - CAMHS		Work in Progress
10. Professional Staff Registration		Planning
11. Clinical Audit		Planning
12. Directorate Review – Ophthalmology / ENT		Planning
13. Public Health	Advisory	Final Report
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		Work in Progress
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	Final Report
23. Shadow IT		Planning
24. Welsh Intensive Care Information System	Substantial	Final Report
25. RGH Central Decontamination Unit (capital systems from 2024/25)	Reasonable	Final 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		Draft Report
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:

Rating	Definition
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
Capital Projects – Service Readiness	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.
Directorate Review - CAMHS	Brief issued	To ensure that appropriate arrangements are in place for the management of risk and performance within the CAMHS directorate.
Occupational Health	Brief issued	To provide assurance over the arrangements and controls in place for the management of the occupational health service.
Discharge Planning	Draft brief issued	This review will focus on the arrangements and mechanisms within the Health Board to facilitate the safe and efficient discharge of patients.

Standing Orders Compliance

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

Substantial Assurance

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Review Reference	ABU-2526-02
Fieldwork	September - October 2025
Executive Sign Off	November 2025
Audit Committee	December 2025
Executive Lead	Rani Dash, Director of Corporate Governance Robert Holcombe, Executive Director of Finance, Procurement and VBH
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager

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

Executive Summary

Purpose

The overall objective of the audit was to assess Aneurin Bevan University Health Board's (the 'Health Board') adherence to the Model Standing Orders (Reservation and Delegation of Powers) and Standing Financial Instructions, as determined by the Welsh Government (WG).

Overview

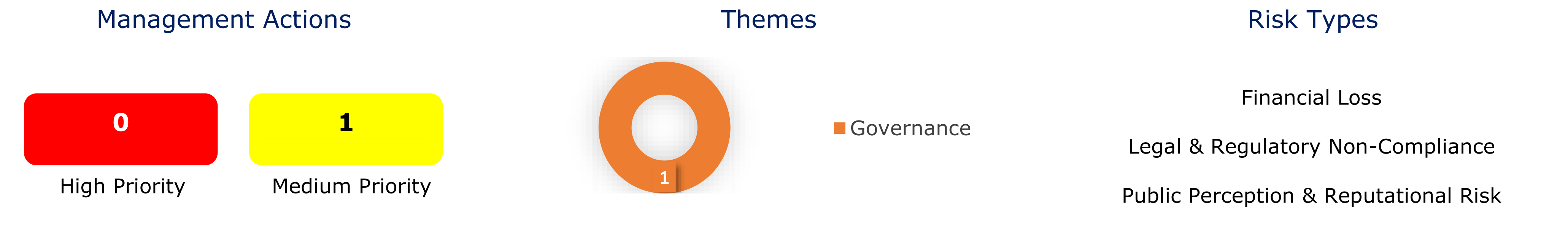
We have concluded substantial assurance on this area, with good compliance throughout the sample tested. We also assessed the internal review completed by the Corporate Finance Team over the Health Board's adherence to the Model Standing Financial Instructions, where we confirmed that a comprehensive review had been completed. The only matter that requires management attention is the future role of inactive advisory groups.

Finally, we sought to review the current progress of the requirement for senior managers to provide a nil declaration of interests, if they have none to register. However, this continues to be managed with the Audit Recommendation Tracker process and at this stage, insufficient time has passed to enable a review of the recommendation implementation. Therefore, we will review this aspect within the annual Follow-up of High Priority Recommendations review.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	The Model Standing Orders are adhered to across a sample of key areas, including, but not limited to the governance framework, Board membership, committees and advisory groups, meetings and associated documentation.	1	**Reasonable**
2	The Standing Financial Instructions review completed by the Health Board assessed all relevant requirements and was supported by appropriate evidence. Any actions required following the review were implemented accordingly.	-	**Substantial**
3	Relevant audit recommendations previously raised will be tested where appropriate to do so.	-	**Substantial**



Findings & Agreed Action Plan

Objective 1: The Model Standing Orders are adhered to across a sample of key areas, including, but not limited to the governance framework, Board membership, committees and advisory groups, meetings and associated documentation	**Reasonable**

Overview / Summary of Observations

A 'Model Standing Orders Reservation and Delegation of Powers For Local Health Boards' template document is provided by Welsh Government to ensure health boards structure their governance frameworks to a common scope and standard and we confirmed that with appropriate tailoring, the Health Board had used this template to create their own governance documents as well as the structures and processes e.g. Board, committees, members, meeting cycles etc. that these prescribe.

Our examination of the Standing Orders (SO) documentation confirmed that the Health Board had adopted the broad framework of the Welsh Government model in respect of scope, schedules, appendices etc. Further examination of sample areas of these were then made against the Welsh Government model, results of which are recorded by exception in the sections below.

Committees and advisory groups

The Advisory Group structure prescribed within the Welsh Government model SO, the Stakeholder Reference Group and Healthcare Professionals Forum are not currently active within the Health Board (**Finding 1**) and that the posts of chair for each of these groups are vacant.

Meetings and documentation

We noted that the Board had not published a forward work programme for 2025/26 at the time of the audit but a copy of the draft programme which is due to be submitted to their next meeting was shared. We noted forward plans are published for the sample committees we reviewed, including (i) Audit, Risk and Assurance Committee, (ii) Patient Quality, Safety and Outcomes Committee and (iii) Partnerships, Population Health and Planning Committee.

Values and standards of behaviour – Board, Committee and Officers declaration of interests, offers of gifts

We noted the processes in place for managing potential conflicts of interests for Board, Committee members and officers in their dealings with external companies, contractors or suppliers and examined the protocols that were in operation. The regime is one of self-declaration of conflicts, where they arise, and it is the responsibility of all to comply with this mandatory requirement.

For increased control for the staff cohort where there is higher likelihood of conflicts, there is a requirement to make an annual declaration detailing each and all conflicts, or alternatively to make a nil return.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Inactive Advisory Groups** Within the Advisory Group structure, prescribed within the Welsh Government Model Standing Orders, the Stakeholder Reference Group and Healthcare Professionals Forum are not currently active in the Health Board and the posts of chair for each of these groups are vacant.	Risk that advisory groups operating in the health board do not align with the Welsh Government prescribed model.	**Agreed Action:** The Health Board acknowledges that the Stakeholder Reference Group and Healthcare Professionals' Forum are currently inactive and that Chair positions remain vacant. Since their original establishment in 2009, the Health Board has significantly evolved its approach to engaging clinical professionals and stakeholders. To address this, a comprehensive mapping exercise of existing engagement arrangements will be undertaken. This will inform an options appraisal for the Board to determine the most effective way to re-establish the required advisory fora, ensuring compliance with Standing Orders, avoiding duplication, and delivering maximum benefit.
			Expected Evidence of Implementation: • Completion of mapping exercise and options appraisal report. • Formal Board decision on future arrangements for the Stakeholder Reference Group and Healthcare Professionals' Forum. • Documented implementation of agreed actions, including appointment of Chairs and activation of the groups.
		Medium Priority	**Officer:** Director of Corporate Governance / Head of Corporate Governance **Target Implementation Date:** 30 September 2026
	Theme: Governance	Control Operation	

Objective 2: The Standing Financial Instructions review completed by the Health Board assessed all relevant requirements and was supported by appropriate evidence. Any actions required following the review were implemented accordingly.	**Substantial**

Overview / Summary of Observations

In September 2025, the Health Board performed a comprehensive self-assessment exercise to assess how local procedures align with the Model Standing Financial Instructions (SFIs). The Health Board's SFI document is derived from and mirrors a Welsh Government model and contains 95 sub-sections, all of which were included in the assessment. Where the Health Board assessed a sub-section non-compliant, this was recorded as an exception and an action recorded to address the gap.

Eight such gaps were identified in the Health Board's self-assessment, and these were documented in an action plan (although the version we saw in our audit did not include any action target dates). The outcome of the self-assessment was reported to the Audit, Risk and Assurance committee at their September 2025 meeting.

In our own review of the Health Board's SFI self-assessment, we took a random sample of the 95 sub-sections and examined the Health Board's self-assessment evaluation recorded. Of the 10 sub-sections in our random audit sample, all had been assessed by the Health Board as compliant with the SFIs and material had been provided to support the status.

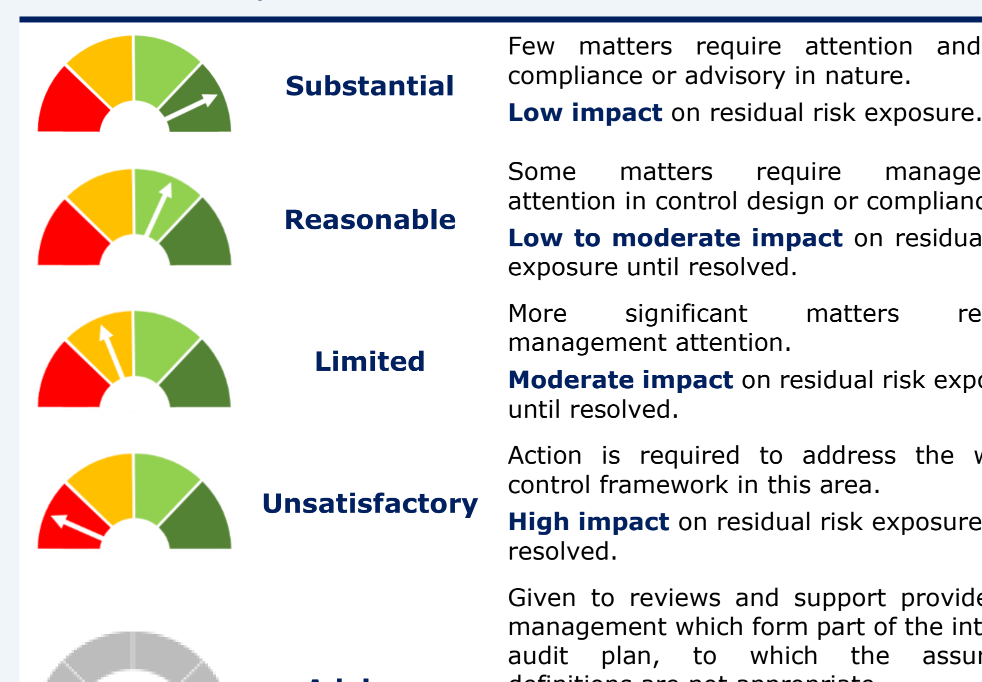
Objective 3: Relevant audit recommendations previously raised will be tested where appropriate to do so.	**Substantial**

Overview / Summary of Observations

Whilst we identified that a new process has been introduced for all senior managers to record declarations of interest, including a nil return, this has only recently been implemented. Relevant audit actions (external and internal) relating to this continues to be tracked via the Audit Recommendation Tracker and we will review the implementation progress within the Follow-up of High Priority Audit Recommendations review, scheduled for quarter four. At this stage there are no further conclusions to report.

Appendix A

Assurance Opinion



Substantial – Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.

Reasonable – Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.

Limited – More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.

Unsatisfactory – Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.

Advisory – Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

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Welsh Intensive Care Information System

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

Substantial Assurance

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Review Reference	ABUHB-2526-24
Fieldwork	October 2025
Executive Sign Off	12th November 2025
Audit Committee	December 2025
Executive Lead	Paul Solloway
Head of Internal Audit	Stephen Chaney

Executive Summary

Purpose

To ensure lessons learnt and / or any associated actions regarding the work completed to date on the Welsh Intensive Care Information System (WICIS) are appropriately addressed by Aneurin Bevan University Health Board (the 'Health Board'). This audit has only focussed on the steps taken by the Health Board to incorporate lessons learnt / actions identified following the pausing of the WICIS Programme (the Programme). We have not assessed or reviewed the ongoing suitability of WICIS for the Health Board or the appropriateness of the actions taken during the initial rollout of the Programme. Instead, this review focussed on risks that have been identified by the Health Board and subsequent remediation / lessons learnt identified.

Overview

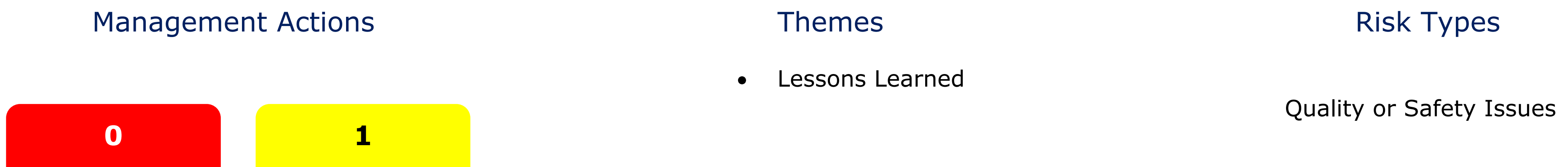
We have concluded **substantial** assurance on this area. The WICIS Programme was subject to a number of issues which has led to it being paused. The Health Board has reviewed the programme, identified lessons and effectively managed associated actions arising regarding the programme. The matter requiring management attention is:

- Enabling a structured process to ensure actions from lessons learned are implemented and tracked within the Digital Directorate. Whilst we confirmed that actions have been implemented, there is scope for the tracking process to be improved upon.

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	An exercise has been undertaken to identify learning and actions within the Health Board from work to date on the WICIS	1	**Reasonable**
2	The Health Board has plans in place to mitigate any risks associated with delays in delivery of the WICIS	-	**Substantial**



High Priority

Medium Priority

Findings & Agreed Action Plan

Objective 1: An exercise has been undertaken to identify learning and actions within the Health Board from work to date on the WICIS	Reasonable

The Welsh Intensive Care Information System (WICIS) was intended to replace the paper-based documentation system used in Welsh intensive care units. Its overarching objective was to digitise and centralise all critical care documentation and workflows across Welsh ICUs, improving efficiency, accuracy, and patient safety. It also aimed to eliminate the need for manual data collation during ward rounds and clinical decision-making.

Although the project progressed through the stages of infrastructure setup, training, and user acceptance testing, the WICIS system was never deployed into live clinical use. Initial challenges emerged in 2021, when infrastructure and operational risks relating to system functionality were first identified. These concerns evolved into significant and unresolved patient safety risks, compounded by missing functionality and poor overall usability. Collectively, these deficiencies rendered the system unfit for clinical deployment.

The WICIS programme had widespread negative impacts on Aneurin Bevan University Health Board (the Health Board). Clinically, it introduced major safety risks, reduced staff confidence, and disrupted training due to poor system performance. Operationally, it increased workload, created inefficiencies, and caused repeated delays. The Health Board invested in the programme, with over 50 individuals directly involved across governance, delivery, and clinical assurance functions, including clinical, technical, and managerial staff. The Health Board also incurred expenditure on equipment exceeding £55,000. Repeated implementation delays led to further costs and inefficiencies, as training sessions had to be cancelled and rescheduled, placing additional pressure on staff and requiring ongoing supplier coordination.

The Health Board undertook a review of the WICIS programme to capture key learning and determine appropriate actions arising from its experience and also contributed to an independent review, which reported to Welsh Government and identified learning points. The reviews found that the programme encountered critical failure points across multiple domains, including clinical safety, usability, governance, supplier engagement, data integrity, technical reliability, and training. These, along with identified issues within the national programme including discrepancies between local and national hazard logs, a lack of inclusive clinical safety workshops, and instances where national decisions overrode local assurance led to the Health Board's decision to withdraw support for WICIS.

Key lessons from the reviews have been collated and included within a lessons learned register for the Digital Directorate. Following this, relevant lessons and actions have been included within other programmes. However there is no structured process for monitoring and ensuring lessons are embedded in procedures and other programmes, with the current process mainly relying on staff reviewing the register.

Key Findings		Risk & Impact	Agreed Management Action
1	There is no structured process for monitoring and ensuring lessons are embedded in procedures and other programmes, with the current process mainly relying on staff reviewing the register.		**Agreed Action:** As part of the Digital Project Management Framework, the Project Initiation Document (PID) template will be updated to include a dedicated "Lessons Learnt" section. Each lesson will explicitly reference the originating project. Additionally, regular reviews of lessons learnt will be incorporated into project health checks. This process will ensure that lessons are consistently captured and embedded into future project PIDs.
			Expected Evidence of Implementation: Updated PID template. Internal approval and publication of the revised template. Delivery of targeted communications and training sessions to all project teams. Regular project health checks evidencing the embedding of lessons into new projects.
		Medium Priority	**Officer:** Assistant Director of Digital Transformation **Target Implementation Date:** 31 March 2026
	Theme: Lessons Learnt	Control Design	

Objective 2: The Health Board has plans in place to mitigate any risks associated with delays in delivery of the WICIS	Substantial

The Welsh Intensive Care Information System (WICIS) was envisioned as a transformative platform to digitise intensive care operations, replace manual processes, enhance clinical safety, and improve data quality and accessibility across NHS Wales. However, significant gaps in usability, safety, and integration ultimately rendered the system unfit for clinical implementation, leaving the Health Board reliant on the previous paper-based processes that are time consuming, prone to error, and limit data accessibility for audits and decision making. As the pause in WICIS has resulted in the continued operation of the previous processes, it has not increased inherent risk.

Throughout its involvement, the Health Board demonstrated strong governance, transparency, and a sustained commitment to patient safety. The Health Board identified, recorded, and escalated project risks including dual intensive care processes, prescribing safety, workflow disruption, and funding delays through detailed risk registers and highlight reports. These were actively monitored and mitigated in collaboration with the Welsh Government and Digital Health and Care Wales (DHCW). The Health Board's recommendation to delay the implementation, based on safety and data integrity concerns, ultimately led to the cessation of the WICIS programme.

Prior to the decision not to proceed with WICIS in its current form, the Health Board undertook a series of strategic and operational actions. It formally escalated concerns through a detailed report in October 2023, outlining critical safety hazards and system defects that prevented clinical sign-off. This led to a joint decision with national stakeholders to pause the project and re-plan collaboratively. The Health Board also conducted an internal evaluation, including clinical hazard analysis, usability testing, and time-motion studies, which were shared nationally in early 2024 to support external review and inform future development. The Health Board also reflected on its governance processes, noting that early decisions may have lacked full local oversight due to the dual role of its Clinical Lead, who also served nationally.

The Health Board maintained a well-defined communication framework, using regular meetings, reports, and stakeholder updates to manage risks and ensure transparency. Engagement activities such as workshops, surveys, and training supported multidisciplinary clinical involvement. However, the Risk Review (09/04/2024) observed that while these structures were in place, their effectiveness were sometimes undermined by system instability, shifting priorities, and communication delays, which affected staff engagement and confidence.

Appendix A

Assurance Opinion

	Opinion	Description
	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.
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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Business Continuity Plan

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

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Review Reference	ABU-2425-06
Fieldwork	August – September 2025
Executive Sign Off	October 2025
Audit Committee	December 2025
Executive Lead	Hannah Evans, Director of Strategy, Planning and Partnerships
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager

Executive Summary

Purpose

The review of Business Continuity Plan (BCP) was completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2025/2026 Internal Audit Plan.

As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response.

The audit examined and assessed the adequacy and completeness of business continuity plans and response protocols in a sample of the services within the Health Board's divisions. However, we did not include IT disaster recovery testing within this review, as it is assessed separately.

Overview

We have concluded reasonable assurance on this area, as we confirmed that BCPs are in place for the sample tested, including action cards. However, further work is required to embed and increase staff awareness over the BCP process, including the testing arrangements and subsequent updates to the BCPs (including action cards). The significant matters requiring management attention include:

- None of the three services in the audit sample reported having conducted any testing of their BCP.
- Incident response action cards in the audit sample were not role specific, did not record the event that would trigger their use, were not all critical function specific and were not stored in hard copy in a safe place ready for use.

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

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There is an effective business continuity management system in place.		**Substantial**
2	There were robust business continuity plans in place, which had adequately been tested, so that core business functions can continue to be delivered in the event of a disruptive incident.	1,2	**Limited**
3	Business continuity plans were easily accessible within each service delivery group and for appropriate staff; and that there was access to the guidance and framework for business continuity management.	1	**Reasonable**
4	Processes were in place to warn, inform and advise relevant stakeholders on a timely basis in the event of a business continuity incident.	3	**Reasonable**

Management Actions
1
High Priority
2
Medium Priority
Themes
1
1
1
Information, Data Quality & Data Accuracy
Risk Management
Training & Development
Risk Types
Quality or Safety Issues
Financial Loss
Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: There is an effective business continuity management system in place. | **Substantial**

Overview / Summary of Observations

The Health Board has an organised approach to business continuity management, built around its Emergency Planning team and has developed and adopted a model that responds to the business continuity duties of Category One responders set out in the following authoritative sources:

- Civil Contingencies Act 2004;
- NHS Emergency Prepared, Resilience and Response Guidance; and
- NHS Health and Care standards.

Collectively, these prescribe Business Continuity Plans (BCP) that incorporate the following elements:

- Risk Assessment and Resilience;
- Command and Control Structures;
- Training;
- Plan test exercises;
- Governance and Accountability;
- Multi-agency Engagement;
- All-Hazards Approach; and
- Compliance Monitoring.

The audit reviewed the policy, guidance and template materials that make up the Health Board's Business Continuity Management Model and confirmed their inclusion of these elements, prior to then testing a sample of division's and services business continuity plans for compliance.

Objective 2: There were robust business continuity plans in place, which had adequately been tested, so that core business functions can continue to be delivered in the event of a disruptive incident. | **Limited**

Overview / Summary of Observations

Business continuity plans (BCPs) are developed and maintained at service level, ratified through their clinical and management teams, signed off by divisional, directorate or department management and uploaded to the Health Board's BCP repository.

To assess BCP compliance, completeness etc. we conducted a range of audit tests on a random sample of three BCPs selected from different services within the divisions of the Health Board.

1. Risk Identification and Assessment

A Business Impact Assessment (BIA) tool was used to assess a service's activities to identify its critical functions (CF) that require a BCP to protect them against interruption. The services sampled had utilised a different approach to identifying CFs (some at a more detailed level than others), different formats had been employed and the level of evidence of this step in the process varied across the sample.

We noted that for one of three sample services, BCP interruption risks (e.g. loss of electrical power, loss of services/ supplies) were evident in the service's risk register, but other divisions reported there was no expectation that services would replicate/ reflect BCP risks in service risk registers.

2. Continuity Planning

Our review found that the BCP of only one of the three services in the audit sample examined all five of the business continuity threats (loss of: IT, staffing, utilities, premises and key supplier(s)) in the Health Board's emergency planning BCP model but accept that continuity planning is a continuous developing process.

3. BCP Testing and Monitoring

None of the three sampled services had conducted nor scheduled any test exercises of their BCPs (**Finding 1**). The Emergency Planning team had recently introduced a business continuity dashboard. However, this recorded that only one of the Health Board's 108 service level BCPs had conducted any test exercises.

BCPs record incident response plans accompanied by action cards. The latter are designed to provide unambiguous instructions of exactly what officers need to do in the event of an incident occurring, but we noted the following weaknesses with these (**Finding 1**):

- action cards did not record triggers i.e. the event that would trigger their use;
- action cards were not role specific;
- not all action cards were CF specific but were more broad, describing generic level actions; and
- hard copy action cards should be stored in a safe, accessible place ready for use, but two of the three services in the audit sample reported not doing so.

4. Training and Awareness

In our sample services, we were advised that only a small number of senior staff were familiar with the BCP protocols, processes and procedures, mainly through their involvement with the preparation of BCP materials. All three sample services examined acknowledged the need to extend BCP training to further key staff but had not yet scheduled any training events (**Finding 2**).

5. Governance and Escalation

For all service BCPs sampled we did not see populated formal document control panels (prepared by, approved by, expiry etc.).

We were provided with an example of a division monitoring and co-ordinating the production the BCPs of its services, but no evidence of division management sign-off of these.

Division managers reported BCP status to the quarterly Emergency Preparedness Resilience and Response (EPRR) strategy group in a Business Continuity Update standing agenda item.

	Key Findings	Risk & Impact	Agreed Management Action

1	**BCP and action cards**
	We noted none of the three sampled services had conducted nor scheduled any test exercises of their BCPs.
	Additionally, we noted the following weaknesses with BCP action cards:
	• action cards do not record triggers i.e. the event that would trigger their use;
	• action cards are not role specific;
	• not all action cards are critical function specific, but are more broad-based describing generic level actions; and
	• hard copy action cards are not stored in a safe place ready for use.
		Risk that BCP do not operate effectively and planned responses to interruption events may not be enacted fully and effectively.	**Agreed Action:**
			The EPRR team will work with all service areas to ensure that local Business Continuity Plans (BCPs) are regularly tested and that action cards are updated to address identified weaknesses.
			Specifically:
			• Develop and roll out a train-the-trainer package and supporting test and exercise toolkit to enable divisions/directorates to conduct and record regular BCP exercises.
			• Support services to review and update all action cards to:
			  ○ include clear activation triggers;
			  ○ define role-specific responsibilities; and
			  ○ align actions to critical functions.
			• Ensure that hard copies of BCPs and action cards are securely stored and readily accessible in key operational areas.
			Monitor completion and effectiveness through local BCP assurance audits and reporting to the EPRR Group.

			Expected Evidence of Implementation
			• Approved train-the-trainer and test/exercise toolkit.
			• Records of completed BCP exercises conducted by services.
			• Sample updated BCP action cards showing:
			  ○ documented activation triggers,
			  ○ named roles/responsibilities, and
			  ○ linkage to critical functions.
			• Confirmation and/or photographs of securely stored hard copies in operational areas.
			• Divisional/local BCP audit reports confirming plan review and compliance.
			• Standing EPRR Group agenda item capturing divisional assurance updates on BCP testing and action card maintenance.

		High Priority	**Officer: Head of Planning – Civil Contingencies** **Target Implementation Date: 31 March 2026**
	Theme: Risk Management	Control Design	
2	**Training for key staff in their role and responsibilities in respect of delivering business continuity** We were advised that in the sample services that we examined, only a small number of senior staff are familiar with the BCP protocols. All three sample services examined acknowledged the need to extend business continuity plan training to further key staff, but had not yet scheduled any training events.	Risk that staff are unaware of their responsibilities during planned responses.	**Agreed Action:** The EPRR team will ensure that key operational and managerial staff across all divisions/directorates receive appropriate training in their roles and responsibilities for delivering business continuity. Specifically: • Identify and confirm Business Continuity (BC) leads within each division/directorate. • Develop and deliver a stand-alone, role-specific training package focused on staff responsibilities for activating, managing, and maintaining BCPs. • Ensure BC leads are equipped to cascade this training to other key staff within their areas. • Monitor completion and effectiveness through service-level audits and regular reporting to the EPRR Group. These actions will ensure that all key staff understand their specific roles within the business continuity framework and can implement BCPs effectively during service disruption.

			Expected Evidence of Implementation: • List of appointed BC leads for all divisions / directorates • Approved and issued BC role-specific training package. • Training attendance records demonstrating that BC leads and key staff have completed training. • Evidence that training has been cascaded to relevant operational staff (e.g., attendance logs, training summaries). • Local BCP audit reports confirming that staff are aware of their responsibilities and can evidence training completion. Standing EPRR Group updates capturing divisional assurance on training delivery and coverage.
		Medium Priority	**Officer: Head of Planning – Civil Contingencies** **Target Implementation Date: 31 March 2026**
	Theme: Training & Development	Control Design	

Objective 3: Business continuity plans were easily accessible within each service delivery group and for appropriate staff; and that there was access to the guidance and framework for business continuity management.	**Reasonable**

Overview / Summary of Observations

The Health Board's Emergency Planning SharePoint pages serve as a repository for all BCPs and action cards as well as guidance documents and templates for information and use. Documents are deposited in this repository when they have been completed by a service and ratified by their divisional management, but we noted that at the time of the audit this was sparsely populated. The Emergency Planning team operate a matrix format dashboard that indicates whether BCPs are deposited but we noted this does not accurately record the documentation that is present and requires update.

For local storage/ availability of BCP related documentation and materials we noted that only one of the three services examined reported keeping hard copy action cards in a safe place and ready for use in the event of an interruption event. **Finding 1**.

Objective 4: Processes were in place to warn, inform and advise relevant stakeholders on a timely basis in the event of a business continuity incident.	**Reasonable**

Overview / Summary of Observations

Command, control and co-ordination protocols were present in each of the service BCPs sampled in the audit, including for determining incident severity rating and linked escalation pathways, roles and responsibilities of operational response, and command and control teams and their contact details for prompt alerting and liaison.

BCPs examined in the audit record incident response actions designed to lead to a resumption of a service. This can involve co-ordinating with a wide range of individuals and teams internally and externally. Action cards provide a step-by-step response plan and where appropriate, include steps to contact/ liaise with individuals or teams – however, weaknesses in the action cards have been identified at **Finding 1**.

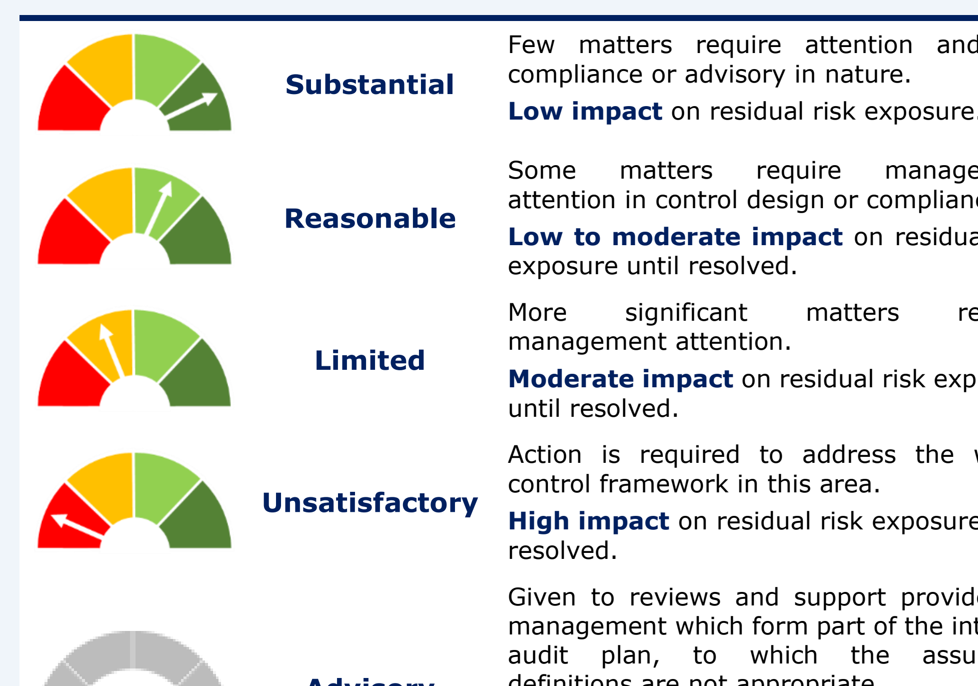
BCPs examined in the audit included contact tables to facilitate prompt liaison in the BCPs but in one case, the BCP document, instead of listing these for each individual involved, inappropriately provides a link to a SharePoint location that may not be operable in during a continuity event **Finding 3**.

	Key Findings	Risk & Impact	Agreed Management Action
3	**BCP contact details protocols** We noted an instance in the testing where BCP stakeholder contact details were recorded in the form of a SharePoint location that may not be operable in an interruption event and mean key resources cannot be mobilised.	Risk that incident response plans may not be successfully implemented.	**Agreed Action:** The EPRR team will ensure that current and accessible contact details for all key stakeholders is available and usable during any service interruption. Specifically: • Each service area will maintain hard copy BCP and action card folders containing up-to-date contact details for all critical staff, partner organisations, and stakeholders. • These folders will be stored securely and accessibly in designated operational areas to ensure they can be used if electronic systems (e.g., SharePoint) are unavailable. These actions will ensure that essential contact information remains accessible during an interruption, enabling timely and effective incident response. **Expected Evidence of Implementation:** • Confirmation showing hard copy BCP and action card folders are available in each service area.

			• Evidence of up-to-date contact lists included within those folders. • EPRR audit reports confirming that hard copy plans and contact details are in place, accurate, and accessible. Divisional assurance updates presented to the EPRR Group demonstrating ongoing compliance.
		Medium Priority	**Officer: Head of Planning – Civil Contingencies** **Target Implementation Date: 31 March 2026**
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A

Assurance Opinion



	Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Cyber Security

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

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Review Reference	ABU-2526-22
Fieldwork	July - Sept 2025
Executive Sign Off	November 2025
Audit Committee	December 2025
Executive Lead	Paul Solloway
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit Martyn Lewis, IT Audit Manager

Executive Summary

Purpose

To assess Aneurin Bevan University Health Board's (the 'Health Board') governance process for cyber security, associated risk statements and the management and delivery of improvement plans. In addition, we also assessed the Cyber Incident Response Plan.

Overview

We have concluded **reasonable** assurance on this area. Cyber security risks are actively managed by the Cyber Security Team as part of the broader Digital Risk Register, with appropriate oversight and reporting mechanisms in place. While the Strategic Risk Register does not explicitly list cyber security as a standalone risk, it does reference key cyber security controls, primarily under SRR 006A.

The newly introduced Digital Governance Structure is still in its early stages, with some groups having met only once at the time of our fieldwork. However, the inclusion of a standing cyber security agenda item at the Governance Assurance Group meetings (covering both clinical and corporate services) is a positive step. This should help raise staff awareness and strengthen the Cyber Security Team's oversight across the organisation, which comprises of approximately 14,000 staff members[1].

The deployment of systems such as Palo Alto will support asset management and help identify shadow IT, thereby enhancing the organisation's cyber security posture. This however will require staff engagement and resource. These requirements were flagged during our review, alongside concerns about competing priorities affecting progress on the cyber improvement plan (NIS Assurance Group). Encouragingly, a considerable number of actions covered by the NIS Assurance Group were closed off during our fieldwork, and the Group's monthly meetings should help ensure continued progress.

Although a Cyber Incident Response Plan is in place, we have identified several areas that require further consideration. We acknowledge that some of these areas have been escalated and reported as part of the recent Cyber Resilience Unit (CRU) audit.

Therefore, the matters requiring management attention include:

- The Health Board's Strategic Risk Register (Strategic Risk SRR 006A) has outdated cyber security controls recorded against the risk and the risk title and threat do not explicitly outline the cyber security risk(s) to the organisation. However, whilst this is reported as a high priority, it represents a small component of the overall testing completed within the audit and thus, the impact on the overall assurance rating. Nonetheless, the risk should be addressed as soon as possible.
- Cyber security risks are not recorded on Datix which is not in line with the organisation's Risk Management Policy and Procedure.
- Recent phishing campaign results show a high click rate across the organisation (12%) and the planned targeted training for compromised staff has not yet been implemented. Additionally, mandatory Information Governance and Cyber Security training completion rates are below the 85% target at 77% (as reported in September 2025), increasing the risk of low staff awareness and vulnerability to cyber threats.
- The Cyber Security Incident Response Plan has not been tested. Action cards for each member of the Cyber Incident Response Team (CIRT), as outlined in the plan, have not been developed. Communications have not been prepared for any audience outside of the Health Board. Additionally, the Cyber Security Team lacks the expertise and resources to manage a cyber event internally, and no formal third-party support has been agreed.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The terms of reference for the NIS Assurance Group does not include timescales for reporting into the Board/Finance and Performance Committee and at the time of fieldwork an update on progress had not been provided since December 2024.

[1] https://abuhb.nhs.wales/about-us/the-health-board/

Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The risks associated with cyber security are appropriately stated, recorded, understood and managed within the organisations risk appetite	1, 2, 3	**Reasonable**
2	An appropriate governance process for cyber security across the organisation is in place which enables monitoring, reporting and effective management	3	**Reasonable**
3	Identified actions to improve cyber security are progressed appropriately	-	**Substantial**
4	An appropriate cyber incident response plan is in place	4	**Limited**

Management Actions

High Priority	Medium Priority
2	**2**

Themes

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Cyber security questionnaire summary of responses

As part of our fieldwork, we distributed a questionnaire to Executives Directors, Independent Members (inc. Chair and Vice-chair) and a sample of senior leaders. In total, we issued the questionnaire to 39 staff members, and we received a 31% response rate. The aim of the questionnaire was to assess the organisation's awareness, understanding, and appetite for cyber security risks. Below is a summary of the responses.

Cyber security updates

Do you regularly receive updates on cyber security risks and incidents during board meetings?
Do you regularly receive updates on cyber security risks and incidents during any other committee meetings?
Do you receive cyber security updates at any other meetings?

o **100%** of Executive Directors answered 'Yes' to at least one of the questions above.
o **100%** of Independent Members (inc Chair / Vice-Chair) answered 'Yes' to at least one of the questions above.
o **14%** of senior leaders answered 'Yes' to at least one of the questions above.

Cyber security risks and actions to mitigate the risks

Have you seen cyber security risks on a risk register?
o **50%** of respondents had seen a cyber security risk(s) on a risk register.

Are you aware of any actions being taken to reduce the current cyber security risk to its target level, or a cyber improvement plan?

o **75%** of Executive Directors answered 'Yes' to the questions above.
o **100%** of Independent Members (inc Chair / Vice-Chair) answered 'Yes' to the questions above.
o **57%** of senior leaders answered 'Yes' to the questions above, one response did highlight 'Other' and that they do not know the detail.

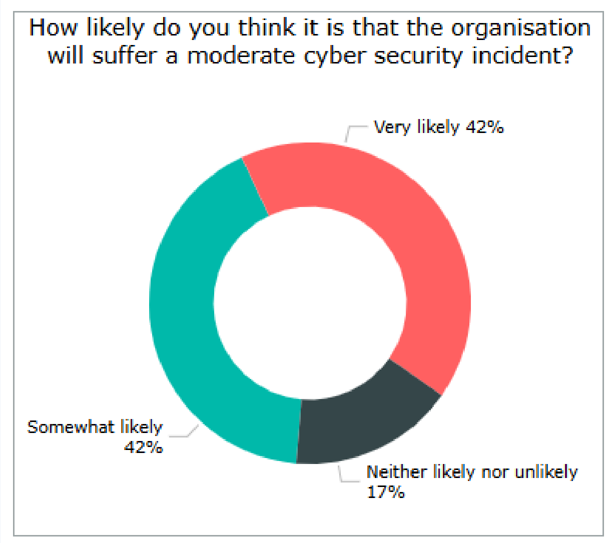
What do you think are the most significant cyber weaknesses for the organisation?

The common responses to this question included: individuals and user compliance, issues with systems and the everchanging cyber security environment resulting in a lack of awareness, and more sophisticated approaches to cyber attacks.

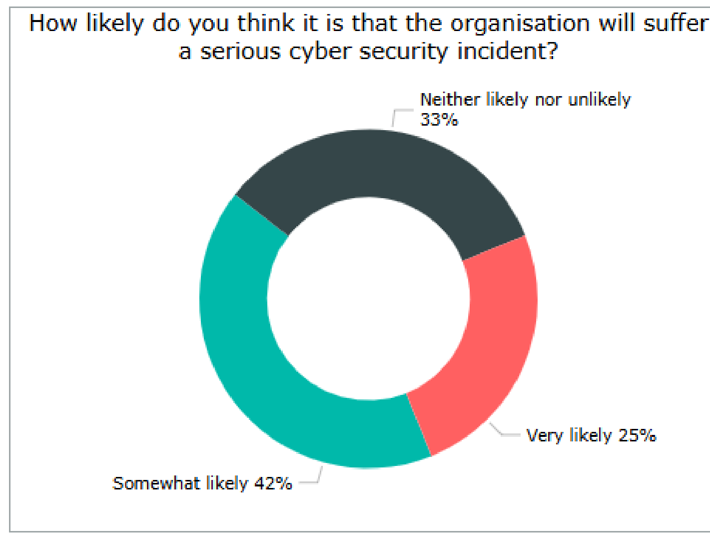
What do you think the most likely impact of a cyber incident would be?

The common responses to this question included: patient safety risks, an inability to access (or a total loss of) patient information or systems, an inability to operate services.

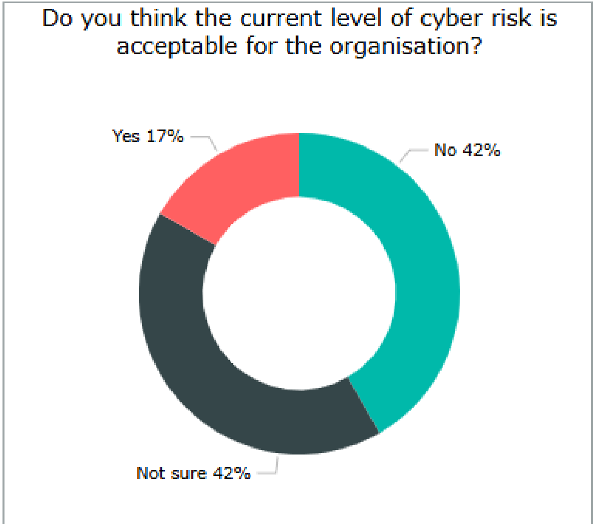
How likely do you think it is that the organisation will suffer a moderate cyber security incident?



How likely do you think it is that the organisation will suffer a serious cyber security incident?



Do you think the current level of cyber risk is acceptable for the organisation?



Findings & Agreed Action Plan

Objective 1: The risks associated with cyber security are appropriately stated, recorded, understood and managed within the organisations risk appetite	**Reasonable**

Overview / Summary of Observations

The Strategic Risk Register (SRR) includes a digital infrastructure risk (SRR 006A), which references cyber-related controls. However, cyber security is not explicitly identified or described as a standalone threat or risk. While the key controls listed under SRR006A are cyber security-related, several were found to be outdated or inactive. Furthermore, we were informed that the Cyber Security Team do not have regular visibility of the Strategic Risk Register and do not contribute to its updates, as such the current cyber security risk may not be accurately and clearly stated on the Strategic Risk Register.

The absence of a risk explicitly outlining cyber security, would be supported by responses to the questionnaire we shared with senior staff members in the Health Board, where only 50% of respondents indicated that they had seen a cyber security risk on a risk register. In addition, only 17% of respondents felt the current level of cyber risk was acceptable, with 42% 'Not sure' and another 42% stating that it was not acceptable (we recognise the small sample size).

The organisation has an established risk appetite framework which outlines thematic areas of risk, each with a clearly defined appetite level. The risk most closely aligned to cyber security on the Strategic Risk Register (SRR 006A) is currently scored at 12 and aligned to an 'Open' appetite and the 'Service Delivery' theme. However, if cyber security were explicitly referenced, the more appropriate risk appetite theme may be 'Compliance and Safety', which carries a 'Minimal' appetite. This would place the current score outside the organisation's stated appetite and more accurately reflect statements raised by senior leaders in questionnaire responses, particularly regarding the potential impact of a cyber incident on patient safety.

The Cyber Security Team actively manage risks through the Digital Risk Register maintained on SharePoint, with evidence of reporting, monitoring and escalation. Risks are identified through monitoring, incidents, assurance activity, and escalation from Governance Assurance Groups (GAGs). These risks are discussed at monthly compliance meetings, and while minutes are not taken, updates are incorporated into the monthly cyber reports and escalated to the Information Governance Group via the performance report. However, the organisation's Risk Management Policy and Procedure indicates that all risks should be recorded on Datix, and as they currently are not for cyber security, this limits visibility outside of the Digital, Data & Technology (DDaT) teams.

Additionally, the organisation's Risk Appetite Statement specifies that "risk register entries will be categorised by the risk appetite theme" which indicates that risks recorded on Datix require a risk appetite theme to be recorded. However, the Digital Risk Register does not currently require a risk appetite score or theme. We note that each risk on the Digital Risk Register includes a target score which could indicate the appetite, however, there are no target dates recorded for mitigation or for achieving these scores. This limits the ability to assess when the target score will or should be achieved.

Our testing confirmed that progress to treat risks is being made and there is evidence of risks being closed on the risk register. Recent additions to the Cyber Risk Register were reported in the monthly cyber security report and the performance report to the Information Governance Group. The transfer of risks from the Cyber Security Team to wider digital teams for mitigation is agreed at the monthly compliance meetings, with the Cyber Security Team retaining oversight of progress and providing support where required at these meetings. It was also highlighted that all members of the Cyber Security Team have completed ISO 005 Information Security Risk Management training.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Strategic Risk Register** The key controls recorded on the Strategic Risk Register against Strategic Risk 006 Part A (SRR 006A) are cyber security focused, however some are outdated or no longer relevant. The current risk and threat recorded for SRR 006A does not explicitly outline cyber security, although all the key controls for this risk and threat are cyber security focused. This could be updated to raise the profile of the cyber security risk to the organisation. The current risk appetite theme for SRR 006A is 'Service Delivery' which indicates an 'Open' risk appetite level. However, the most appropriate risk appetite theme for cyber security may be 'Compliance and Safety' which has a 'Minimal' risk appetite level, and this would mean the current risk score is outside of the risk appetite for the organisation.	Outdated cyber security controls on the Strategic Risk Register may misrepresent current risk exposure, reducing visibility and preparedness.	**Agreed Action:** At a strategic level, the Strategic Risk Register (SRR) is intended to capture broad organisational risks, rather than focusing on specific areas. Detailed and operationally focused risks, such as those relating specifically to cyber security are more appropriately captured within the Corporate Risk Register (CRR). This approach ensures that sensitive information and specific control measures are managed securely. The SRR will continue to reflect digital risk at a strategic level, with cyber security risks managed and monitored through the CRR where a more granular level of detail and assurance can be maintained. We recognise that some of the key controls currently listed under SRR 006A are outdated or no longer relevant and a comprehensive review will be undertaken to ensure that: • The risk and key controls remain current, relevant, and aligned to the organisation's risk appetite. • References to cyber security within SRR 006A accurately reflect its role within the wider digital risk landscape.
			Expected Evidence of Implementation: • Updated version of SRR 006A reflecting refreshed risk, controls • Strategic Risk Reports to the Board and Finance and performance Committee with the updated assessment. • Confirmation that specific cyber security risks have been reviewed and, where appropriate, captured and monitored within the CRR**.**

		High Priority	**Officer:** ICT Cyber Security Manager/ Head of Corporate Risk and Assurance **Target Implementation Date:** 31 January 2026
	Theme: Risk Management	Control Design	
2	**Cyber security risks not recorded on Datix and no risk appetite recorded** The organisational Risk Management Policy and Procedure states that "The Health Board Risk Management System, Datix, should be used to record, manage, monitor and review all risks." However, the cyber security risks for the organisation are currently only recorded on SharePoint as part of the wider Digital Risk Register. The Digital Risk Register does not require a risk appetite score or theme to be recorded; however, the organisation Risk Appetite Statement highlights that risk register entries will be categorised by risk appetite theme. This limits the visibility of risks to only the Digital, Data & Technology teams, where they also do not have a defined risk appetite.	Cyber security risks not being recorded on Datix limits visibility to only the DDaT teams.	**Agreed Action:** While the Risk Management Framework sets the expectation that all organisational risks are recorded in Datix, it is recognised that Datix does not currently provide the functionality needed for effective digital risk management. In agreement with the Digital, Data & Technology (DDaT) team, operational digital and cyber risks will continue to be recorded and managed via the SharePoint Digital Risk Register in the interim. This ensures effective operational oversight and reporting within the governance structure, while corporate and strategic-level digital risks remain recorded on Datix in line with the Risk Management Framework. Given that Datix is due to be decommissioned within the next two years, with a replacement system anticipated sooner, this approach avoids duplication and maintains efficiency. The DDaT team will be a key stakeholder in the design, scoping, and procurement of the new organisational risk management system to ensure it is optimised, user-friendly, and capable of adapting to the evolving demands of an advancing digital environment.
			Expected Evidence of Implementation: • Confirmation that corporate and strategic-level digital risks are recorded and monitored within Datix.

			• Copy or extract of the SharePoint Digital Risk Register demonstrating active management of operational digital and cyber risks. • Governance meeting minutes evidencing regular oversight and escalation of digital risks. • Addition of risk appetite and theme to the directorate SharePoint risk register
		Medium Priority	**Officer:** ICT Cyber Security Manager/ Head of Corporate Risk and Assurance **Target Implementation Date:** Completed
	Theme: Risk Management	Control Operation	

Objective 2: An appropriate governance process for cyber security across the organisation is in place which enables monitoring, reporting and effective management. **Reasonable**

Overview / Summary of Observations

The governance structure for Digital, Data & Technology (DDaT) has been revised with an aim to enhance oversight, monitoring, and reporting at all levels. The inclusion of a standing cyber security agenda item at the Divisional Governance & Assurance Groups (covering both clinical and corporate services) aims to help promote cyber security awareness across the organisation and support two-way communication. A member of the Cyber Security Team attends each of these meetings and provides updates on topics such as phishing campaigns and business continuity planning and asks for any cyber risks or issues to be flagged to them.

Although the new structure outlines the Governance Assurance Groups should report into the Information Security Assurance Sub-Group, this is yet to take place, and it is possible that these groups will report directly to the Information Governance Group chaired by the Senior Information Risk Owner (SIRO). The SIRO provides regular cyber security updates to the Finance and Performance Committee - the designated committee for cyber security - as part of the Information Governance Reports, and it is outlined that this will now be done on a quarterly basis. While dedicated cyber reporting to the Board has not occurred recently, brief updates are provided within the Finance and Performance Committee Chair's Update Report.

The Cyber Security Team oversees cyber security for the whole organisation of 14,000 staff members[2] and consists of the Cyber Security Manager, and a small team of senior specialists and analysts. Although the team is currently at full complement, the increasing demands and complexity of their work across governance, technical oversight, and assurance activities has placed pressure on resources. The Cyber Security Manager has escalated concerns and proposed a revised structure to include junior staff to support operational delivery.

The Cyber Security Team produce a monthly report that includes updates from the wider Digital, Data & Technology teams, (e.g. Desktops, Business Systems) and performance metrics including desktop and service patching levels, vulnerability management (e.g. MS Defender) and Halo handled calls. Although there are only a limited number of documented KPIs, there is clear evidence of monthly monitoring and reporting of performance metrics.

Efforts to raise cyber security awareness across the organisation is evident through a dedicated intranet site, carousel communications, and phishing simulations. Despite these initiatives, performance in phishing campaigns remains poor, with 12% of targeted staff clicking on simulated malicious links, as reported in July 2025, with a reported target of 5% and compared to another NHS Wales health board where a 2% click rate was reported in May 2025. Given that phishing was the most common type of cyber breach or attack in 2024, affecting 84% of businesses and 83% of charities[3], the absence of targeted training for compromised users is a notable gap. The Cyber Security Team has recognised this and has procured MetaCompliance licenses for all staff to enable full Active Directory synchronisation and access to enhanced training packages.

In addition, compliance with mandatory Information Governance and Cyber training remains below the organisational target of 85%, with completion rates at 77% in September 2025. These factors suggest that further work is needed to strengthen staff awareness and resilience against cyber threats. Both the poor phishing simulation performance and low training compliance have been flagged for possible inclusion on the Cyber Risk Register to ensure appropriate monitoring and scrutiny.

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[2] https://abuhb.nhs.wales/about-us/the-health-board/

[3] https://www.gov.uk/government/statistics/cyber-security-breaches-survey-2024/cyber-security-breaches-survey-2024

	Key Findings	Risk & Impact	Agreed Management Action
3	**Staff awareness and training** Recent phishing simulations indicate a click rate of 12% across the organisation. The absence of targeted training for compromised staff, combined with mandatory Information Governance and Cyber Security training completion rates falling below the Health Board's 85% target, increases the risk of continued vulnerability. It was suggested that staff awareness should be added as a cyber security risk to raise the profile and ensure further monitoring of progress.	High phishing compromise rates and low training uptake increase cyber risk due to a lack of staff awareness.	**Agreed Action:** Management accepts the recommendation and will address the findings through the following actions. • Continue the phishing simulation programme, using the established baseline to drive measurable improvement. • Deliver targeted follow-up training modules to individuals who regularly fail simulations, using tailored content linked directly to the exercises. • Report phishing simulation outcomes monthly through relevant governance groups to support monitoring of staff awareness improvements. • Enhance the visibility of cyber security messaging through regular internal communication and security awareness campaigns. • Work collaboratively with Information Governance, Counter Fraud, and other stakeholders to maximise use of available training resources. • Ensure cyber security staff awareness is appropriately reflected within the corporate risk framework for ongoing oversight.
			Expected Evidence of Implementation: • Monthly phishing simulation results and reports submitted through governance structures. • Governance and Assurance Group minutes demonstrating review of security awareness materials and outcomes. • Copies of cyber security awareness campaigns and communications issued via multiple channels. • Evidence of a corporate risk register entry to monitor staff awareness as part of the cyber security risk profile.
		Medium Priority	**Officer:** ICT Cyber Security Manager **Target Implementation Date:** 31st January 2026
	Theme: Training & Development	Control Operation	

Objective 3: Identified actions to improve cyber security are progressed appropriately.	**Substantial**

Overview / Summary of Observations

The organisation has developed a cyber security improvement plan based on the findings from the Cyber Resilience Unit (CRU) audits of the Health Board's Cyber Assessment Framework (CAF) self-assessment, which focused on the Clinical WorkStation (CWS) system. The plan is being overseen by the NIS Assurance Group, which meets monthly and reports into the Information Governance Group chaired by the SIRO.

Although the CAF self-assessment was completed for a critical system, any weaknesses in current systems should be identified through monitoring, incidents and reporting through the Governance Assurance Groups (GAGs). For new systems, requests are required to go through the Digital Service Request process, and at this point the Cyber Security Team will be notified and complete what is required of them (cloud assessment, third-party assessment, code of connection etc). If this process was not followed, then work has been undertaken to include cyber security considerations into the procurement processes.

The latest version of the plan identifies four objectives that have exceeded their target completion dates, and the reason provided for these delays were primarily due to resource constraints and competing priorities. Despite this, there is evidence of ongoing progress against the plan, and updates continue to be reported to the Information Governance Group.

Testing confirmed that closed actions, such as improvements to third-party contract processes, have led to cyber security being embedded in new procurements, although legacy contracts remain a challenge. In-progress actions, such as privileged access management, are being supported by new policy development and semi-automated processes.

While governance structures are in place and progress is evident, updates on improvement objectives being managed by the NIS Assurance Group to the Finance and Performance Committee and the Board has been inconsistent, with no evidence of this since December 2024. To strengthen oversight, reporting timescales could be formalised in the NIS Assurance Group's Terms of Reference, ensuring regular scrutiny at Committee and Board level.

Objective 4: An appropriate cyber incident response plan is in place. | **Limited**

Overview / Summary of Observations

The organisation has a Cyber Security Incident Response Plan (the 'Plan') in place, detailing key procedures, roles, and communication protocols to be followed in the event of a cyber incident. The Plan includes a requirement for testing to be completed every six months using fictitious scenarios; however, no formal testing of the Plan has been conducted to date. While there are intentions to carry out testing within Digital Services, followed by tailored exercises for the Governance Assurance Groups (GAGs), this has yet to be implemented. The Cyber Security Team did recently host a tabletop exercise facilitated by Tarian, however, this did not constitute a test of the Plan itself. Testing of the Plan is listed as a current key control on the Strategic Risk Register which may need to be reviewed, and the lack of formal testing was flagged by the Cyber Resilience Unit (CRU) in their June 2025 audit.

Roles and responsibilities are broadly defined within the Plan, including the establishment of a Cyber Incident Response Team (CIRT). While the Plan refers to the creation of action cards to clarify individual duties, the Cyber Security Team could not confirm that these have been developed. This limits the operational clarity of the response process. There has recently been a Digital Business Continuity Clinical Lead recruited (who will also cover cyber), and an Incident and Problem Manager for ICT that would support the Cyber Security Team with the incident response if the Plan was to be invoked.

Communication mechanisms are partially in place, with key contacts listed and systems such as Tickertape and email/SMS messaging available for internal notifications. However, there are no dedicated, pre-written communications for cyber incidents tailored to different audiences outside of the Health Board.

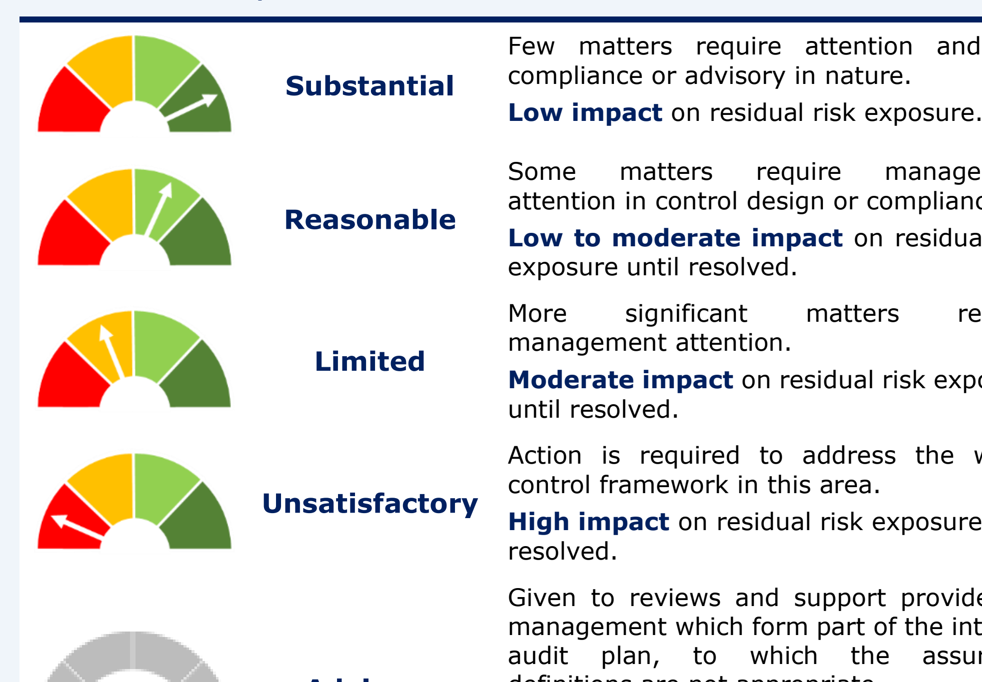
The Cyber Security Team has limited internal capability to manage a cyber incident independently. Forensic investigation skills are not present within the team, and there is no formal agreement in place for third-party support. The team confirmed they would rely on external assistance but acknowledged that this is not prearranged.

The findings around testing of the plan and third-party support have already been raised via the CRU and reported to the Information Governance Group in August 2025, each of them has been assigned high-risk scores on the NIS Assurance Groups register. They are now being monitored through the NIS Assurance Group and any escalations from this group will be reported to the Information Governance Group that is chaired by the SIRO. While the existence of a response plan is a positive foundation, the lack of testing, unclear communications, and limited internal capability suggest that further development and formalisation are required.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Cyber Incident Response Plan** • The Cyber Incident Response Plan highlights that the plan should be tested every six months but his has not been done. • The Cyber Security Team do not have the capabilities, expertise or resources to deal with a cyber event internally and they do not have third-party support formally agreed. • The incident response plan highlights that there should be action cards that define the duties of everyone in the Cyber Incident Response Team (CIRT), however these have not been drafted. • Communications have not been drafted for any audience outside of the Health Board.	Limited cyber response capability and a lack of testing weaken preparedness, increasing the risk of delayed or ineffective action during a cyber incident.	**Agreed Action:** A tailored tabletop exercise will be undertaken within the next three months to specifically test the current Cyber Incident Response Plan, as required. The scenario will incorporate the areas identified in the audit findings, including clarity of team responsibilities, escalation pathways and communication requirements. Following completion, the Cyber Security Team will produce a formal post-exercise report that clearly documents lessons learned and required improvements. These improvements may include the creation of action cards, enhanced external communication arrangements and the securing of specialist third-party cyber support. Learning and feedback from the recent national DHCW exercise will also be reviewed and used to strengthen the Health Board's Cyber Incident Response capability in line with the existing plan.
			Expected Evidence of Implementation: • Copy of the tabletop exercise scenario • Post-exercise report including improvement actions and implementation owners • Updated Cyber Incident Response Plan testing schedule (2026–27) • Documentation confirming the review and options appraisal for external specialist support (e.g., forensic retainer) • Draft or completed action cards supporting the Cyber Incident Response Team roles and responsibilities • Communications templates developed in collaboration with the Communications Team for external use during a cyber incident.
		High Priority	**Officer: ICT Cyber Security Manager** **Target Implementation Date: 31st January 2026**
	Theme: Cyber Security	Control Operation	

Appendix A

Assurance Opinion



Opinion	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

RGH Central Decontamination Unit

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

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Executive Sign Off	15 November 2025
Audit Committee	16 December 2025
Executive Lead	Hannah Evans, Executive Director Strategy, Planning and Partnership
Audit Team	Huw Richards, Head of Internal Audit Murray Gard, Audit Manager

Executive Summary

Purpose

The review was commissioned in accordance with the 2025/26 Internal Audit Plan, as agreed by the Audit, Risk and Assurance Committee. The overall objective of this audit was 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

Overview

We have concluded reasonable assurance over this project area, based on our review of governance, financial controls, contractual compliance, and quality arrangements. This assurance reflects the position at the time of our audit fieldwork and recognise the project controls being applied.

As of 14 July 2025 (week 25 of 42), an estimated 15-week delay to the project delivery programme was being reported. This was being attributed primarily due to steel and M&E design issues adversely impacting the procurement programme. Associated contractual extension of time claim submissions remain under review, with root cause analysis recommended. Despite potential 35% programme overrun, recovery efforts continue. Financially, the forecast outturn cost remains within the allocated project budget of £4.023m. However, contingency had significantly reduced to £63,780 (with 17 weeks of the original contract programme remaining). Quality assurance had been supported by the supervisor, with no formal workmanship concerns raised.

Governance arrangements had developed during the project's delivery. The Business Justification Case (BJC) clearly established individual's responsibilities, with the Senior Responsible Owner role transitioning to the Director of Estates and Facilities following approval. While the Project Board was not established until February and first met in March 2025 i.e. after procurement and site activities had commenced, it has since met regularly with strong attendance and adherence to its Terms of Reference. Supporting governance tools included the Project Execution Plan (PEP), monthly cost reports, commercial meetings, and lessons learned from previous audits.

Contractual and valuation processes were broadly robust, with contracts managed under the Joint Contracts Tribunal (JCT) Standard Building Contract (SBC) 2016 and variations processed in line with established controls.

Valuations were independently verified and supported by vesting certificates where appropriate, ensuring alignment with the associated budget and approvals. Change management arrangements had been applied consistently, with a sample review confirming compliance.

Other matters requiring management attention include:

- The August derogation schedule identified some deviations from standards requiring further justification and sign-off,
- Adviser appointments followed the Shared Business Services (SBS) framework, although improvements could be made around indemnity cover, KPIs, and insurance records.
- Recognising the design issues experienced at this and wider UHB capital projects there may be benefit in management reviewing the design development arrangements being applied across all capital projects; this may include for example, the adequacy of the determination and management of the design brief, adequacy of site survey information, design team appointment processes, design sign off arrangements etc.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have also been identified that do not impact the overall opinion and are highlighted for management information:

- VAT reporting and potential reclaim were addressed through bi-monthly Project Performance Reports to Welsh Government and the Project Board. Incorporating VAT implications into monthly cost reports would provide the Project Board with greater visibility of the full outturn position and strengthen financial oversight.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	**Project Performance:** An assessment of performance against key project objectives (e.g. time, cost, benefits, critical success factors etc.).	1,2,3	**Limited**
2	**Project Governance and Management:** Assurance that appropriate governance, management and reporting arrangements are in place for the current project phase.	2,4,5,6	**Reasonable**
3	**Contractual arrangements:** To obtain assurance that parties contracted to the Health Board have been appropriately appointed, including the timely completion of appropriate contractual documentation.	2,7	**Limited**
4	**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.		**Substantial**
5	**Change Management**: A robust change management process is defined and applied ensuring the impact of changes on time and cost are adequately controlled		**Substantial**

RGH Central Decontamination Unit Time and Cost Position- At a Glance:

Time

The latest reported position July 2025 highlighted:

Key Milestone	Key Dates
Original Contract Completion Date	27/10/25
Original Contract Duration	42 weeks
Anticipated Delay:	15 weeks
Anticipated Contract Completion Date	12/02/25
Anticipated Occupation Date post commissioning	24/03/26

Cost

The latest cost report July 2025 reported the following summary of costs:

Cost	Forecast Outturn (Ex VAT) £	Budget (Ex VAT) £
Contractor cost including uplift and agreed/ anticipated variations	2,546,020	2,222,834
Client costs including direct costs/fees	1,413,297	1,365,339
Contingency (excluding agreed and anticipated variations)	63,780	434,924
Total Cost	**4,023,097**	**4,023,097**

Findings & Agreed Action Plan

Objective 1: Project Performance (Time/Cost/Quality)	**Limited**

Overview / Summary of Observations

As of 14 July 2025 (week 25 of a 42-week programme), the project was experiencing an estimated 15-week delay, under review by the Contract Administrator. The delay is primarily linked to design issues in steel and mechanical/electrical works, which hindered timely material orders. The contractor's extension of time and loss/expense claim remained unresolved at fieldwork conclusion. Given the potential 35% programme overrun, a root cause analysis is recommended.

Financially, the forecast outturn cost (as at the end of July) was £4,023,097, within the approved budget, though the remaining contingency had fallen to £63,780 (from £434,924). This relatively low balance requires close monitoring considering the programme extension.

The Health Board appointed an external supervisor, providing monthly site reports. No workmanship issues have been formally recorded, with any concerns addressed directly onsite.

It was highlighted within the August 2025 derogation schedule that while deviations from standards were recorded, several lacked adequate justification and documented sign-off. Also, by 7 July 2025, 13 RFIs had been issued and closed. While the RFI process was functional, response timeliness was identified as an area for improvement. Given the design issues observed within this and other Health Board capital projects, it would be prudent to undertake a review of the design development arrangements currently in place. Such a review may encompass, among other matters the adequacy of the determination and management of the design brief, adequacy of site survey information, design team appointment processes, design sign off arrangements etc.

Accordingly, limited assurance had been determined due to material delays, and weaknesses in quality controls; despite (At the time of the audit fieldwork) being forecast to remain within budget.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Extension of Time** At the conclusion of fieldwork, the contractor's extension of time and associated loss and expense claim submission had not been agreed. Given that the delay was material, potentially representing a 35% extension to the original 42-week programme, a root cause analysis should be undertaken. This should examine the justification for the claim, assess any potential liabilities, and capture lessons to inform the management of future projects.	Unresolved delay may lead to increased financial liability.	**Agreed Action:** Work is ongoing through the contractual process and is led by the project's Cost Advisor. This work includes assessment of cause but will also consider what reasonable (if any) mitigation has been put in place by the contractor to manage the impact of the delay, as per the JCT contract. The outcome may not be concluded until the end of the project, but will continue to be monitored through the Commercial Meetings. A financial allowance will be made within the contingency to manage the potential cost pressure.

			Expected Evidence of Implementation: Conclusion of contractor's extension of time and expense claim. Discussion through Lessons Learnt, including discussion on liabilities in order to inform future projects.
		Medium Priority	**Officer:** Senior Responsible Officer Project Director **Target Implementation Date:** 30 April 2026
	Theme: Lessons Learnt	Control Operation	
2	**Derogation Schedule** A derogation schedule records and approves deviations from standards, policies, or contract terms. The latest schedule (August 2025) was reviewed and identified several weaknesses e.g. some derogations lacked sufficient justification, and evidence of formal sign-off was not documented. In addition, the September 2025 risk register highlighted an amber-rated risk (score 12) relating to derogation approval and design variations. With project completion expected in February 2026, unresolved derogations may result in delays or challenges at handover and commissioning. Action was required to provide full justification and secure timely approvals for all derogations. Progress and resolution of these matters should be formally reported through the Project Board.	Unapproved derogations risk project delays and handover challenges without formal resolution and governance oversight.	**Agreed Action:** Urgent review of derogation schedule ensuring agreement and sign-off to the latest derogations. Derogation schedule reviewed by Head of Works & Estates. Derogation schedule will be presented to relevant subgroups for review and sign off.
			Expected Evidence of Implementation: Agreed and signed-off derogation schedule
		High Priority	**Officer:** Divisional Director Estates and Facilities **Target Implementation Date:** 31 December 2025
	Theme: Approvals	Control Operation	
3	**Requests For Information** As of July 2025, a total of 13 RFIs had been issued, all of which were closed. A review of the Health Boards RFI process highlighted the following: • Seven RFIs were closed after their due dates, with delays ranging from 4 to 42 days.	Ineffective accountability without process improvements.	**Agreed Action:** The RFI process forms part of the JCT contract. It will not always be possible for the RFI's to be closed out within the allocated 14 day turn around due to complexities within design development. If this is not possible the Project Manager will be notified and the RFI's will continue to be monitored through Design Team Meetings. Where there is a potential delay which will impact on programme/ cost, the risk will be managed through the contractual process.

	• Although the tracker includes a section to record potential cost and schedule impacts, in most cases no quantitative assessment of the impact of delays was documented. • Six RFIs had multiple individuals assigned. To strengthen accountability, consideration should be given to designating a single lead responsible for coordinating and ensuring timely closure of each RFI. While no further RFIs remained open, lessons from this project and other capital projects should inform future schemes by reviewing the design development arrangements and ensuring timely closure, documenting cost and schedule impacts, and assigning clear accountability for each RFI.		Where appropriate a single lead will be identified, however this will be dependent on the nature of the RFI raised as they often have dependencies of a multi-discipline nature.
			Expected Evidence of Implementation: Discussion of RFI's at Design Team meetings including discussion on potential time/ cost impact. Discussion at Design Team Meetings in relation to a dedicated owner of an RFI, clarifying whether it is appropriate or not for a single owner to be identified. A separate lead for each RFI has been identified for each organisation and is currently being implemented by the Contractor. Findings in future Capital Audits
		Medium Priority	**Officer:** Programme Manager/ External Project Manager **Target Implementation Date:** Complete
	Theme: Performance Monitoring	Control Operation	

Objective 2: Project Governance and Management	Reasonable

Overview / Summary of Observations

The Business Justification Case (BJC) defined governance roles including the Senior Responsible Owner (SRO), Project Director, and Service/Clinical Lead, supported by Estates, Finance, and specialist advisors. Following approval, the SRO responsibility appropriately transferred to the Director of Estates and Facilities, reflecting the scheme's scope.

The first progress meeting took place on 21 January 2025, ahead of the establishment of the formally defined governance arrangements. A combined Project Board and Team were established during February and first met 3 March 2025, although some activities e.g. design development were already progressing. Best practice would reflect the implementation of formal governance structures prior to project delivery, with reporting lines clearly established.

Once operational, the Project Board has met regularly (March–June 2025) with consistent attendance from key representatives. Terms of Reference were met, and meetings followed a standard agenda. Governance arrangements were further supported by a Project Execution Plan (updated July 2025), monthly cost reports, and commercial meetings. While VAT reporting was excluded, Capital Finance monitored the same and included updates at bi-monthly Project Progress Reports (PPR) to the Project Board, ensuring oversight of costs.

Additional assurance included Project Manager summaries and highlight reports, aligning with the scheme's scale and incorporating lessons from prior audits. However, risks remain e.g. The July 2025 construction risk register had not been costed, financial impacts of programme delays were not fully reflected (although this was rectified in the September risk register following audit fieldwork), and no Project Bank Account (or formal exemption) was in place, contrary to Health Board Standard Financial Instructions.

Accordingly, reasonable assurance had been provided in relation to Project Governance and Management.

Key Findings		Risk & Impact	Agreed Management Action
4	**Project Board** Our review noted that project activities (appointment of advisers, site handover, design finalisation etc commenced prior to the establishment of the Project Board. The absence of formal governance arrangements at this stage potentially posed risks to decision-making, accountability, and assurance over scope control/cost. Good practice requires a Project Board to be in place prior to initiation of works to provide oversight and ensure alignment with the project's business case. We recognise that no action can be taken at this project, however there should be learning to inform future schemes.	Initiating a project without a Project Board risks ineffective oversight and potential misalignment with scope, cost, and business case objectives.	**Agreed Action:** The RGH Decontamination Unit previously reported to the Endoscopy Project Board. The Project Board was put on hold following the completion of the Endoscopy Project, due to the delay of the delay of the completion of the Decontamination Unit Business Case. Delay was due to the agreement of the revenue cost, during which time however oversight and scrutiny was provided at an Executive level and also through the Health Boards Pre-Investment Panel Process. The delay caused an unplanned delay to the Project commencement date. Future projects will ensure continuity of governance procedures.

			The Decon Project has been unique in respect of its dependency on the Endoscopy Project. Should this type of project be taken forward in the future, rationale for pausing/ stepping down Project Boards will be formally recorded and clear accountability structures will be in place for the interim period.
			Expected Evidence of Implementation: Futures Projects of this nature will note rationale for pausing/ stepping down Project Boards with clear accountability structures during the interim period being in place. Findings in future Capital Audits
		Medium Priority	**Officer:** Project Director **Target Implementation Date: Completed**
	Theme: Governance	Control Operation	
5	**Project Bank Account** Welsh Procurement Policy Note (WPPN) 04/21 requires that all Welsh Government construction and infrastructure contracts, and other appropriate contracts valued at £2m or more, utilise a Project Bank Account (PBA) unless compelling reasons for exemption are documented and approved. Similarly, Health Board SFIs require the Director of Finance to ensure PBA policy compliance for capital projects over £2m or formally seek exemption from Welsh Government. For this project, no PBA was established, and management had not confirmed whether an exemption application had been submitted. It was noted, however, that the main contract was an extension of the previous Endoscopy Redevelopment arrangement, and therefore a PBA was not considered, as the previous project had not applied a PBA; an issue highlighted in the last audit report. Project payments are currently managed through monthly valuations/invoices, with defined purchase orders in place. Internal processes should be reviewed to ensure PBA considerations (and exemptions, where relevant) are explicitly documented at the initiation of all capital projects over £2m.	Failure to establish or document PBA exemption risks non-compliance to Health Board SFIs.	**Agreed Action:** Review internal process to ensure all necessary documentation is considered and completed prior to contract start date ensuring the governance process is followed and correctly implemented.
			Expected Evidence of Implementation: Signed documentation showing the correct process being followed.
		Medium Priority	**Officer:** Project Director **Target Implementation Date:** 31 December 2025
	Theme: Governance	Control Operation	

6	**Financial Management (Contingency)** The contingency position was actively reported, with provision made for a potential extension of time, loss, and expense claim that remained under assessment. A costed risk register was developed and submitted as part of the BJC, however, this was not t updated until September 2025 (circa 9 months into construction). The Project Board should be fully appraised of the potential cost implications of anticipated risks to support more informed decision-making.	Project decisions may be less informed, potentially leading to unanticipated costs, resource misallocation.	**Agreed Action:** Regular review of cost risk register taking into consideration current and potential future risks. **Expected Evidence of Implementation:** Costed Risk Register reviewed and updated. Project to ensure that the Risk Register is reviewed and updated on a monthly basis to ensure contingency position is accurate Findings in future Capital Audits
		Medium Priority	**Officer:** Senior Responsible Officer **Target Implementation Date: Completed**
	Theme: Reporting	Control Operation	

Objective 3: Contractual Arrangements	**Limited**

Overview / Summary of Observations

The BJC determined the procurement route for the main contractor i.e., adopting the JCT Standard form Building Contract Excluding Quantities (2016 Edition), extended based on professional advice from the earlier Royal Gwent Hospital Endoscopy Unit refurbishment. A formal contract instruction, signed by the Health Board Chief Executive, varied the original contract prior to commencement on site. A purchase order was also raised, demonstrating compliance with financial controls and the All-Wales "no purchase order, no pay" policy.

The contractor provided £5m public indemnity insurance, considered appropriate for the scheme's value.

To avoid duplication from previous reviews, the focus of this assessment was on adviser appointments. It was noted that procurement and contract strategies were not explicitly documented within the BJC or as a separate governance document. Adviser appointments were made under Service Level Agreements (SLAs) from the Shared Business Services framework across various professional service lots. However, several supplementary conditions were introduced, including reduced indemnity cover. While other inconsistencies were identified e.g., the KPI sections within the SLAs were not always applied. NWSSP: Procurement Services were not engaged during the adviser procurement process.

Furthermore, the Health Board did not verify insurance documentation for advisers. While the use of a framework provides some assurance, the project should ensure insurance validity is monitored throughout the project lifecycle.

Given these findings, limited assurance was concluded regarding the contractual arrangements, particularly in relation to adviser procurement and oversight.

Key Findings		Risk & Impact	Agreed Management Action
7	**Appointment of Advisers** The approved BJC did not specify the procurement route for appointing advisers, and Procurement Services were not engaged in the appointment process. Advisers were appointed through the Shared Business Services framework. A review of four SLAs highlighted: • Several supplementary conditions had been added to the SLAs, including a limitation of indemnity cover to the value of the award. There was no evidence of challenge to confirm that such amendments were appropriate or acceptable to the Health Board prior to signing. • Three of the four SLAs lacked KPI requirements, (although it was confirmed that KPIs would be utilised). • Management Information sections were vague, with one stating "not used." • Insurance documentation was not maintained by the Health Board. Although the engagements were undertaken via a framework, the Health Board should ensure that insurance cover remained valid for the duration of the project. Noting the above, the Health Board should review its internal procedures/processes to ensure early involvement of NWSSP: Procurement Services, formal review of contract terms (including indemnity and insurance), and inclusion of clear KPI and management information requirements in all SLAs.	Ineffective SLA controls risk inadequate adviser accountability, insufficient insurance, and performance monitoring arrangements.	**Agreed Action:** Agreed. Ensure the BJC specifies the procurement route and engagement of Procurement Services. Ensure the SLA is reviewed in line with the Shared Business Services framework (SBS). Inhouse review of the SLA and challenge to ensure contracts are correct and aligned to the SBS framework. Request insurance document to check validity of insurance. Inclusion of KPIs in the contact documentation. **Expected Evidence of Implementation:** Future projects - provide necessary documentation demonstrating the correct procedures and process have been flowed in line with the Shared Business Services framework. Ensure scrutiny of SLA's specifically reviewing indemnity levels. Findings in future Capital Audits
		High Priority	**Officer:** Project Director **Target Implementation Date:** Completed
	Theme: Contractual	Control Operation	

Objective 4: Valuation and Payments	**Substantial**

Overview / Summary of Observations

The contractor's monthly valuations (payment requests) were reviewed and certified by the external Quantity Surveyor, supported by Clerk of Works input to confirm the quality of works. Our review of the valuation process identified no issues and highlighted several strong controls.

Valuations were subject to thorough cross-checking, with measured works verified against site records, progress reports, and consultant/Contract Administrator inspections to ensure only completed works were certified, avoiding advance payments. Reported progress was validated by comparing contractor-claimed percentages with actual physical progress, with appropriate application of preliminaries.

Certification also extended to materials both on and off-site, with ownership transferred to the Employer through vesting certificates where applicable. All valuations were reviewed and formally approved by the Contract Administrator/Quantity Surveyor.

In addition, internal Health Board financial approvals were consistently obtained in line with delegated authorities, ensuring compliance with governance requirements. Valuations were also reconciled against the project budget and financial forecasts to monitor expenditure and cost to completion.

According, Substantial Assurance had been determined noting the valuation and certification process was assessed as robust, with effective checks in place to safeguard financial control and ensure payments reflected actual, verified progress.

Objective 5: Change Management | **Substantial**

Overview / Summary of Observations

The variations and change register were maintained as a live tracker and made regularly available to the Project Board. Contract instructions were counter-reviewed by the Health Board and formally reported through Project Board meetings.

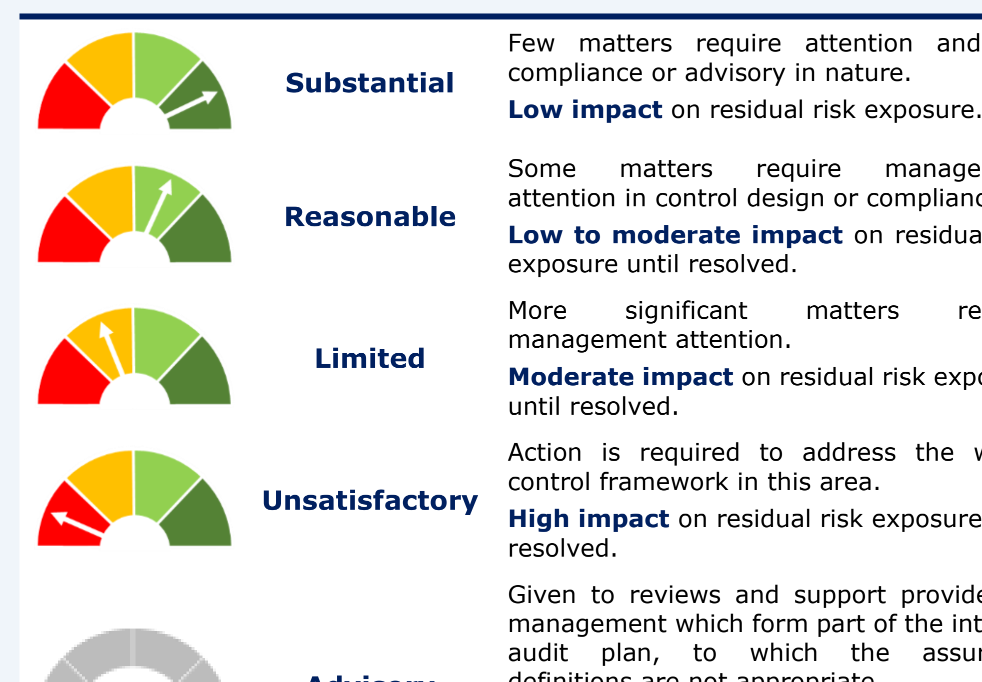
A clear procedure for managing changes was documented within the Project Execution Plan (PEP). This included: identification of a variation, issue of a Variation Order and costs by the contractor, Quantity Surveyor review and commentary, Contract Administrator/Project Manager review with Health Board leads (covering cost and programme impacts), followed by acceptance or rejection. Accepted changes were formalised through contract instructions in line with contract terms and counter-signed by the Health Board (representative). Once authorised, changes were implemented. In addition, the Health Board introduced the use of a Project Change Form (PCF) alongside contract instructions to strengthen governance.

A sample of variations totalling £175,597.24was reviewed for substantiation and compliance with procedure. Compliance with process requirements was confirmed.

According, Substantial Assurance had been determined noting that whilst governance and procedural compliance were appropriate.

Appendix A

Assurance Opinion



Opinion	Definition
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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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

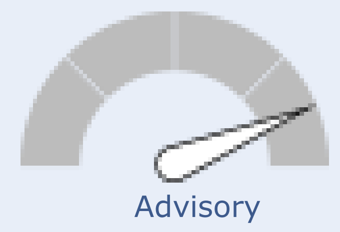
Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Public Health

Final Advisory Review Report

2025/26

Aneurin Bevan University Health Board



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Review Reference	ABU 2526-13
Fieldwork	September – October 2025
Executive Sign Off	November 2025
Audit Committee	December 2025
Executive Lead	Tracey Daszkiewicz, Executive Director of Public Health and Strategic Partnerships
Audit Team	Stephen Chaney, Head of Internal Audit
	Eifion Jones, Deputy Head of Internal Audit
	Rhian Gard, Audit Manager

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

EXTERNAL • QUALITY • ASSESSMENT

Executive Summary

Purpose

To determine if the Health Board had 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.

As an advisory review, this report has not been assigned an overall assurance rating and does not provide mandatory or formal recommendations, but rather options for management to consider for implementation. A number of items have been raised aimed at improving internal controls and/or compliance. These will need to be considered against other priorities and available financial / non-financial resources.

Overview of findings

Since 2023, the Public Health Team has been integrated into Aneurin Bevan University Health Board (the 'Health Board'), having previously operated as part of Public Health Wales.

This transition represented a significant organisational change, introducing new processes and ways of working as the team continues to adapt to its operational environment within the Health Board. During the initial transition, many existing practices were maintained; however, the current strategic focus is on embedding public health initiatives at a local level, aligning closely with the Health Board's community-based approach. The team's overarching mission is to "build a Healthier, Fairer, Safer and Stronger Gwent for all".

The Health Board is the first designated Marmot Region in Wales, meaning it is a network of local stakeholders working together and applying Marmot principles, to tackle health inequities and address the social determinants of health. The team works collaboratively with local authorities, voluntary sector organisations, and community groups to advance shared public health objectives, reduce health inequalities, and promote equity across the population. Active participation in the Public Services Board (PSB) ensures strategic engagement in the development and delivery of wellbeing initiatives, supporting the Health Board's wider priorities.

Our review found that substantial progress had been made, with some of the positive areas summarised within **Appendix A.** Given the advisory nature of this review, we did not assign formal priority ratings to the management considerations, however the following areas of focus have been identified:

- To demonstrate how the 2025/26 workplan and future workplans will contribute to the achievement of the overall IMTP objectives – and demonstrate adherence to the Future Generations (Wales) Act 2015.
- The public health annual report could then summarise on progress to deliver against these expectations.
- Governance arrangements at Senior Leadership Team, Finance SLT and supporting working groups could be reviewed for consistency and alignment with best practice.
- A specific financial delivery plan is required to address the anticipated £560,000 underspend currently being reported.
- Performance monitoring would benefit significantly from the establishment of performance framework principles – establishing clear expectations, targets and performance indicators – outlining the implications of non-delivery.
- While key risks are regularly discussed at the respective forums, there is opportunity to capture and co-locate risks within a single risk register – reflecting the Health Board agreed approach to risk management.

Findings & Management Considerations

Objective 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).

As the first designated Marmot Region in Wales this strengthens the Health Board's alignment with the Well-being of Future Generations (Wales) Act (the 'Act'). In addition, alignment to the Act and national priorities are reflected in the Health Board's Integrated Medium-Term Plan (IMTP) and the broader 10-year strategy (Gwent 2035), which was in the process of being finalised. Management advised that an overarching plan is currently in development to inform the Health Board's 10-year Strategy. A Planning Advisory Group (PAG) had been established to develop the workplan for 2025/26, which was consistent with the IMTP, and to support implementation and provide regular updates on progress.

The annual workplan only provides details of the in-year activity, accordingly there are many aspects of the IMTP that are not included/ addressed. Introducing a bridging document/ plan would provide greater clarity and direction contributing to the overall achievement of the IMTP objectives. Additionally, it would provide details of strategic prioritisation of local/ national initiatives and recognise those that cannot be achieved. This should also include SMART targets for delivery to allow meaningful performance monitoring **(Management Consideration 1)**.

While the Director of Public Health and Strategic Partnerships is currently the Senior Responsible Officer (SRO) and there is alignment throughout the IMTP, linkage to the Wellbeing of Future Generations (Wales) Act 2015 was not explicitly reflected in the team's 2025/26 workplan. This will need to be considered in the 2026/27 planning cycle, particularly considering a response was required by the Welsh Government by the end of October 2025 on the alignment with the Act **(Management Consideration 2)**.

Each year, Directors of Public Health prepare a report detailing the health status of the population and the region that they oversee. These reports focus on specific topics or populations and highlight factors that influence local health and wellbeing. They also outline potential actions for improving health outcomes in the area. The *We Are Gwent* Public Health Annual Report for 2024/25 (supported by the Gwent Joint Strategic Assessment (JSA)) aligned with the IMTP and provided a foundation for addressing health inequalities and the wider determinants of health. However, it primarily presented a high-level overview of the current position and required actions - it lacked detailed trend analysis and specific recommendations, which are essential for effective planning and implementation of IMTP objectives **(Management Consideration 3)**. During post audit discussions management advised that progress is underway to establish a plan of work, to produce topic based annual reports as well as the overarching one. The aim of the Director of Public Health Annual report was to be conversational in nature and reflective of discussions which take place in the communities.

Ref	Management Considerations	Potential Risk & Impact
1	**Strategic Planning** There appears to be no short and medium-term delivery plans that bridges between the in-year workplan and the overarching IMTP objectives. Introducing such a plan could provide greater clarity and direction for individual initiatives, outlining specific goals and the steps required to achieve them. This plan would serve as a single point of reference for all national/ local initiatives and other deliverables that contribute to the achievement of the IMTP objectives.	• There is a lack of clear strategic prioritisation impacting the implementation of the IMTP objectives. • Progress in implementing medium to long term local/ national strategies is not monitored. • A lack of coordination between local and national initiatives leading to misalignment. • Inadequate identification of resource needs leading to unfunded initiatives and patient neglect.

2	**Future Generations Act** There is a lack of reference to the Wellbeing of Future Generations (Wales) Act principles in the current work plan. There needs to more focus on the 2026/27 work plan to ensure it is embedded appropriately and that progress can be demonstrated.	• Risk of non-compliance of a statutory duty on public bodies to carry out their work in a way that improves the social, economic, environmental, and cultural well-being of Wales.
3	**Public Health Annual Report** The 2024/25 Public Health Annual Report: *We are Gwent* could be strengthened going forward to ensure it reports on the progress to deliver against national/ local strategies as defined within the annual workplan and IMTP.	• Risk of the Public Health Annual Report not providing a comprehensive overview of the team's current focus, plans for going forward and performance on delivering initiatives.

Objective 2: 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.

The Public Health Team comprised 49.8 WTE staff with significant knowledge and experience in public health matters. Monthly Senior Leadership Team (SLT) meetings were held with the Director of Public Health and Strategic Partnerships and Public Health Consultants to discuss strategic matters and areas of concern. During these meetings an action log was reviewed, and follow-up communications shared via email after the meeting. However, there were no formal minutes to document discussions, decisions, or who raised specific concerns. Furthermore, there was limited evidence of detailed discussions on the performance of initiatives or projects, including whether any were underperforming. Terms of reference for the SLT were not provided during the review (**Management Consideration 4**).

A separate Finance SLT meeting also takes place monthly with the same personnel. This forum reviews Project Initiation Documents (PIDs), resource requirements, and budget considerations. However, terms of reference for this meeting were also not provided. We attended the October 2025 meeting and, whilst PIDs were discussed, no financial update was provided, although the forecast underspend of £560,000 underspend was discussed in broad terms (**Management Consideration 4**). Noting the significance of the underspend, a detailed financial plan is required to address this in the remaining period for 2025/26 (**Management Consideration 5**).

Contract management meetings, project scrums, and team meetings were the primary forums where deviations from planned activities were identified, but there were inconsistencies in the governance arrangements observed. While some had terms of reference (some of which were still in draft and not yet formalised) and action logs, others did not, making it unclear who the members were, what constituted a quorum, or how actions were identified and then tracked. In some cases, actions were recorded informally via email, and there was no structured mechanism to monitor progress. Additionally, it is unclear whether formal evaluation exercises or impact assessments have been conducted (**Management Consideration 6**).

Clear escalation arrangements were in place with the option to escalate project issue onwards to the tactical group (comprising Heads of Public Health and their deputies) or ultimately the Senior Leadership Team (SLT) or directly to the Director of Public Health and Strategic Partnerships.

When assessing performance of individual initiatives, key aspects of a sound performance framework were absent i.e. key performance indicators, targets/ benchmarks, implementation plans, evaluation/review and standardised reporting arrangements **(Management Consideration 7)**. We recognise that not everything in Public Health can be easily measured, as much of the work is preventative. However, we were informed that a Gwent Indicator Framework "The Gwent Joint Strategic Assessment 2024/25" will form the basis of tracking and monitoring going forward.

Additionally, there was no formal risk register in place, although work was underway to address this, with support from Corporate Services, and a draft framework was discussed at the October 2025 SLT meeting (**Management Consideration 8**).

The Public Health Team has undergone significant change, and it was evident that further work will be needed to improve consistency, oversight, and transparency.

Ref	Management Considerations	Potential Risk & Impact
4	**Governance** Both the SLT and Finance SLT meetings may benefit from improved governance arrangements. For example, agreed terms of reference, established quorum, standard agendas, standardised reporting, performance indicators and minuting and/or decision logs.	• Lack of clear management oversight • Insufficient monitoring of key performance aspects, leading to poor implementation

5	**Financial Management** Appropriate financial plans should be developed to address the reported anticipated £560,000 underspend as a priority.	• Inadequate management of the financial position • Delivery of initiatives does not align with the anticipated spending profiles
6	**Initiative/ Project Management Arrangements** At present, the management arrangements across initiatives / projects differs significantly. Some will maintain operational meetings and terms of references, minutes and action logs, whilst other initiatives do not hold meetings, but rather report directly to the SLT. There were examples of decisions and oversight being discussed via emails too – rather than meetings. Clearly defined expected governance is key to ensuring appropriate oversight with regards actions, budget and resource.	• Inconsistent oversight and decision making • Unclear accountability, missed actions, or misaligned priorities
7	**Performance Management Framework** A robust performance management framework would establish clear performance expectations linked to national and strategic objectives – against which performance can be measured.	• Lack of oversight of performance • Poor record keeping
8	**Risk Management** Currently, public health issues and risks are raised at the various meetings and through correspondence, however a risk register of all relevant risks is not maintained.	• Lack of visibility and oversight of risks • Corrective action is not implemented to address known risks

Objective 3: 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.

Welsh Government grants and funding play a crucial role in implementing local and national initiatives with public health specialists across key areas collaborating with national and local partners. Joint Strategic Needs Assessments (JSNAs) and Discovery Reports routinely inform the Public Health Team's understanding of population needs. These tools support evidence-based decision-making and planning, helping to identify local priorities that align with national objectives and promote a cohesive approach.

The Public Health Team report to the Welsh Government and Public Health Wales regarding how certain budgets are spent. Oversight is provided via quarterly returns. The SLT had recently started meeting monthly alongside the Finance SLT and within these meetings they reviewed resource and funding requirements to support implementation. However, this process lacks a formal structure in terms of what the key priorities and initiatives are and what progress needs to be met and by when. The current workplan of 2025/26 does not provide sufficient detail to guide these decisions effectively as it does not outline the funding, resources and staffing required for each of the initiatives to ensure progress is met.

As noted under **Objective 1**, the arrangements would benefit from improved linkage between the annual workplan and the overall IMTP objectives for public health. This would serve as a single source of all local and national initiatives, highlighting any inter-dependencies – ultimately contributing to the achievement of the IMTP objectives and adherence with the Well-being of Future Generations (Wales) Act 2015.

Objective 2 also highlighted the benefits of introducing a performance framework. Establishing a robust framework would ensure alignment of national and strategic objectives, enabling comprehensive analysis of both qualitative and quantitative data, to support effective reporting.

There was no overarching programme or master plan to coordinate focus across initiatives and projects and demonstrate key successes. A more structured and coordinated approach is required to ensure robust management, prioritisation, and delivery of key activities.

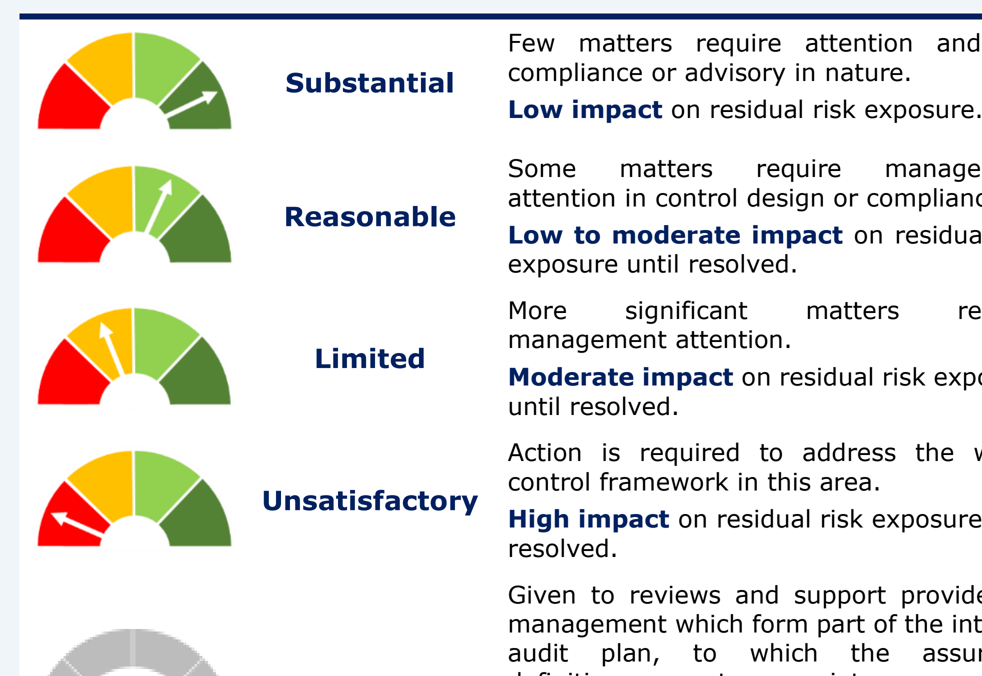
Appendix A

What is working well

Positive achievements
• The Health Board is the first Marmot region in Wales and is focused on reducing health inequalities by addressing their root causes. • Alignment exists between local strategies and national priorities, which are reflected in the Health Board's Integrated Medium-Term Plan (IMTP). • There is a work plan in place for all the public health initiatives taking place in 2025/26. • There is a Senior Leadership Team and Finance SLT that oversees strategic and operational delivery. • There are regular touch points taking place within the Public Health team, these include: Contract meetings, Project Scrums, Tactical group and squads. • Specialists across key areas collaborate with national and local partners. • There are steering groups in place for some initiatives where actions are discussed with key stakeholders.

Appendix B

Assurance Opinion



	Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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

Date issued: December 2025

Document reference: 3997A2024

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About this document

1. This document provides the Audit, Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board.
2. We also provide additional information on:
   - Other relevant examinations and studies published by the Audit General.
   - Relevant corporate documents published by Audit Wales (e.g. fee schemes, annual plans, annual reports), as well as details of any consultations underway.
3. Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 Exhibit 1 summarises the status of our current and planned accounts audit work.

Exhibit 1 – Accounts audit work

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Audit of Accounts 2025-26	Rob Holcombe – Director of Finance and Procurement	We will follow the audit approach designed as part of our planning work and undertake appropriate audit testing to enable to Auditor General to provide his opinions on the financial statements of the Health Board.	Planning	June 2026
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.	Audit underway	Audit Plan was presented to the Sept 2025 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
Structured Assessment 2025 - Core	Chief Executive Officer	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Final	Report at this Committee

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
Structured Assessment 2024 Deep Dive - Review of investment in digital systems	Chief Executive Officer	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Report drafting	February 2026
Local project work 2025 – GP Managed Contact Arrangements	Chief Executive Officer	We are reviewing the Health Board's arrangements for awarding the contracts to GPs who are members of the eHarley Street Group, as well as the on-going contract management arrangements relating to these practices. We will draw upon work already undertaken by Internal Audit to inform our work as appropriate.	Report drafting	February 2026
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.	Project Brief issued – work to start in January 2026	Spring 2026

Area of work	Executive Lead	Focus of the work	Current status	Planned date for consideration
All-Wales thematic review of cancer services	Chief Operating Officer	This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Scoping	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.

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

Title	Publication Date
Digital Health and Care Wales – Review of Stakeholder Engagement Arrangements	July 2025
Temporary Accommodation – Long term crisis?	July 2025
Cost Savings Arrangements – A checklist for NHS Board Members	June 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
Interim Report 2025-26	November 2025

8 There are no relevant Audit Wales consultations currently underway.

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

Structured Assessment 2025

Aneurin Bevan University Health Board

November 2025

About us

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Audit snapshot

What we looked at

1 We looked at how well Aneurin Bevan University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations;
- how it produces key plans and strategies; and
- how it manages its finances.

2 We also looked at the Health Board's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

Why this is important

3 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

4 The Health Board has an effective Board supported by continued good governance arrangements. Clear and high-quality information helps the Board carry out its duties. Support from the Good Governance Institute has also improved how reports are written and presented. The Board listens well to patients and service users, but it could do more to hear from staff.

5 The Health Board is improving how it manages risks and is finalising its corporate risk register. This year, it approved a new long-term strategy and delivered a Welsh Government approved three-year Integrated Medium-Term plan. These plans give the organisation a clear direction, with set milestones and targets.

6 Although financial oversight is strong and the Health Board has a good track record of savings delivery, its financial position is getting worse. It submitted a balanced three-year plan but now expects a deficit of £19.9 million by the end of the year. To meet these financial challenges, the Health Board must focus on transforming services and delivering its strategy. This is an area we have previously recommended for improvement but is not yet well-progressed.

What we recommend

7 We have made six recommendations to the Health Board, which focus on

- introducing reporting on declarations of interest compliance;
- making more use of staff stories at Board;
- formally reporting progress on actions following patient safety leadership walk rounds;
- improving Patient, Quality, Safety Outcomes Committee reporting;
- improving oversight of local clinical audit activity; and
- tracking recommendations from other bodies including Healthcare Inspectorate Wales.

Key facts and figures

Following de-escalation in March 2025, under the Welsh Government Escalation and Intervention arrangements, the Health Board is currently at Level 3 (enhanced monitoring) for finance, strategy and planning, and performance and outcomes related to urgent and urgent care pathways at the Grange University hospital.

The Health Board has an approved three year Integrated Medium-Term plan (IMTP) for 2025-28.

The Health Board did not meet its financial duty to break even against its revenue resource limited over the three years 2022-23 to 2024-25 reporting a cumulative deficit of £93.7 million for 2022-25.

In 2024-25, the Health Board aimed to save £40.5 million but successfully saved £45.5 million, of which £32 million was recurrent.

The current 2025-26 year-end forecast position for the Health Board is a £19.9 million deficit, against a breakeven target from Welsh Government. This year, £28.3 million of its £42.5 million planned savings are recurrent.

The Health Board has fully implemented 12 outstanding recommendations since our last structured assessment report. Two recommendations remain in progress, three have not yet started, and one has been replaced by a new recommendation this year.

Our findings

Board effectiveness and openness

The Health Board operates openly and transparently but improvements are needed on outdated policies, declarations of interest, walkrounds reporting and hearing the staff voice

Public openness of board business

8 The Health Board continues to demonstrate that it is being open and transparent about Board and committee activities:

- it continues to livestream and publish recordings of all public Board meetings;
- the public can observe any public board meeting;
- it publishes Board and committee papers a week before each meeting on its website;
- uses private sessions only when needed to discuss sensitive topics; and
- has open and transparent Board and committee discussions, especially when discussing challenges.

9 The Health Board could further enhance transparency by making documents available in Welsh and in formats that are easy to use.

10 The Health Board recognised that members of the public cannot attend committee meetings. To address this. they are producing short public summaries to increase transparency of committee business.

Supporting effective board conduct

11 The Health Board has clear and up-to-date governance arrangements that help the Board and its committees run effectively. The Audit, Risk and Assurance Committee ensures key governance controls are in place. This includes routinely overseeing compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

12 The absence of a Stakeholder Reference Group and a Healthcare Professionals Forum is gap and represents a breach of Standing Orders. While it has a Clinical Advisory Forum, this group does not offer the same level of representation at Board meetings. In addition, meeting minutes of the forum are not shared with the Board or published on the Health Board's website.

13 In February 2025, Internal Audit gave substantial assurance on how the Health Board manages declarations of interest and gifts. The Health Board has widened the group of staff who must make declarations, but more assurance is needed to confirm compliance with these new rules.

14 About 40% of the Health Board's policies are still out of date, with little improvement since last year. The Health Board now reports progress in its performance report. We have previously recommended stronger review processes, and further action is needed - especially where outdated policies create unnecessary risk.

Assurance on Joint Commissioning Committee effectiveness

15 The Joint Commissioning Committee (JCC) was set up in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.

16 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance on JCC business, as well as the Health Board's involvement in JCC meetings and activities. Our work shows that both the Board and the Patient Quality, Safety and Outcomes Committee receive routine assurance on the work of the JCC. This assurance is appropriately supported by the Chief Executive who as a member of JCC, highlights any notable issues through the Chief Executive's Board briefing.

Board and committee meeting effectiveness

17 The Board and its committees work effectively. Their terms of reference, business cycles and work plans are all up to date. Board and committee chairs are actively involved in the meeting agenda setting process.

18 The Health Board appropriately considers how its committees operate and makes changes if needed. In April 2025, it established a Mental Health and Learning Disabilities Committee to provide greater oversight and scrutiny of this area following concerns around its performance. In addition, it has:

- appointed a new chair of the Partnerships, Population Health, and Planning Committee; and
- increased the frequency of the Finance and Performance Committee which provides greater opportunity for scrutiny and depth of challenge.

19 Board and committee meetings continue to be well chaired, and most run to time. Independent Members participate fully in meetings, providing reasonable scrutiny on the information presented. However, on occasion we see some members focus too much on operational detail.

20 There is a reasonable process for committees to provide assurance to the Board and share information with each other. However, these assurance reports are placed in the consent agenda and are not usually discussed. As we recommended last year, the Board should make sure there is enough opportunity to not only raise but discuss escalated issues.

21 In September 2025, Internal Audit gave limited assurance on the Health Board's management of health and safety risks. They found insufficient escalation of risks and recommended the Health Board improve monitoring at committee and Board level by December 2025.

22 Board and committee papers are generally timely, well-structured, and highlight key risks and decisions. The Health Board has arranged training on report writing and presentation from an external provider. The Corporate Governance team now reviews all papers before they go to committees, which has improved their quality.

Hearing from staff and service users

23 The Health Board continues to engage staff well, using methods including Chief Executive open meetings, Executive drop-ins, and newsletters. Board and committee sessions also include regular patient stories. However, the Health Board could make more use of staff stories at public Board meetings to give the Board valuable feedback on staff views.

24 The Health Board uses a range of approaches to hear from patients and service users from diverse backgrounds, including good community engagement with hard-to-reach groups and consideration of service user diversity. Board members also visit frontline services, and patient safety leadership walk rounds take place. The Patient, Quality, Safety Outcomes Committee receives high-level updates on these activities, but there is no reporting on actions taken in response to issues identified.

Board cohesion and continuous improvement

25 The Health Board has a stable Executive, with all roles filled. Over the last year, the Health Board has appointed:

- a new Medical Director; and
- appointed the existing Director of Nursing as the Deputy Chief Executive.

26 The Health Board has good processes for inducting new Independent Members and has recently appointed two, representing Trade Unions and the Third Sector. As of October 2025, there are two vacancies: the Director of Social Services (local authority partner) and the Local Government Independent Member. These gaps are being managed but both the Chair and the Vice Chair will also come to the end of their terms in 2026. The Health Board will need to manage this overall position carefully.

27 The Health Board's arrangements for Board and committee self-assessments continue to be effective. These considered their composition and effectiveness of how they work. The outcomes informed the review of each committee's terms of reference, and the programme of board development. In 2024-25, these board development sessions covered topics including:

- estates strategy;
- long-term strategy and plan development, prior to approval;
- health pathways; and
- cyber security.

28 There is a comprehensive Board development plan in place for 2025-26, with support from the Good Governance Institute. This included work to improve how the Board works, building effective relationships, scrutiny and governance, and strategic risk-based assurance.

Providing board assurance

The Health Board has reasonable arrangements to provide assurance on risks and performance, but it needs to strengthen quality assurances

Managing strategic and corporate risks

29 The Health Board has a comprehensive Strategic Risk Register reviewed at every Board meeting, forming part of its Board Assurance Framework. The Health Board aligned its key strategic risks to its Integrated Medium-Term plan and allocated Executive Director responsibility for individual strategic risks. It has completed assurance mapping for each strategic risk, building on work started last year and continues to score risks in line with its risk appetite. The Health Board assigns each risk to a committee for assurance who also use this to inform Board and committee agenda setting.

30 The Health Board's Corporate Risk Register was still in draft during our review, with the Executive Team working with operational teams to complete it. The Health Board plans to implement the register in November 2025. Once it is in place, the Health Board must ensure the Strategic Risk Register reflects any new risks identified on the Corporate Risk Register.

Managing performance

31 The Health Board implemented its Performance Management Framework in September 2023. The framework based on three domains aligns with the Welsh Government Escalation and Intervention arrangements[1]. Internal Audit gave reasonable assurance in its review earlier this year. In September 2025, the Board subsequently approved an update to its Performance Management Framework.

[1] There are five levels of monitoring in use, routine arrangements, area of concern, enhanced monitoring, targeted intervention, and special measures.

32 This revision has strengthened the framework with increased focus on leadership and corporate governance, in addition to routine performance and quality review. These additional aspects include for example, ensuring policies are up to date, staff training, compliance and response to audit recommendations.

33 The Health Board has continued to improve its organisational performance reporting. The report now has four sections, each presented by the relevant Executive Director. Following last year's Structured Assessment, the report includes details on key areas for improvement and actions to address underperformance, as well as targets and comparisons where available. The Health Board has also strengthened its focus on primary and community services by adding more measures.

34 Over the past two years, we have seen escalation and de-escalation where required and improving reporting to committee and Board. Nonetheless, there have remained significant performance and financial challenges. The Health Board now needs to fully implement and embed the new framework, ensure that it operates effectively and achieves the desired impact.

Monitoring quality and safety

35 The Health Board has a quality strategy that commits to delivering safe, effective, and compassionate care. This strategy is underpinned by statutory duties from the Health and Social Care (Quality and Engagement) (Wales) Act 2020. It is mapped to the six pillars of quality[2] and includes delivery milestones to drive progress. Our 2025 Quality Governance Follow Up Review found the Health Board is making progress on recommendations, including implementing the Duties of Quality and Candour. However, more time is needed to embed changes and improve training compliance and monitoring.

[2] The six domains of quality are defined by NHS Wales and are embedded in legislation through the Health and Social Care (Quality and Engagement) (Wales) Act 2022. They are; safe, timely, effective, efficient, equitable and person centred.

36 Since our review, the Health Board has set out clear and sound governance arrangements and accountability for clinical and quality governance within its Quality Management System Framework 2025-28. The framework is operating well with evidence of operational teams escalating quality issues effectively. The new Quality Management Group reports to the Executive Committee and provides assurance to the Patient Quality, Safety Outcomes Committee.

37 The Patient, Quality, Safety Outcomes Committee oversees quality and monitors performance. It receives a regular Quality Outcomes Framework report, which is comprehensive but very long[3]. In some areas, we found the presentation confusing, with significant opportunity to better identify areas of concern. The report needs to be drafted in a way that clearly highlights areas of concern to committee members. The report also does not identify learning effectively. In July 2025, the Health Board had four Duty of Candour events, but the report did not include lessons learned.

38 The Patient, Quality, Safety Outcomes Committee receives regular updates on the Health Board's 2025–26 Clinical Audit Plan, which is on track for delivery. However, the plan only covers the mandatory national clinical audit programme. There is no local clinical audit programme or oversight of audit activity within divisions, which could mean missed opportunities for learning and providing targeted assurance to the Committee.

Tracking and monitoring recommendations

39 The Health Board has reasonable processes for monitoring and tracking audit recommendations. It keeps an audit tracker for both Audit Wales and Internal Audit recommendations, which Executive Directors update and review, especially for open actions.

40 The Health Board is now making good progress in addressing our previous recommendations:

[3] In June 2025, the report was 113 pages

- 12 out of 18 recommendations from past structured assessment reports are now complete. Two are in progress, with three not started and one has been superseded; and
- eight out of 11 of our 2024 Review of Cost Savings recommendations have been completed. We discuss this more in **paragraph 64**.

41 The Health Board is continuing to strengthen its approach to following up and implementing outstanding audit recommendations. Recently the Health Board has included a regular focus on progress of audit actions in its Performance Management Framework to strengthen accountability for delivery.

42 The Health Board does not track quality focused recommendations, such as those made by Healthcare Inspectorate Wales and the Public Services Ombudsman for Wales.

Preparing strategies and plans

The Health Board has a new clear long-term strategy and medium-term plan, and is looking to address assurance gaps on plan delivery

Producing key strategies and plans

43 The Health Board approved its new ten-year strategy “Gwent 2025- Better Health, Better Care, Better Lives” in May 2025. This replaced the previous Clinical Futures Strategy which had been in place for more than a decade. The Health Board developed the strategy following comprehensive engagement with stakeholders and partners. The strategy has clear aims, a focus on population health, aligns with national frameworks, and reflects the Wellbeing of Future Generations Act. The Health Board will formally launch the strategy in October 2025 with planned local roadshows and videos.

44 The Health Board is working on its clinical services plan. A number of services in the enhanced Local General Hospitals are now under consideration as part of the development of a Business Case for Nevill Hall Hospital. The Health Board is currently undertaking a gap analysis to inform its new clinical services plan. This work is vital to tackle current performance and financial pressures and to create sustainable services that meet people’s needs.

45 The Partnerships, Population Health and Planning Committee oversees strategy and plan development prior to Board approval. The Health Board also shares draft strategies and plans with Independent Members during development sessions before they are formally approved at public Board meetings.

46 Following committee oversight, the Health Board submitted an approvable, financially balanced Integrated Medium-Term Plan (IMTP) for 2025-28. It developed the plan with input from its divisions and a wide range of internal and external stakeholders. The Health Board's IMTP aligns with the long-term strategy and sets out clear priorities. It translates these ambitions into operational priorities and measurable actions over three years. The plan clearly identifies key actions for the first year, with milestones and outcome measures, although the detail for years two and three is less clear.

47 Welsh Government approved the plan, but it came with 14 accountability conditions that the Health Board is tracking and reporting on throughout the year. The Health Board is making satisfactory progress against these conditions; however, its financial position has worsened, with a forecast deficit of £19.9 million at month five. As a result, the Health Board is unlikely to meet the requirement to deliver a financially balanced plan. We discuss this further later in the report.

48 The Committee also oversees the development of corporate plans. Recently, it reviewed work on the People Plan, Estates Plan, and Digital Strategy. The People Plan has now been approved, while the Digital Strategy is still being developed. In October 2025, the Committee also looked at lessons from the previous IMTP and discussed plans for developing the 2026–29 IMTP. This shows a positive approach to learning and reflection.

Board assurance on partnership working

49 In April 2025, Welsh Government instructed the Chairs of Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to establish a South-East Wales Regional Joint Committee. In September 2025, the Board approved the establishment and terms of reference of the Committee.

50 The Partnerships, Population Health and Planning Committee provides assurance to the Board on partnership work. This includes regional partnership boards, public services boards, and collaboration with other Health Boards, including Cwm Taf Morgannwg University Health Board and Cardiff and Vale University Health Board. The Board also receives regular updates on wider partnership activity, including joint working across Wales.

51 There are several risks related to partnership working. Our recent work on eye care services highlighted concerns with the complexity of partnership decision making and reporting. While regional solutions are expected to support long-term service sustainability, the capacity to develop and deliver these programmes whilst also managing immediate operational pressures is challenging.

Monitoring delivery of strategies / plans

52 The Health Board's arrangements for overseeing its corporate strategy and plans are effective, but plans are not yet delivering the scale of change needed. The Health Board's IMTP includes clear delivery milestones, outcomes, and performance measures. In September 2025, the Board received an update on quarter one delivery for 2025–26, which showed the Health Board was on track. To support delivery, the Health Board has developed a range of enabling plans and strategies, most of which include clear milestones.

53 The Health Board recognised the need to improve oversight of priority programmes. To address this, it has strengthened its reporting approach to provide specific oversight of the following areas:

- place-based care and population health;
- planned care;
- mental health and learning disabilities; and
- clinical redesign.

54 The Board appropriately delegates strategy and plan oversight to its committees. While officers provide updates on key strategies and programmes, these are often narrative summaries, making it difficult to assess whether plans are on track, what actions are being taken, and whether timelines have changed.

Managing finances

The Health Board oversees finances well, but faces increasing challenges in the future

Meeting financial objectives and duties

55 The Health Board did not meet all its financial duties in 2024-25. Of the three duties, it met its capital resource limit, reporting a small underspend of £0.066 million. However, it did not:

- spend within its revenue resource limit for the three-year period 2022-23 to 2024-25; and
- have an agreed three-year IMTP for 2024-27.

56 Because a balanced financial position was unlikely, Welsh Government set the Health Board a target deficit of £7.3 million. The Health Board met this, reporting a year-end deficit of £7.1 million. Welsh Government also gave extra support in 2024–25, including a recurring £9.5 million allocation in December 2024 and a conditional recurring £31 million.

57 The Health Board submitted a balanced financial plan for 2025–26, based on achieving £40.4 million in savings. At submission, this was split as £15.7m confirmed savings, £10.3m opportunities, and £14.4m yet to be identified.

58 In July 2025, Welsh Government reduced the Health Board’s escalation status from Level 4 to Level 3. This reflected progress against its financial improvement plan, including meeting the agreed control total for 2024–25 and having an approved three-year plan for 2025–28.

59 By month five of 2025–26, the Health Board changed its forecast from breaking even to a £19.9 million deficit. This means it is unlikely to meet its financial duties for the year. It also raises doubts about whether the original balanced plan was sufficiently realistic.

Financial planning arrangements

60 The Health Board identifies major financial risks, such as higher prescribing, Continuing Healthcare, delayed discharge, ward pressures and mental health service costs. It also has a strong record of making savings. In 2024-25, it saved £45.5 million against a target of £40.5 million, with £32 million being recurring savings. This strong planning and past success gave confidence that the 2025-26 financial plan, part of the IMTP approval process, could be delivered. However, as noted earlier, the plan is proving difficult to achieve, and the Health Board is now forecasting a deficit.

61 The Health Board is engaging its divisions and directorates to identify savings. This includes savings identified in its 'Opportunities Compendium', division plans and savings ideas from staff. The Health Board has continued to have a strong approach to value and sustainability, with several of its workstreams developing schemes to support this years required financial savings[4].

62 The Board is appropriately informed of the required savings to achieve financial balance, the savings approach and the risk of non-delivery. Savings updates to the Board indicate schemes that are off-track (no plan in place and not expected to achieve). However, we have not seen any learning reported on failed or under-delivering schemes.

63 The Health Board's financial plan for 2025–26 was predicated on £40.4 million in savings, which it subsequently increased to £42.5 million. By month six, £15.1 million had been delivered, in line with the phasing and recognising the split between confirmed savings, opportunities, and areas yet to be identified.

64 In 2024, Audit Wales reviewed the Health Board's approach to Cost Savings. Of the 11 recommendations in that report, the Health Board has made good progress: nine are complete, one is in progress, and one has not yet started. Areas which require further progress are set out in **Appendix 2.**

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[4] The Health Board has five areas within its value and sustainability approach, Continuing Healthcare (CHC), medicines management, Procurement and non Pay, service redesign and workforce.

Financial management arrangements

65 The Health Board has a good approach to financial controls oversight. The Board reviews its Standing Orders and Standing Financial Instructions frequently, most recently in September 2025. It proactively assesses compliance with them. The Health Board completed a self-assessment against its Standing Financial Instructions this year, providing assurance to the Audit, Risk and Assurance Committee. This highlighted good compliance and some areas to improve, including meeting the break-even duty, clarity in workforce budgets for divisions, guidance on prepayments and policies on grant funding. Internal Audit will also undertake a compliance review of both Standing Orders and Standing Financial Instructions in 2025-26.

66 The Board delegates financial oversight to the Audit, Risk and Assurance Committee and the Finance and Performance Committee. These committees discharge their responsibilities appropriately. This includes overseeing reports on compliance with financial processes and controls, and assurances from internal audit and counter fraud work. The Health Board reports on high-value purchases and single tender actions, although there remains a lack of analysis of trends of single tender actions. This makes it hard to see if the Health Board is improving its approach to procurement.

67 The Health Board prepared and reviewed its financial accounts properly before and after the audit. It submitted its draft financial statements for external audit on time. For 2024-25, the Auditor General gave an unqualified opinion on the accounts, meaning they were true and fair. However, the regularity opinion was qualified because the Health Board did not meet its revenue resource allocation over the three-year period.

Monitoring financial performance

68 There are good arrangements for overseeing financial performance, but they mainly focus on the current year and give less assurance about how this will affect future years.

69 Both the Board and the Finance and Performance Committee receive regular financial performance reports. These show the current position against statutory revenue and capital limits, as well as progress on savings and the underlying financial position.

70 The Finance and Performance Committee continually looks in depth at key financial issues. This year the frequency of these meetings has increased. These areas include savings plans as well as reports from the Value Based Healthcare Programme and efficiency reports. The papers clearly explain financial risks and help support open and useful discussions.

71 The Health Boards' reports continue to provide a good overview of the current year performance, but do not give detail on how the Health Board will recover its position in the medium to longer term. Reports should be more focused on the Health Boards progress in delivering financially sustainable service models linked to service productivity, value, and efficiency.

Recommendations

72 The following table details the recommendations arising from our work.

Recommendations

R1	The Health Board should report every six months to the Audit, Risk and Assurance Committee compliance with declarations of interest by staff cohort, identifying actions the Health Board is taking to address non-compliance (**paragraph 13**).
R2	To ensure that the staff voice is heard at Board, the Health Board should ensure that staff stories are routinely used at both Board and committee meetings **(paragraph 23).**
R3	The Health Board should ensure that reports to the Patient, Quality, Safety Outcomes Committee highlight issues raised through patient safety leadership walk rounds and the actions to address them (**paragraph 24**).
R4	The Health Board should redevelop its Quality Outcomes Framework report to better highlight issues and provide assurance. This should include improving the report format, presentation of data, trends, targets and actions (**paragraph 37**).
R5	To provide targeted assurance on local quality issues, the Health Board should ensure its clinical audit plan includes local clinical audit activity, which is determined through a risk-based assessment and appropriately resourced (**paragraph 38**).
R6	The Health Board should introduce a Patient, Quality, Safety Outcomes Committee audit tracker for recommendations from other review bodies, including Healthcare Inspectorate Wales and Public Services Ombudsman for Wales (**paragraph 42**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period July 2025 to October 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers;
- Model Standing Financial Instructions;
- Relevant Welsh Government health circulars and guidance;
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes;
- Key governance documents, including Standing Orders and Standing Financial Instructions;
- Key strategies and plans, including the IMTP;
- Key risk management documents, including the Board Assurance Framework;
- Annual Report, including the Annual Governance Statement;
- Relevant policies and procedures; and
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chair;
- Chief Executive;
- Director of Strategy, Planning and Partnerships;
- Director of Finance and Procurement;
- Director of Public Health and Strategic Partnerships;
- Director of Corporate Governance;
- Director of Workforce and Organisational Development;

- Chair of Finance and Performance Committee;
- Chair of Audit, Risk and Assurance Committee; and
- Chair of the Patient Quality, Safety Outcomes Committee.

We observed Board meetings as well as meetings of the following committees:

- Patient, Quality, Safety Outcomes Committee;
- Audit, Risk and Assurance Committee;
- People and Culture Committee; and
- Partnerships, Population Health, and Planning Committee.

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

2022 Recommendation 2
Information presented to Board and committees does not always provide the required assurance. Some papers are too long, detailed, and technical. Cover reports continue to follow an SBAR format, but there is variation in their use. The Health Board, therefore, should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees **(Superseded by recommendation 2, 2023).**

2022 Recommendation 7
The Health Board's deteriorating financial position and deterioration in savings deliver indicates that stronger accountability for financial performance and delivery is required. The Health Board, therefore, should review its Scheme of Delegation to ensure it more strongly outlines delegated accountability for the budgetary position and achievement of financial efficiencies at and below executive levels **(In progress, paragraph 63).**

2023 Recommendation 1
The Health Board should provide more timely access to records of committee meetings. It could do this either by ensuring that it livestreams or publishes recording of its committee meetings, or alternatively it could publish unconfirmed committee meeting minutes shortly after the meeting **(Complete, paragraph 10).**

2023 Recommendation 2

The Health Board should develop training and guidance for Health Board staff around the reporting expectations and quality of information presented to the Board and its committees **(Complete, paragraph 22).**

2023 Recommendation 3

The Health Board should establish a robust quality assurance mechanism to review the quality of reports for its Board and committees **(Complete, paragraph 22).**

2023 Recommendation 6

In the Integrated Performance Dashboard, the Health Board should provide more information on the actions required to address underperformance, the impact of past actions taken and where appropriate include benchmarking with other health bodies (**Complete, paragraph 33).**

2024 Recommendation 1

As part of its ongoing long-term strategy and clinical services plan development, the Health Board should:

1.1 Ensure the organisation's new long-term strategy and clinical services plan clearly defines the required sustainable service solutions and decisions for the medium to longer term. This should include a strong focus on population health and prevention **(Complete, paragraph 43);**

1.2 Ensure there is comprehensive engagement with clinical and other staff across all domains of the organisations service provision to feed into the development of the clinical services plan **(Complete, paragraph 43);** and

1.3 Publish well-being objectives either alongside or within its new long-term strategy and ensure Well-being of Future Generations (2015) Act requirements are an integral part of the strategy **(Complete, paragraph 43).**

2024 Recommendation 2

To enable more effective scrutiny of delivery of corporate plans and strategies, the Health Board should ensure that progress reports are clear and contain performance targets and comparative benchmarks, where possible. Reports should also contain clear progress against established milestones to aid scrutiny of progress **(In progress, paragraph 52).**

2024 Recommendation 3

To become financially sustainable in the longer-term, the Health Board should develop a detailed longer-term financial plan that is linked to the new long-term strategy currently in development and three-year route-map and ensure progress against delivery is monitored appropriately **(Not yet started paragraph 59).**

2024 Recommendation 4

The Health Board should strengthen its oversight of Standing Financial Instruction and Single Tender Actions by:

4.1 introducing a self-assessment on Standing Financial Instruction compliance **(Complete, paragraph 65**); and

4.2 ensuring Single Tender Action reports include total contract values, setting out whether Board or Welsh Government approval was needed, and provide trend analysis of numbers and total values of Single Tender Actions for comparative periods in previous years **(Not yet started, paragraph 66).**

2024 Recommendation 5

To enable deeper scrutiny of operational finance and performance, the Health Board should increase the frequency of the finance and performance committee meetings (**Complete, paragraph 70)**.

2024 Recommendation 6

The Health Board should ensure there is effective separation of responsibilities between the role of the Health Board Chair and the Chair of the Partnerships, Population Health, and Planning Committee. The Health Board should seek to appoint a separate committee chair from the wider cohort of independent members **(Complete, paragraph 18).**

2024 Recommendation 7

The Health Board needs to allow sufficient time on Board meeting agendas for the committee chairs to report assurance to the Board and escalate any concerns **(Not yet started, paragraph 20).**

2024 Recommendation 8

The Health Board should ensure there is a clear approach that links the strategic risks in its risk register to the strategic objectives in its annual plan **(Complete, paragraph 29).**

2024 Recommendation 9

The Health Board should ensure there is a stronger focus on primary and community care performance within its Integrated Performance reports (**Complete, paragraph 33).**

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

Recommendation 1

The Health Board needs to work quickly with its divisions and directorates to develop and implement a more consistent approach to the adoption of savings opportunities within its compendium, which will also need to include a greater level of transformative, cross service efficiencies and recurrent savings, to ensure its savings are put on a more sustainable footing **(Complete, paragraph 61).**

Recommendation 2

2.1 The Health Board should clearly demonstrate how the savings and efficiency ideas that it canvasses from its staff are then used to inform and shape deliverable savings schemes **(Complete, paragraph 61).**

2.2 The Health board should put clear arrangements in place to canvass savings and efficiency ideas from service users and other stakeholders **(Complete, paragraph 61).**

Recommendation 3

The Health Board should ensure that all relevant staff are applying its quality impact assessment approach on savings schemes in a consistent manner **(Complete).**

Recommendation 4

The Health Board should strengthen its approach to the reporting of cost savings by ensuring that future savings reports to Board and committees articulate all the savings the organisation needs to deliver each year to meet its Welsh Government control total deficit **(Complete, paragraph 69).**

Recommendation 5

The Health Board should continue to refine and update its medium-term financial plan (route map) to 2026-27 based on internal and external delivery risks and quickly take corrective action where there is slippage in its planned financial trajectory **(Complete).**

Recommendation 6

The Health Board should ensure that its current financial training and capacity building for its budget holders is sufficiently fit for purpose **(Complete).**

Recommendation 7

The Health Board should ensure its accountabilities framework is working as intended and acting as an appropriate lever to manage divisional and directorate underperformance against savings targets **(Complete, paragraph 32).**

Recommendation 8

The Health Board and its committees need to ensure that its identified controls and mitigating action for its strategic financial risks are fit for purpose and that their ongoing scrutiny clearly identifies remedial action where these controls are not having the desired impact **(In progress, paragraph 31).**

Recommendation 9

The Health Board should continue to strengthen its approach to identifying and developing saving schemes with a view to reducing the number of schemes that are rated as red, and to maintain a focus on moving its red and amber schemes to green **(Complete, paragraph 61).**

Recommendation 10

The Health Board should strengthen its current mechanisms for sharing learning on savings schemes to ensure that it gathers and then disseminates learning from schemes that have failed or underdelivered **(Not started, paragraph 61).**

3 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework sets out the risks linked to the organisation's strategic objectives, and the controls and assurances in place to manage those risks.
Clinical Strategy	A Clinical Strategy is a long-term plan that helps shape how healthcare services are designed and delivered to meet the needs of patients and communities.
Corporate Risk Register	A Corporate Risk Register sets out the organisation's significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.
Integrated Medium Term Plan	An Integrated Medium Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.

Term	Description
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.
Single Tender Action	A Single Tender Action is when an organisation buys goods or services from one supplier without going through a competitive process, usually because there is only one suitable option or urgent need.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.

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

Management response form

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should report every six months to the Audit, Risk and Assurance Committee compliance with declarations of interest by staff cohort, identifying actions the Health Board are taking to address non-compliance (paragraph 13).	The Health Board has an established implementation plan for embedding the Standards of Business Conduct Policy. This plan includes monitoring compliance across staff cohorts and identifying areas of non-compliance. Findings from this monitoring will inform twice-yearly reports to the Audit, Risk and Assurance Committee, which will include details of actions being taken to address any non-compliance.	April 2026	Director of Corporate Governance / Head of corporate Governance
R2	To ensure that the staff voice is heard at Board, the Health Board should ensure that staff stories are routinely used at both Board and committee meetings (paragraph 23).	The Board's Forward Workplan for 2026/27 will include a specific commitment to routinely incorporate staff stories at both Board and committee meetings to ensure the staff voice is heard.	April 2026	Director of Corporate Governance / Board Business Manager

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		In addition, the Health Board is exploring informal mechanisms to further enhance staff engagement at Board level.		
R3	The Health Board should ensure that reports to the Patient, Quality, Safety Outcomes Committee highlight issues raised through patient safety leadership walk rounds and the actions to address them (paragraph 24).	Reporting of issues identified during Patient Safety Leadership Walk Rounds, along with the actions taken to address them, is now embedded within the Health Board's governance framework. These issues and corresponding actions are captured in the Performance Report, which is formally submitted to the Quality Management Group (QMG) and subsequently to the Patient, Quality, Safety Outcomes Committee (PQSOC). The first update was presented to QMG in November and will be reported to PQSOC on 2nd December, with ongoing updates provided every two months thereafter.	December 2025	Medical Director Assistant Director for Quality and Patient Safety

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Each report will include a summary of issues identified, actions taken, and progress against those actions to ensure transparency and assurance. In addition, the Performance Report will also be presented to the Executive Committee, providing comprehensive oversight. Responsibility for maintaining this reporting process rests with the Director of Nursing, ensuring that this approach remains a standard part of the Health Board's governance arrangements.		
R4	The Health Board should redevelop its Quality Outcomes Framework report to better highlight issues and provide assurance. This should include improving the report format, presentation of data, trends, targets and actions (paragraph 37).	**Phase 1 – Report Redesign** Improvements to the Quality Outcomes Framework (QOF) report format will be evident in the Q2 report presented to PQSOC in December 2025. Key enhancements include:	**Phase 1** 31 December 2025	Executive Director of Nursing / Deputy Director of Nursing

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		• A redesigned layout that is shorter, more concise, and standardised for consistency. • Enhanced visual presentation of data using run charts to show variation and trends over time. • Clear definitions accompanying each metric to explain what is being measured and why it matters. • Inclusion of performance against agreed targets alongside actual results to strengthen assurance. • A dedicated section outlining implications and associated improvement actions to address areas of concern and improve patient outcomes. **Phase 2 – Enhanced Statistical Analysis** The QOF report will transition to Statistical Process	**Phase 2** **28 February 2026**	Executive Director of Nursing /

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Control Charts **(SPCC)**, enabling statistically significant variations to be visually highlighted and tracked over time. This enhancement will improve assurance by clearly distinguishing normal variation from signals that require action. In addition, work is underway with the Health Board's Data and Digital team to migrate QOF metrics into a live digital application (Qlik), beginning with RL Datix information for Quarter 3 reporting. **Phase 3 – Full Integration** All remaining QOF metrics will be transitioned to SPCC within the digital platform, ensuring consistent, real-time monitoring of trends, targets, and improvement actions across the framework.	**Phase 3** **31 May 2026**	Deputy Director of Nursing Executive Director of Nursing / Deputy Director of Nursing

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	The Health Board should introduce a Patient, Quality, Safety Outcomes Committee audit tracker for recommendations from other review bodies, including Healthcare Inspectorate Wales and Public Services Ombudsman for Wales (paragraph 42).	The Health Board will record and monitor recommendations and actions from Healthcare Inspectorate Wales and the Public Services Ombudsman for Wales through the Audit Management and Tracking (AMaT) system. AMaT reporting will be integrated into the Patient, Quality, Safety Outcomes Committee's assurance process to ensure oversight of progress and completion.	**28 February 2026**	Executive Director of Nursing / Deputy Director of Nursing

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Reference: AC528/caf
Date issued: 17 November 2025

Dear Colleagues

Audit Fees Consultation 2026-27

Over the summer we consulted all our audited bodies, along with other stakeholders, on our proposed fee rates for 2026–27 and the resulting fee scales for local government bodies. Our consultation proposal was to increase our fee rates (i.e. the charge out rates of Audit Wales staff) by 5.5%, This was driven by a combination of inflationary pressures on our cost base and heightened quality expectations.

We received 17 responses, 10 of which highlighted that the proposed fee rates for 2026-27 represent an increase greater than the expected rate of inflation. Respondents also queried how the cost of audit by Audit Wales compares with those from other providers and what Audit Wales is doing itself to minimise cost increases.

The Audit Wales Board and I are very grateful for all the feedback received and take the points raised extremely seriously. In the light of the consultation responses received, I am pleased to say that the final Fee Scheme that we will present to the Senedd's Finance Committee will reflect a lower fee rate increase of 5.3%. This will be achieved by Audit Wales increasing further what was already a stretching spending reduction and efficiency target for itself.

This letter sets out our responses to the main issues raised during the consultation and advice on how audited bodies can further minimise their audit costs.

How we set fees

It is important to note that an increase in fee rates does not necessarily mean that the audit fee for your organisation will rise by 5.3%. The fee charged is based on an estimate of the volume of work and the skills mix required to deliver the audit. For the audit of accounts in particular, this estimate is influenced by the quality of the

accounts and supporting working papers submitted for audit, as well as the timeliness with which audit queries are resolved. Similarly, the cost of a performance audit project can be reduced by timely submission by your organisation of information requested by the audit team and positive engagement with key officers. If the final cost of the audit is lower than estimated, we will issue a refund. Conversely, if the outturn exceeds the estimated fee, an additional charge may be necessary.

For the 2024-25 accounts audits, in some cases, we were able to set audit fees that were lower than those estimated in the previous year's audit plans. These reductions typically reflected efficiencies achieved in the accounts preparation and audit process, which had enabled us to refund part of the 2023-24 fee and rebase our estimate for 2024-25.

I cannot overstress how important this is in minimising the cost of audit. I am statutorily obliged to charge no more than the actual cost of the work we undertake. Hence, if your organisation is well prepared for audit, and if your accounts, systems and supporting information are of good quality and delivered in timely fashion, your audit should be smoother and swifter. If the opposite is the case, we will need to undertake more work and your audit fee will be commensurately higher. Your audit team will be happy to explore how such efficiencies might be identified within your organisation.

Why are Fees rates increasing more than inflation?

The top organisational priority for Audit Wales over the last two years has been to eliminate the backlogs of work that built up during and since the Covid pandemic. This is so that you have audited accounts on which to base decisions delivered in line with statutory deadlines, and performance audit work that is relevant and timely.

To tackle those backlogs we temporarily increased the number of CCAB qualified audit staff we employ. As our overheads must be recovered across the total number of audit staff, this increase enabled us to limit the rise in fee rates this year (2025-26) to just 1.7%, despite facing inflationary pressures of nearly 4%. Additionally, we identified efficiencies in our audit of accounts approach, allowing us to reduce fee scales for this work by an average of 3%, even with the modest increase in fee rates.

Next year we will see the opposite effect. By the end of 2026, we expect to have cleared most of the post-pandemic backlog, and we are reducing our audit staffing accordingly. This will mean fewer staff across whom overheads can be recovered. This is the main reason for the above-inflation increase in fee rates for 2026-27. Across the two years – 2025-26 and 2026-27 – however, you will note that next year's higher rate increase comes after a rise considerably lower than inflation in 2025-26.

To mitigate the impact of next year's increase, we have set an ambitious target to reduce our overheads by over 7% in 2026-27. As already mentioned, following the fee consultation, we have revisited our cost and savings assumptions and reduced our proposed increase in fee rates from 5.5% to 5.3% - although this remains subject to consideration by the Senedd Finance Committee.

Fee comparison

We are often asked how our fees benchmark against other audit providers.

Quality pressures, and the consequent fee increases, are common across both the public and private sectors. These pressures include more demanding auditing standards and enhanced regulatory oversight; responses to audit failures and public trust issues in the private sector that have impacted the entire profession; skills shortages leading to recruitment and retention challenges; and increased complexity within the audit environment.

A recent study by The Audit Reform Lab, based at the University of Sheffield, assessed the performance of the local public audit system in England and drew comparison with the position in Scotland and Wales.

One of the report's observations was that Wales:

"…appears to provide a cost effective, reliable and robust public audit of local authorities, that is now price and performance competitive with private auditors."

Annex 1 includes the relative fee rates from our fees consultation compared with those for English local government bodies. The tables in **Annex 1** show clearly that fee rates in Wales are very significantly lower than those being charged to English local government bodies.

While it is important to highlight how our fee rates compare with publicly available information on audit fees elsewhere, our primary focus remains ensuring that our audits deliver value for money for the Welsh taxpayer while enabling us to maintain a high-quality service. As Auditor General, I am very confident that this is the case.

Cost reduction

We recognise that public bodies are themselves facing considerable financial pressures and that any increase in audit fees will not be welcome. I fully understand, therefore, that we need to demonstrate what we are doing to control our own costs.

A significant focus for us is to reduce our cost base, while maintaining audit quality standards. Over the past ten years, we have reduced the cost of public audit in Wales by 4% in real terms, despite an expanded scope of work, and the higher audit quality requirements I have highlighted. Since I took up post as Auditor General in 2018, key savings we have delivered include:

Reshaping our workforce: We have reduced the proportion of directors and managers thus reducing the overall cost of audit.

Investing for the future: At the same time, we have also invested in our graduate and apprentice development programmes. These provide opportunities for school leavers and graduates in Wales, improve social mobility, and help develop auditors for the future and future financial managers for the Welsh public sector. Many of the people we have trained have moved successfully into finance positions in other Welsh public bodies.

In-sourcing audit work: Since 2021–22, we have ceased using private sector firms for audit delivery. This makes us unique among UK public audit bodies and has protected the public purse in Wales from the significant price increases charged by private providers contracted to deliver work in the public sector elsewhere in the UK.

Reducing travel costs: We have cut travel expenditure from £1.2 million in 2019-20 to just over £200,000 in our coming Estimate. This was achieved through a significant change in the terms and conditions of Audit Wales staff and by changing how we work to minimise travel, delivering both environmental and cost benefits.

Smaller, more efficient offices: We have moved to smaller, cheaper and more energy-efficient offices across Wales, saving around £250,000 annually despite rising utility costs.

Challenging non-pay budgets: More generally, we continually review our operating model and non-pay budgets to identify and deliver efficiencies wherever possible.

Investing in technology

Investing in technology is central to enhancing audit quality and efficiency, with data analytics playing an increasingly important role. However, inconsistent data quality across public bodies remains a challenge - one we are working to address in collaboration with other audit bodies across the UK and Republic of Ireland. A recent AI pilot has delivered promising results, although we are taking a cautious approach to development, mindful of the risks associated with AI adoption. In the shorter term, our focus is on delivering better quality outcomes through targeted improvements; in the longer term, we aim to embed sustainable efficiencies into our work through smarter use of digital tools.

Once again, however, our ability to apply the potential of technology to our work depends equally on the readiness of our audited bodies. Many audited bodies operate financial and management information systems that are outdated, meaning that the benefits of new technology on our part will be hard to achieve. Whilst I appreciate the financial pressure that public bodies face, I very much hope that investment in such infrastructure will be prioritised. A more efficient audit process would be one small benefit, but far more important, of course, would be the associated strengthening of organisational governance and informed decision-making for our audited bodies.

Proportionality

Some smaller bodies raised concerns during the consultation that their audit fees appeared disproportionate to their size. While I understand and empathise with these concerns, it is important to emphasise that our audit approach is determined by professional auditing standards, which do not permit the application of a different methodology for smaller organisations.

In practice, some smaller bodies can also present complexities and risks that are not necessarily reflected by their size, and these factors can influence the cost of audit delivery.

We are aware of various initiatives - both from the Financial Reporting Council and international standard-setters – which are exploring how audit can be made more proportionate. We are monitoring and engaging with these developments.

I hope this response helps to clarify the various issues raised during the fees consultation. If you have any further questions, please do not hesitate to contact either myself or Ann-Marie Harkin, Executive Director of Audit Delivery.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Annex 1: fees comparison

Table 1: Audit Wales proposed fee rates 2026-27

Grade	Rate (£ per hour) 2026-27	Rate (£ per hour) 2025-26
Audit Director	189	183
Audit Manager	146	141
Audit Lead	120	115
Senior Auditor	96	91
Auditor	66	66
Graduate trainee	63	59
Apprentice	50	47

Source: Consultation on Fee Scales 2026-27

Table 2: PSAA rate card for 2024-25 audits

Grade of Staff	Hourly Rate
Partner/Director	£428
Senior Manager/Manager	£236
Senior Auditor	£153
Other Staff	£117

Source: Rate card - PSAA

Note

Public Sector Audit Appointments Ltd (PSAA) is an independent, not-for-profit company established by the Local Government Association (LGA) in England. One of its main roles is to set audit fees for local government bodies in England. PSAA reported that around 98% of eligible local government bodies have opted in to its fee scheme.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 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 1st 31st October 2025**
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: REPORTING OFFICER:	**Alex Curley – Head of Procurement**

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
This report provides the Audit, Risk and Assurance Committee with an update in relation to the single tender / quotation action requests submitted to Procurement and is a standing report covering these key issues as part of the Committee's work plan for the year. The paper reports the outcome of these requests. Appendix A provides specific detail regarding the Single Quotations / Actions that have been submitted and approved for the period 1st September 2025 to 31st October 2025.
Cefndir / Background It is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action or a Single Quotation action are submitted to the Chief Executive for consideration. The Deputy Head of Procurement will provide a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for

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

- Review of Single Quotation and Tender Requests.

Asesiad / Assessment

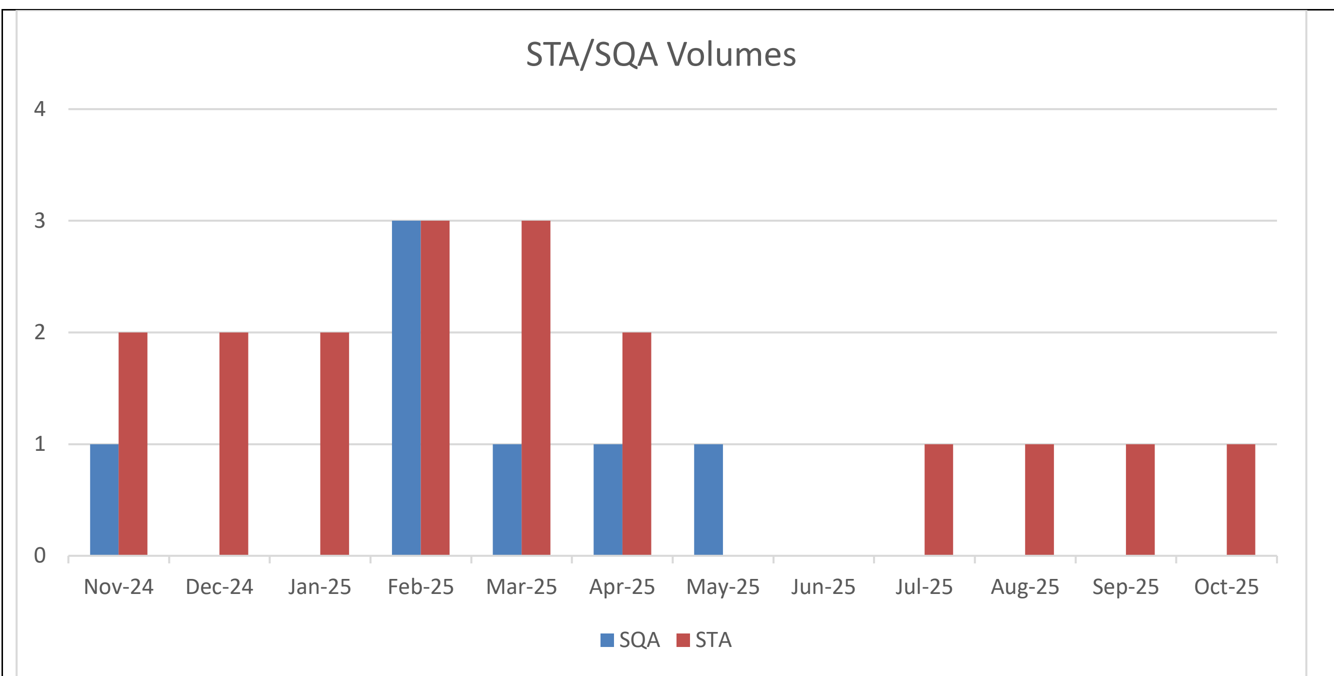
The Audit, Risk and Assurance Committee should note the detail of the attached table (Appendix A) and should monitor the number and value of business that are being submitted for a Single Tender or Single Quotation approval. The overarching guidelines on spending of public money are that it should be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

There has been 1 request submitted which has been approved during the period with an annual value of £89,589.90 Ex VAT. This sole request was for goods and services (including maintenance) relating to the upgrade of CCTV, Door Access and Control Systems. The request was justified under technical compatibility as the Original equipment installed is a closed protocol system meaning only the original equipment manufacturer can upgrade and maintain the equipment.

Category under the SFI justifying the use of STA	Occurrences (no.)	Value (£/annum)
Follow-up work where a supplier has already undertaken initial work in the same area (and where the initial work was awarded from open competition);	0	-
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	1	89,589.90
The need to retain a particular contractor for genuine business continuity issues (not just preferences	0	-
An interim agreement prior to joining an all-Wales Collaborative Agreement.	0	-
In line with Policy and justified STA	1	89,589.90
Not in accordance with STA rationale	0	

STA Monitoring

STAs bypass competitive procurement, so tracking trends helps the committee monitor **adherence to procurement policy**.



The volume analyses highlight's the low volumes of STA / SQA (Single Quotation Actions) consistently occurring. With the peak in Feb-March reflecting the number of annual re-appointments for servicing/technical capacity issues.

Argymhelliad / Recommendation

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

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

Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]()	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Agenda Item:3.8

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 December 2025
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Progress Report December 2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Lavington Head of Counter Fraud

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

Er Gwybodaeth/For Information

To update the Audit, Risk and Assurance Committee (ARAC) of the work undertaken by the Counter Fraud Team in order to provide assurance that this work remains effective.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In order to remain compliant with the NHS requirements of the Government Functional Standards S013 the Counter Fraud Department are required to report the progress of their work to the ARAC.

Cefndir / Background

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by Counter Fraud is set around four key principles:

Key Principle 1: Strategic Governance - to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit & Risk Assurance Committee will continue.

Key Principle 2: Inform and Involve – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud, bribery and corruption in the NHS. Effective use of multi-

media channels in order to reach staff across the Health Board will be vital to effective delivery of this principle.

Key Principle 3: Prevent and Deter – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.

Key Principle 4: Hold to Account - to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated. Also to make those responsible pay back the losses in order that this money can be placed back into patient care.

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the WG directions, NHS bodies are also obliged to demonstrate compliance with the Government Functional Standards 013 - Counter Fraud (GovS 013), which came into effect from 1st April 2021.

Asesiad / Assessment

Period of reporting – 01/09/2025 – 14/11/2025

1. Inform and Involve

Corporate Induction

Counter Fraud awareness at Corporate Induction remains a mandatory requirement. Subsequently all new starters have an immediate input into Counter Fraud when commencing employment with ABUHB.

E Learning (Figs for Q2)

Since February 2024, the ESR Counter Fraud E-Learning module has been mandated for ABUHB staff. During Q2 1248 members of staff have completed the learning. When benchmarked against other NHS Organisations, since mandating training, ABUHB can be seen to be performing satisfactorily. (See table). Further information is available at Appendix 2 in the All Wales Q2 report.

Health Body (Mandated E-Learning)	Staff Completion Q2	Staff Completion YTD	No of Employees * (As at 31/12/2024)	Compliance Percentage	Month Mandated
ABUHB	1,248	2,046	15,592	87%	Feb 2024
BCUHB	1,342	2,389	21,323	85%	April 2021
DHCW	24	27	1,249	97%	May 2024
HDUHB	989	1,598	12,193	90%	May 2021
VEL	534	1,425	1,873	67%	April 2025
WAST	317	562	4,398	81%	Aug 2023
Health Body (E-learning not yet mandated)					
C&VUHB	6	11	17,561		
CTMUHB	16	21	13,204		
HEIW	3	3	628		
NWSSP	105	178	6,117		
PTHB	1	1	2,646		
PHW	16	23	2,610		
SBUHB	146	249	14,673		
TOTAL	**4,747**	**8,533**	**114,067**		

Fraud Awareness

Presentations

Fraud presentations during this period have continued to be delivered. In total 6 in person presentations have been delivered across the workforce. These have included general fraud awareness sessions, manager specific sessions, and bespoke presentations to specific departments.

Departments met include:

Health Visitors

Mental Health Commissioning Team

Family and Therapies Divisional Management Team

GPIMHS Clinical

NHH Medical Teams

ABUHB Clinical Services team

Digital

The Digital Awareness Strategy implemented continues to focus on three main avenues. All are supported by the MS Office suite of Apps.

1. AB Pulse
2. Viva Engage
3. Sway

The Counter Fraud Pages hosted on AB Pulse continue to be updated and remain available to all staff.

A Viva Engage Counter Fraud Department community page continues to be successful. This has allowed the team to reach a wide audience in an impactful way – 28 posts have so far been created and the channel now has 180 new members. Total views generated has increased to 63,681

In addition to the work carried out on the Digital Pages and Viva Engage, a monthly newsletter has been distributed across the organisation via the Communications Team. The topic areas covered since September are:

Festive Fraud

International Fraud Awareness Week Initiatives

Primary Care Focus – (Targeted as a result of a number of trends in this area)

2. Hold to Account

Investigations & Referrals

The team has received a total of **65** contacts requiring Counter Fraud advice in this reporting period. This takes the total for the year to **134**. All have been assessed and actioned.

10 new investigations have been opened as a result.

15 Investigations are currently open. Of these **6** are being actively investigated and **9** are awaiting third party updates.

During this period CF investigations have resulted in **2** disciplinary sanctions (2 dismissals)

A sanitised table of cases for 25-26 is at **Appendix 1**

Overpayments of Salary

5 referrals have been made to the team regarding significant Salary Overpayments totalling **£33,020.73.** None of these have been promoted to formal investigation for fraud/theft offences. All have been returned to Payroll for recovery via the ABUHB Accounts Receivable team.

NFI

December 2024 saw the release of the latest data from the National Fraud Initiative. A total of 295 matches, relevant to the Counter Fraud Department, have now been assessed. These await responses from the matched agency. This year's exercise has resulted in 3 ongoing criminal investigations of staff members suspected of working elsewhere whilst on sick leave with ABUHB.

During this period a further 24 staff members have been identified as being linked to Company Directors of Trade Creditors to ABUHB by address. These have been cleared and requests made for a DOI to be made.

3. Prevent and Deter

Alerts and Bulletins

1 Fraud Alert has been disseminated to all HB areas. This concerned Certificate of Sponsorship scam emails.

Fraud Prevention Notice

No Fraud Prevention Notices have been issued by the NHS CFA during this period.

Local Proactive Exercises (LPE)

There are now a number LPE's being actively worked on by the department. Areas of work being prioritised are listed below.

- Staff Leavers – Uniform, ID badges etc
- WP10 Community Prescription Security
- Overpayments of Salary
- Petty Cash
- Diabetes Pump/Sensor Equipment controls
- Agency Worker – Pre employment checks
- GP Practice Manager Fraud
- Declarations of Interest
- NHS Recruitment
- Medical Staffing – Working in already contracted time

There have been numerous positive outcomes arising out of this work such as the development of targeted awareness campaigns and disruption activity.

Risk Assessment

The following Risk Assessments have now been commenced. Where complete these have been forwarded to the relevant stakeholders. An overview of their status is provided below – for further detail a copy of the Full Fraud Risk Profile can be shared if required.

Fraud Risk	Department	Status	Comments	Response
Expenses	Finance	Complete and subject to future reviews	No action required	NA
Retention of Salary Overpayments	Finance/WOD	Commenced	Requires completion and dissemination	NA
Agency Worker PEC's	WOD/Bank	Commenced	Near Completion	NA
Direct Recruitment PEC's	WOD/NWSSP	Commenced	Near Completion	NA
Petty Cash	Finance	Commenced	Near Completion	NA
Primary Care WP10	Primary Care Team	Complete – awaits response	Disseminated – 25 April 25. Acknowledged by Department awaits response. Chase up email sent 19/11/2025.	NO

Secondary Care WP10	Medicines Management	Complete and subject to future reviews	Recommendations implemented New SOP developed all actions complete	YES
Omnicell Storage	Medicines Management/Pharmacy	Complete awaits review by Head of CF	To be disseminated when reviewed	NA
Impersonating Medical Personnel	WOD/Medical Directorate/Security	Commenced	Awaits completion	NA
Staff Leavers	WOD/Security/Data and Digital	Commenced	Near Completion	NA
Special Leave	WOD	Complete	Disseminated 30/10/2025 October – awaits formal response	NO
Weight loss Medication	Medicines Management/Primary Care	Complete	Recommendations implemented all actions complete	YES
Agile Working	WOD	Complete	Disseminated –23 July 25. Meetings held with WOD to discuss. Formal Response expected December	YES – awaits formal response

4. Strategic Governance

Regular contact has been maintained between the Head of Counter Fraud, Director of Finance and Fraud Champion throughout the reporting period, ensuring a top-down approach to developing an effective Counter Fraud Culture within the organisation.

All policy review meetings, Local intelligence Network Meetings and Counter Fraud Liaison Group meetings have been attended by a member of the team.

All necessary reports have been completed and submitted within the timescales permitted.

5. Other

The Q2 NHS Wales Operational report compiled by the Counter Fraud Service Wales is included for reference at Appendix 2. This report provides bench marking data from across all NHS Wales organisations.

Argymhelliad / Recommendation

That the Audit, Risk and Assurance Committee take assurance from the information provided in this report that the Counter Fraud provision remains effective, compliant and focussed.

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

Appendix 1

INV/23/****	Claiming payment for shifts not worked	28/07/2023 - CO		Full investigation carried out and case file submitted to CPS. CPS declined to prosecute. The matter has been referred back to HR for consideration of disciplinary proceedings.
INV/23/01520	Failing to notify non payment of salary sacrifice	28/07/2023 - CO		Referred to Accounts Receivable for financial recovery
INV/23/02427	Salary Overpayment	27/10/2023 - CO		Referred back to AR for financial recovery. No offences identified
INV/24/00857	Theft from omnicell	05/04/2024	15/08/2025	Fully investigated and IUC carried. Full admission - Proportionate for disciplinary only - Warning
INV/24/00944	Leave fraud	16/04/2024	14/10/2025	Managerial Issues only. Referred back for disciplinary
INV/24/01205	Salary overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01199	Salary Overpayment	13/05/2024		Enqs Carried out. No offences disclosed - returned to AR for financial recovery
INV/24/01290	Mass Vacc recruitment	21/05/2024		Negotiated reduced payment tba
INV/24/02846	eMPLOYEE ALSO Working for Charity but getting paid by hb AND cHARITY	08/11/2024	23/07/2025	Discilpinary warning and redeployed
INV/24/02857	Patient believed to have sold medication on that was prescribed to her	12/11/2024	01/07/2025	Full investigation carried. Subject interviewed and admitted offence. Dealt with on a Civil Basis. Recovery of £282.47 achieved and prevention of £3389.64 made as a result of CF intervention.
INV/24/03033	Member of staff - theft of prescription from ward and attempting to have it disseminated at community phartmacy	27/11/2024		Awaits Disciplinary
INV/24/03222	Staff member who provides training suspected of not carrying out her duties and making false representations	16/12/2024	17/07/2025	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/25/00329	NFI - working for Concil at same time as HB	06/02/2025		Awaits Disciplinary
INV/25/000508	working as a barmaid in a local club while on sick	19/02/2025	19/02/2025	No Offences Disclosed
INV/25/00819	WClaiming for extra hours not worked	19/03/2025		false reporting, case closed
INV/25/00849	Suspected to be claiming for shifts not worked	19/03/2025	12/11/2025	Unable to prove offences
INV/25/000847 Duplicate INV/25/00116	Self allocation of shifts and overtime fraud allegation	19/03/2024	15/04/2025	Awaits outcome of disciplinary investigation
INV/25/000848	Family sending medication to subject who now resides in Pakistan	19/03/2025	08/04/2025	Fully investigated. Information passed to relevant GP practice. Now closed
INV/25/000904	Local Care Provider	25/03/2025	04/04/2025	Intelligence passed to Gwent Police. Not NHS Related
INV/25/01027	Suspicion over veracity of application form	02/04/2025	15/05/2025	NFA
INV/2501069	Suspicion over Prescritpion Issue to obatin benefits	08/04/2025	15/04/2025	Intelligence passed to Gwent Police.
INV/25/01088	Salary overpayment	10/04/2025	17/07/2025	referred to AR, full payment made
INV/25/01259	Intel from NHS CFA - subject is from overseas has no right to remain and has signed up with GP surgery	07/05/2025	04/06/2025	Information shared with Police and Home Office. No offences NHS. All required actions carried out

INV/25/01374	Suspicion of Non Dispensed items not being endorsed on prescriptions, specifically Dapagliflozin . Information supplied by R Evans.	16/05/2025	18/07/2025	No evidence gathered to substantiate - Closed NFA
INV/25/01471	Allegation both parties receiving free NHS treatement when not entitled	28/05/2025		No offences - with Overseas Patient team for recovery
INV/25/01454	GP HCA accessing patient records and reprinting WP10s (predominantly Co-Codamol/Zapain)	23/05/2025	11/09/2025	Case Ongoing
INV/25/1483	Multiple issues re dispensing	28/05/2025	04/06/2025	NFA - no offences identified. Information shared with Community Pharmacy team.
INV/25/1869	theft of fentanyl / storage of fentanyl via CIU	03/07/2025	18/07/2025	No Offences Identified
INV/25/1969	Overseas Patient	14/07/2025	18/07/2025	No Offences Identified
INV/25/1973	Selling on Codeine	15/07/2025	23/07/2025	Intelligence passed on to Gwent Police
INV/25/2127	Submission of suspect prescritpions	23/07/2025	04/09/2025	Case Ongoing
INV/25/2134	Allocation of shifts not worked	25/07/2025	15/08/2025	No Evidence found to substantiate claims
INV/25/2175	Selling Medication	28/07/2025	29/07/2025	Intell Report - Passed to Gwent Pol and GP Practice
INV/25/02424	Failing to disclose medical condition	13/08/2025	15/08/2025	No offences identified
INV/25/02246	Diabetes Meds and Kit sold on Facebpook	31/07/2025	01/10/2025	Case Ongoing
INV/25/02208	Diabetes Meds and Kit sold on Facebpook	30/07/2025		Case Ongoing
INV/25/2409	Suspicion of Lying on App Form	12/08/2025	04/09/2025	No offences fraud identified. Returned to Division re any possible disciplinary
INV/25/2455	Not managing sickness leave of employees	18/08/2025	01/09/2025	Allegation not substantiated
INV/25/2512	Allocation of WLI shifts in SPA time	22/08/2025	01/09/2025	No offences. No requirement to further in dept. Information passed to COO and Div Director
INV/25/2674	WLI claimed for in already contracted time	10/09/2025		No offences. Subject to financial recovery. Proactive exercise commenced.
INV/25/2989	Working in St Joseph's on working day for ABUHB	10/10/2025		Enquiries Commenced
INV/25/03043	Suspected of working elsewhere whilst sick	16/10/2025		Enquiries Commenced
INV/25/3084	Suspected of working for self during contracted time	17/10/2025		Enquiries Commenced
INV/25/3081	selling prescription meds	20/10/2025	29/10/2025	No offences. No further action required
INV/25/3107	Suspected of working elsewhere whilst sick	22/10/2025	31/10/2025	Enquiries Commenced
INV/25/03129	Fraudulently attempting to obtain prescription for deceased person	23/10/2025	12/11/2025	No offences identifed. No further action required
INV/25/03128	Suspected of working else where whilst sick	23/10/2025		Enquiries commenced
INV/25/03149	Suspected selling Prescription Meds	27/10/2025	29/10/2025	Intelligence passed to relevant external agencies
INV/25/03150	Suspected of running plastering business whilst off sick from work	27/10/2025	04/11/2025	No offences identifed. Not linked to ABUHB. No further action required

APPENDIX 2

Counter Fraud Services in NHS Wales

Operational Performance Report 2025/26

Quarter 2 – 1st July to 30th September 2025

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Introduction

This quarterly report format summarises the operational resources, referrals, and performance of the NHS Counter Fraud Service (CFS) Wales National Team and the network of Local Counter Fraud Specialists (LCFS) based at health bodies in NHS Wales during Quarter 2 of 2025/26 (1st July to 30th September 2025). The NHS Counter Fraud Authority (NHSCFA) report to Welsh Government (WG) on the specialist support services provided to NHS Wales via their Service Level Agreement (SLA) with WG via a separate quarterly and annual report document.

1 Resources

1.1 NHS Counter Fraud Service (CFS) Wales

The NHS CFS Wales team is hosted by NHS Wales Shared Service Partnership (NWSSP), part of Velindre NHS Trust who employ the team members. The CFS Wales team Currently consists of 5.93 wte experienced investigators and 0.8 wte administrative support. Their primary role is the investigation and prosecution of serious, complex, or large-scale economic crimes. This includes offences that may involve more than one organisation, cross border investigations and all corruption and bribery cases in NHS Wales. They also provide support and guidance to the LCFS network in Wales and conduct presentations to key stakeholders in NHS Wales.

The CFS Wales team provide a specialist independent investigation resource to NHS Wales. This provides an impartial investigation service if senior NHS executives or management are implicated, as suspects or witnesses, to provide the health bodies with the independent assurance required. The CFS Wales team's employer is Velindre University NHS Trust, a listed regulatory body under POCA 2002. This enables the two Accredited Financial Investigators (AFIs) and three Financial Intelligence Officers (FIOs) on the CFS Wales team to conduct financial investigations, or for the AFIs to restrain and recover funds from convicted persons. The CFS Wales team also work closely with the LCFSs, often providing guidance on investigations or pro-active work, conducting financial intelligence checks, or jointly investigating suitable cases.

1.2 Local Counter Fraud Specialists (LCFS)

WG Directions require each health body to work closely with CFS Wales and nominate a suitably qualified LCFS who are the primary point of contact for all economic crime concerns within their health body. The LCFSs have a key proactive role in raising fraud awareness, identifying risks, and preventing fraud within their health bodies via Local Proactive Exercises (LPEs), while also investigating offences reported at a local level in collaboration with CFS Wales.

The LCFS work is aligned to the delivery of the current Fraud, Bribery and Corruption Standards for NHS bodies (Wales), which are reviewed and updated annually by the NHS Counter Fraud Authority (NHSCFA) under their SLA with WG. The NHSCFA standards are now aligned with the new Cabinet Office Standards on Counter Fraud Work and since 2022 NHS Wales has adopted the new Cabinet Office Functional Standards.

The table below summarises the counter fraud resources in NHS Wales during Q2 of 2025/26. This is consolidated from data provided to CFS Wales by the Lead LCFS at each health body. In the larger health bodies, the health boards with the most LCFS resources are SBUHB at 3.2 wte and 0.6 admin support, and ABUHB with 3.40 wte. This data is reconfirmed via the ratios of LCFS : NHS staff in the table below which shows that ABUHB and SBUHB have the best ratios (0.22) while CTMUHB (0.12) and C&VUHB (0.13) have the lowest ratios of LCFS : Staff in the larger health bodies.

HEIW, Powys and WAST are the best resourced within the smaller health bodies with 0.62, 0.45 and 0.45 LCFS wte respectively, while NWSSP has the lowest ratio at 0.16.

C&VUHB LCFS Team also provide an LCFS service to Velindre, HEIW, DHCW and PHW, while SBUHB LCFS Team also provide an LCFS service to CTMUHB and PTHB.

Larger Health Bodies	**LCFS Annual WTE**	**Admin Support Annual WTE**	**Annual Planned LCFS Days**	**Q2 LCFS Days**	**YTD LCFS Days**	**Annual Staffing budget**	**Staff Headcount (at 31.12.24) ***	**LCFS wte per 1,000 NHS staff**
Aneurin Bevan UHB (ABUHB)	3.40	0	701	159	346	£227,069	15,592	0.22
Betsi Cadwaladr UHB (BCUHB)**	3.00	0.5	715	204	327	£216,596	21,323	0.14
Cardiff & Vale UHB (C&VUHB)	2.30	0	505	124	250	£162,238	17,561	0.13
Cwm Taf Morgannwg UHB (CTMUHB)	1.60	0.2	616	116	217	£159,577	13,204	0.12
Hywel Dda UHB (HDUHB)	2.00	0	440	111	213	£119,067	12,193	0.16
Swansea Bay UHB (SBUHB)	3.20	0.6	704	176	352	£177,484	14,673	0.22
SHAs and Trusts								
Digital Health & Care Wales (DCHW)	0.39	0	85	21	42	£27,315	1,249	0.31
Health Education & Improvement Wales (HEIW)	0.39	0	85	24	45	£27,315	628	0.62
NHS Wales Shared Services Partnership (NWSSP)	1.00	0	210	49	97	£53,602	6,117	0.16
Powys THB (PTHB)	1.20	0.2	308	77	154	£93,526	2,646	0.45
Public Health Wales (PHW)	0.45	0	100	25	50	£32,135	2,610	0.17
Velindre NHS Trust (VUNHST)	0.45	0	100	25	50	£32,135	1,873	0.24
Welsh Ambulance Service Trust (WAST)	2.00	0	420	105	210	£120,000	4,398	0.45
TOTAL	**21.38**	**1.5**	**4,989**	**1,216**	**2,353**	**£1,448,059**	**114,067**	**Average is 0.26**
NHS Counter Fraud Service Wales (CFS Wales)	5.93	0.8	1,299	274	548	£490,068		
ALL WALES TOTAL	**27.31**	**2.3**	**6,288**	**1,490**	**2,901**	**£1,938,127**		

** Staff Headcount data is correct at 31.12.24. We are awaiting update from Stats Wales with more recent figures.*
*** BCUHB Annual Planned days updated for Q2 due to new LCFS in post.*

1.3 NHS Counter Fraud Authority (NHSCFA)

The WG purchase specialist support services from the NHSCFA for NHS Wales under the terms of an annual SLA. A meeting to review the NHSCFA SLA with WG took place on 19th March 2025 when a workplan and budget was agreed for 2025/26. The funding amount for 2025/26 is £264,188. NHSCFA provide separate quarterly and annual reports to WG and CFS Wales to account for the specialist support services provided to NHS CFS Wales and LCFSs in Wales.

The specialist support services purchased from NHSCFA include the Digital Fraud Unit, Dental Advisor, Fraud Training, Risk Measurement and Quality Assurance Services which are reviewed and monitored via the quarterly reports and six-monthly meetings between NHSCFA, WG and CFS Wales. A NHSCFA senior management representative also attends the NHS Wales Counter Fraud Steering Group (CFSG) Quarterly Meetings.

NHS counter fraud colleagues from England, Northern Ireland, Scotland, and Wales hold a Four Nations Meeting to review counter fraud strategies, workplans and emerging NHS fraud trends and risks. It was agreed that future meetings would be held annually, the next meeting is in Edinburgh in November 2025.

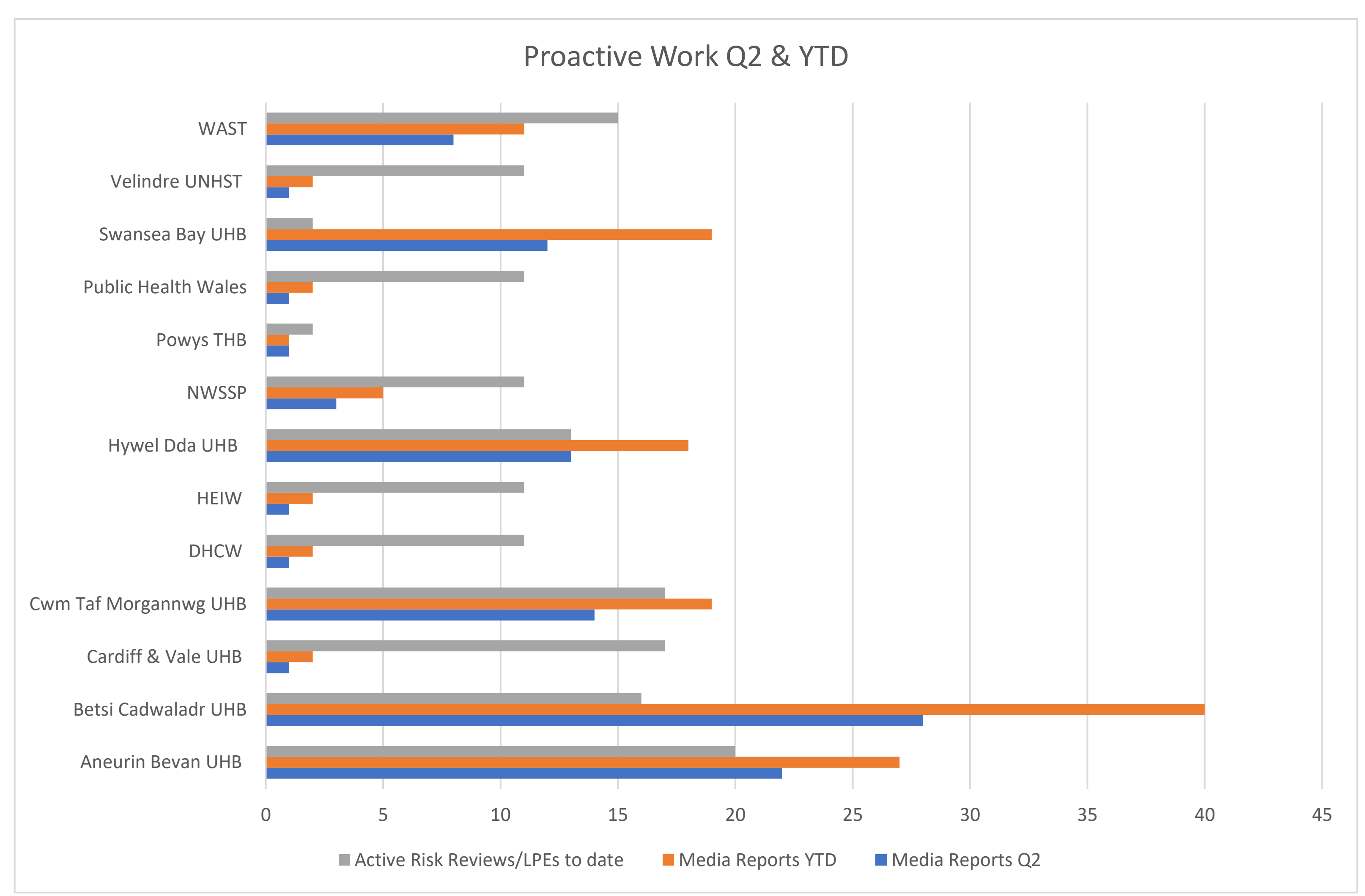
NHSCFA staff attended the NHS Wales LCFS Forum on 23.9.25 in Mamhilad and conducted updates on the Clue Case Management System and reviewed the recent Engagement visits to NHS Wales health bodies and the planned Engagement visits for 2025/26.

2 Proactive Work: Media Reports and Risk Reviews conducted by LCFSs during Q2 of 2025/26

The following table summarises some of the pro-active work completed at each health body during Q2 of 2025/26. LCFSs are required to promote successful investigations via media reports on the staff intranet, social media websites and staff newsletters as a deterrent to fraud. Risk Reviews include fraud proofing policies and Local Pro-active Exercises (LPEs) to reduce or deter fraud.

During Q2, the most media reports were generated by Betsi Cadwaladr (28). The LCFSs are currently working on 157 Risk Reviews/LPEs. This figure is a combination of active risk reviews continued from Q1, and new reviews commenced in Q2. ABUHB completed the most risk reviews or LPEs to date (20) followed by C&VUHB (17) and CTMUHB (17). The quarterly total of media reports fluctuates as it is dependent on reports on ongoing court cases and the CFA, CFS Wales and LCFSs successfully promoting the court case outcomes in the media or newsletters.

Proactive Work / Media Reports & Risk Reviews	Media Reports		Active Risk Reviews/LPEs to date
	Q2	YTD	
Aneurin Bevan UHB	22	27	20
Betsi Cadwaladr UHB	28	40	16
Cardiff & Vale UHB	1	2	17
Cwm Taf Morgannwg UHB	14	19	17
DHCW	1	2	11
HEIW	1	2	11
Hywel Dda UHB	13	18	13
NWSSP	3	5	11
Powys THB	1	1	2
Public Health Wales	1	2	11
Swansea Bay UHB	12	19	2
Velindre UNHST	1	2	11
WAST	8	11	15
TOTAL	**106**	**150**	**157**



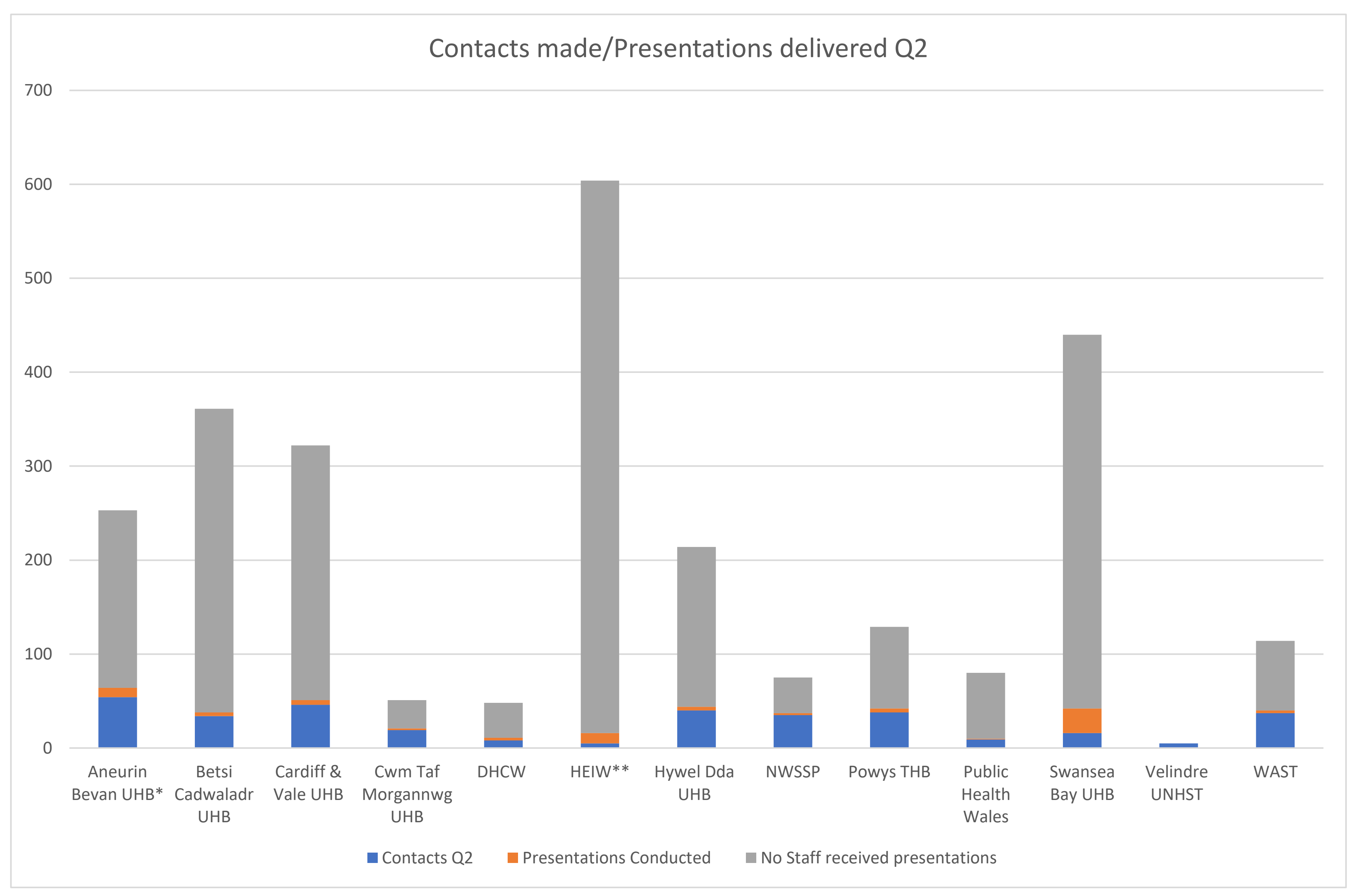
2.1 Number of Contacts made to LCFSs requiring advice on fraud related queries and Counter Fraud Presentations during Q2 of 2025/26

The table below summarises the total fraud query contacts made to each health body during Q2 of 2025/26, via telephone calls, MS Teams or email. The LCFSs received a total of 308 enquiries in Q2. During Q2, the health body that received the most contacts was ABUHB (54), followed by CVUHB (46) and HDUHB (40). While DHCW (8), HEIW (5) and VEL (5) have reported the lowest number of fraud related contacts, but this is largely due to the relatively small size of their organisations.

The table also summarises the presentations delivered to NHS staff during Q2. ABUHB LCFSs provide online counter fraud video presentations for staff to access during their induction process, while other health boards use virtual presentations formats to raise staff awareness of fraud risks. During Q2 a total of **2,188** staff received 71 fraud awareness presentations in NHS Wales. The highest number of presentations was at SBUHB (26) which were delivered to 398 staff. There were also a considerable number of staff who received presentations at HEIW (588 staff via 11 presentations) and BCUHB (323 staff via 4 presentations).

Contacts / Presentations	Contacts Q2	Presentations Q2		Contacts YTD	Presentations YTD	
		No Conducted	No Staff		No Conducted	No Staff
Aneurin Bevan UHB*	54	10	189	82	20	329
Betsi Cadwaladr UHB	34	4	323	62	9	684
Cardiff & Vale UHB	46	5	271	89	7	331
Cwm Taf Morgannwg UHB	19	2	30	38	2	30
DHCW	8	3	37	14	4	53
HEIW**	5	11	588	14	13	711
Hywel Dda UHB	40	4	170	85	14	390
NWSSP	35	2	38	63	6	89
Powys THB	38	4	87	61	8	137
Public Health Wales	9	1	70	14	1	70
Swansea Bay UHB	16	26	398	29	41	704
Velindre UNHST	5	0	0	14	2	13
WAST	37	3	74	69	7	119
TOTAL	**346**	**75**	**2,275**	**634**	**134**	**3,660**

** Includes number of staff who accessed and completed the ABUHB on-line counter fraud induction course.*
*** HEIW staff figures include student nurses who are not directly employed by HEIW but receive bursaries via HEIW.*



3 Counter Fraud Awareness E-Learning Staff Completion Figures 1st July to 30th September 2025

The data below (Table 3.1) is compiled and provided by health bodies to NWSSP Digital Learning and lists the number of staff at each health body that completed the NHS Wales Counter Fraud E-Learning Module in Q2. ABUHB, BCUHB, HDUHB, WAST, VEL and DHCW have mandated the Fraud E-Learning training module and therefore their completion data is higher. DHCW has very high completion rates (97%).

Table 3.2 displays the increasing number of staff who have completed the E-Learning module over the last three financial years. The low numbers of staff completing the training in Q2 at some large health bodies CVUHB (6), CTMUHB (16) and the year to date, remains a cause for concern despite presentations to staff raising fraud awareness This will be discussed at the Counter Fraud Liaison Group (CFLG) meeting on 6.11.25. The health boards that have mandated training have a compliance percentage figure from NWSSP for Q2. This figure reflects the percentage of staff who are compliant with completing the Counter Fraud E-Learning Module at the end of Q2 (30.09.25). The NHS Wales Fraud E-Learning module was updated and re-launched in mid-April 2025. The Welsh language version of the training module has recently been finalised by CFS Wales and NWSSP and is now available for staff.

Table 3.1

Health Body (Mandated E-Learning)	Staff Completion Q2	Staff Completion YTD	No of Employees * (As at 31/12/2024)	Compliance Percentage	Month Mandated
ABUHB	1,248	2,046	15,592	87%	Feb 2024
BCUHB	1,342	2,389	21,323	85%	April 2021
DHCW	24	27	1,249	97%	May 2024
HDUHB	989	1,598	12,193	90%	May 2021
VEL	534	1,425	1,873	67%	April 2025
WAST	317	562	4,398	81%	Aug 2023
Health Body (E-learning not yet mandated)					
C&VUHB	6	11	17,561		
CTMUHB	16	21	13,204		
HEIW	3	3	628		
NWSSP	105	178	6,117		
PTHB	1	1	2,646		
PHW	16	23	2,610		
SBUHB	146	249	14,673		
TOTAL	**4,747**	**8,533**	**114,067**		

** Staff Headcount data is correct at 31.12.24. We are awaiting update from Stats Wales with more recent figures.*

Table 3.2

Health Body	2022/23	2023/24	2024/25
ABUHB	87	5,646	6,620
BCUHB	2,295	4,334	9,727
CTMUHB	22	27	39
C&VUHB	12	56	23
DHCW	0	962	340
HDUHB	5,109	2,299	4,289
HEIW	0	19	7
NWSSP	5	119	1,073
PHW	28	69	46
PTHB	49	4	2
SBUHB	99	325	214
VEL	81	32	4
WAST	22	3,451	1,009
TOTAL	**7,809**	**17,343**	**23,393**

4 NHS CFS Wales Statistics / Operational Outcomes – 1st July to 30th September 2025

The table below summarises the CFS Wales operational data and sanctions secured in Q2. The CFS Wales team were investigating **27** cases at the start of the quarter and were dealing with **25** active cases at the end of Q2 with **4** new referrals received and **6** cases closed during the reporting period. The total recovered by CFS Wales in Q2 was **£49,085** with two criminal convictions secured in Q2.

The 16 active financial investigations currently conducted by CFS Wales listed at Para 4.1 are in addition to the **27** active CFS Wales investigations in the table below.

NHS CFS Wales Team (CFS Wales) – Q2 2025/26													
NHS Organisation	No of open cases as at 30/06/2025	No of referrals received	No of cases closed	No of open cases at 30/09/2025	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
									Criminal			Disciplinary	Civil
									Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	3	1	1	3	£0	£0	£0	0	1	0	0	0	0
Betsi Cadwaladr UHB	3	1	1	3	£9,154	£9,154	£0	0	0	0	0	0	0
Cardiff & Vale UHB*	4	1	1	4	£0	£80	£0	0	0	0	0	1	0
Cwm Taf Morgannwg UHB	6	0	1	5	£0	£0	£0	0	0	0	0	0	0
DHCW	1	0	0	1	£0	£0	£0	0	0	0	0	0	0
HDUHB	3	0	0	3	£0	£0	£0	0	0	0	0	0	0
HEIW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	0	1	0	1	£0	£0	£0	0	0	0	0	0	0
Powys THB	2	0	1	1	£14,791	£14,851	£22,186	0	0	0	0	0	0
Public Health Wales	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	5	0	1	4	£49,231	£25,000	£13,067	0	1	0	0	0	0
Velindre UNHST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
WAST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
TOTAL	**27**	**4**	**6**	**25**	**£73,176**	**£49,085**	**£35,253**	**0**	**2**	**0**	**0**	**1**	**0**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified. CFS Wales and LCFS have started to follow the Public Sector Fraud Authority (PSFA) guidance on fraud prevented calculations and included this data from Q2, this will be discussed at the next CFLG meeting on 6.11.25.*

***Includes one investigation returned to the health board due to the work invested by the SBUHB LCFS.*

NHS CFS Wales Team (CFS Wales) – Cumulative 2025/26													
NHS Organisation	No of open cases as at 01/04/2025	No of referrals received	No of cases closed	No of open cases at 31/03/2026	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
									Criminal			Disciplinary	Civil
									Court Case	Police Caution	Police Community Resolution		

Aneurin Bevan UHB	3	1	1	3	£0	£0	£0	0	1	0	0	0	0
Betsi Cadwaladr UHB	4	3	4	3	£9,154	£9,154	£0	0	0	0	0	0	0
Cardiff & Vale UHB	4	2	2	4	£0	£80	£0	2	0	0	0	1	0
Cwm Taf Morgannwg UHB	6	4	5	5	£31,136	£31,136	£0	0	0	0	0	0	0
DHCW	0	1	0	1	£0	£0	£0	0	0	0	0	0	0
HDUHB	4	0	1	3	£0	£0	£0	0	0	0	0	0	0
HEIW	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	0	1	0	1	£0	£0	£0	0	0	0	0	0	0
Powys THB	1	1	1	1	£14,791	£14,911	£22,186	0	0	0	0	0	0
Public Health Wales	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	6	1	3	4	£49,231	£29,196	£13,067	1	2	0	0	0	0
Velindre UNHST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
WAST	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
TOTAL	**28**	**14**	**17**	**25**	**£104,312**	**£84,557**	**£35,253**	**3**	**3**	**0**	**0**	**1**	**0**

4.1 NHS CFS Wales Financial Investigations – 1st July to 30th September 2025

Velindre University NHS Trust is a regulatory body under the Proceeds of Crime Act (POCA) 2002. This enables Accredited Financial Investigators (AFI) on the CFS Wales team to conduct financial investigations and restrain and recover funds from convicted persons. CFS Wales currently has two Accredited Financial Investigators (AFI) with a third staff member currently undertaking FI training, and three Financial Intelligence Officers (FIO). The table below indicates the number of active CFSW Wales financial investigations at the end of Q2. These are in addition to the **25** CFS Wales active investigations. These are specialist financial investigations conducted by CFS Wales AFIs to support ongoing CFS Wales and LCFS investigations. In total, **22** FIO enquiries were undertaken by the FIO and AFIs in Q2. FIO enquires can include intelligence checks with financial institutions, Suspicious Activity Reports (SARS) or credit reference checks.

5 LCFS Statistics / Operational Outcomes – 1st July to 30th September 2025

NHS CFS Wales Financial Investigations - Active Investigations and FIO checks Q2										Cumulative (01.04.25 to 31.03.26)				
Organisation	FIO Checks QTR 2	Bank Authorities Q2	FI Investigations as at 30/06/25	Referrals	Closures	FI Investigations as at 30/09/25	Q2 Investigation Orders	Q2 POCA Confiscation Hearings	Recoveries QTR 2	FIO Checks YTD	Bank Authorities YTD	Investigation Orders YTD	POCA Confiscation Hearings YTD	Recoveries YTD
ABUHB	0	0	0	0	0	0	0	0	0	1	0	0	0	£0
BCUHB	5	0	1	1	0	2	1	0	0	8	0	4	0	£0
C&VUHB	4	0	2	1	0	3	0	1	£80	4	0	0	1	£160
CTMUHB	2	0	2	1	0	3	1	0	0	6	0	1	0	£0
DHCW	0	0	0	1	0	1	1	0	0	0	0	1	0	£0
HDUHB	0	0	2	0	0	2	0	0	0	0	0	0	0	£0
HEIW	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
NWSSP	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
PTHB	0	0	0	0	0	0	0	0	£60	5	0	0	0	£120
PHW	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
SBUHB	9	0	5	0	0	5	0	0	0	14	4	1	1	£4,196
VUNHST	0	0	0	0	0	0	0	0	0	0	0	0	0	£0
WAST	2	0	0	0	0	0	0	0	0	2	0	0	0	£0
TOTAL	**22**	**0**	**12**	**4**	**0**	**16**	**3**	**1**	**£140**	**40**	**4**	**7**	**2**	**£4,476**

The table below summarises the NHS Wales LCFS operational data and sanctions secured in Quarter 2 of 2025/26. The LCFSs were investigating a total of 143 cases at the start of the quarter, 90 new referrals were reported with 96 cases closed and 1 case transferred to CFS Wales during the reporting period, leaving a total of 136 cases under LCFS investigation on 30th September 2025.

The LCFS investigations secured 7 civil sanctions and 11 disciplinary outcomes in Q2, with recoveries of £102,888 for NHS Wales. HDUHB recovered £84,767 while ABUHB recovered £9,258. During Q2, the LCFS' conducted 13 Interviews Under Caution (IUCs). The LCFS extrapolated data for estimated fraud prevented via LPEs has been included for Q2; HDUHB prevented £126,911 and DHCW prevented £114,931.

SBUHB (30), BCUHB (19) & WAST (19) have the highest number of active investigations at the end of Q2. SBUHB (17) had the highest number of new referrals during Q2 followed by ABUHB (13) and HDUHB (13). HDUHB closed the highest number of cases in Q2 (18), followed by ABUHB (17) and BCUHB (16).

This table is followed by a summary of the cumulative data for 2025/26 to the end of Q2.

Local Counter Fraud Specialists in NHS Wales – Q2 2025/26														
NHS Organisation	No of open cases as at 30/06/25	No of referrals received	No of cases closed	Cases transferred to CFS Wales	No of open cases at 30/09/25	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
										Criminal			Disciplinary	Civil
										Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	18	13	17	0	14	£9,278.47	£9,258	£0	2	0	0	0	3	2
Betsi Cadwaladr UHB	27	8	16	0	19	£12,789.94	£92	£56,339.86	2	0	0	0	2	0
Cardiff & Vale UHB	14	9	12	0	11	£2,633.89	£2,634	£0	0	0	0	0	4	1
Cwm Taf Morgannwg UHB	7	10	2	0	15	£0	£0	£0	0	0	0	0	0	0
DHCW	0	3	2	0	1	£0	£0	£114,931	0	0	0	0	0	0
Hywel Dda UHB*	12	13	18	0	7	£95,374	£84,767	£126,911	4	0	0	0	1	3
HEIW	0	0	0	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	5	6	1	1	9	£0	£0	£0	0	0	0	0	0	0
Powys THB	12	1	4	0	9	£0	£0	£0	0	0	0	0	0	0
Public Health Wales	0	1	0	0	1	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	27	17	14	0	30	£6,137	£6,137	£0	1	0	0	0	1	1
Velindre University UNHST	1	0	0	0	1	£0	£0	£0	0	0	0	0	0	0
WAST	20	9	10	0	19	£500	£0	£500	4	0	0	0	0	0
TOTAL	**143**	**90**	**96**	**1**	**136**	**£126,713**	**£102,888**	**£298,682**	**13**	**0**	**0**	**0**	**11**	**7**

Recoveries may include agreed monthly repayments as the civil sanction was previously recorded at the commencement of the repayment plan. *Prevented data was introduced during Q1 2021/22 and follows guidance from NHSCFA on equations for calculating the fraud / non-fraud prevented in the future due to an investigation. The Loss is recorded when the amount has been investigated and quantified. Therefore, the loss figure may be less than recoveries reported, as these figures may not be reported in same financial period.*

Local Counter Fraud Specialists in NHS Wales – Cumulative 2025/26														
NHS Organisation	No of open cases as at 31/03/25	No of referrals received	No of cases closed	Cases transferred to CFS Wales	No of open cases at 30/09/25	Loss £	Recoveries £	Prevented £	IUCs	Sanctions				
										Criminal			Disciplinary	Civil
										Court Case	Police Caution	Police Community Resolution		
Aneurin Bevan UHB	19	22	27	0	14	£9,560.94	£9,258.47	£67,874	2	0	0	0	3	2
Betsi Cadwaladr UHB	28	23	31	1	19	£12,995.94	£298	£56,340	2	0	0	0	3	0
Cardiff & Vale UHB	13	20	21	1	11	£8,066.89	£8,067	£3,230	0	0	0	0	6	1
Cwm Taf Morgannwg UHB	14	15	13	1	15	£10,508	£10,508	£0	1	0	0	0	1	1
DHCW	1	4	3	1	1	£0	£0	£114,931	0	0	0	0	0	0
Hywel Dda UHB*	11	27	31	0	7	£110,232	£99,625	£136,022	7	0	0	0	2	5
HEIW	0	2	2	0	0	£0	£0	£0	0	0	0	0	0	0
NWSSP	1	11	2	1	9	£0	£0	£0	0	0	0	0	0	0
Powys THB	6	12	8	1	9	£7,373	£5,339	£0	1	0	0	0	0	0
Public Health Wales	0	1	0	0	1	£0	£0	£0	0	0	0	0	0	0
Swansea Bay UHB	20	31	21	0	30	£19,649	£14,777	£0	6	0	0	0	1	2
Velindre University UNHST	0	1	0	0	1	£0	£0	£0	0	0	0	0	0	0
WAST	22	13	16	0	19	£1,000	£500	£1,000	6	0	0	0	1	0
TOTAL	**135**	**182**	**175**	**6**	**136**	**£179,385**	**£148,371**	**£379,397**	**25**	**0**	**0**	**0**	**17**	**11**

6 Working in Partnership

CFS Wales and Lead LCFSs have previously reviewed the Audit Wales reports on counter fraud resources in the public sector in Wales. The reports were tabled at Audit Committees with a response plan agreed for each health body. CFS Wales has recently contributed to the LCFS response to the new CFA LPE on procurement fraud and a co-ordinated response plan for NHS Wales is under review via joint work with CFS Wales and the LCFSs at NWSSP and HDUHB.

CFS Wales has ensured that all risk alerts and updates were swiftly circulated to key stakeholders and routinely share counter fraud articles or documents with LCFS colleagues. CFS Wales staff, LCFSs and NHS CFA staff work closely together and often jointly attend meetings with key stakeholders, e.g., CFSG or PPV meetings and jointly progress suitable reactive investigations or proactive projects. During Q2, CFS Wales staff attended virtual meetings with WG, NWSSP, NHSCFA, PPV, Lead LCFSs, CFSG Sub-Groups, Audit Wales and CPS. The newly formed Counter Fraud Liaison Group (CFLG) which consists of CFS Wales Heads and Lead LCFSs met once in Q2 and is now due to meet on 6.11.25. The CFLG is currently Chaired by the WAST Lead LCFS. The group meet every six weeks to share good practice, intelligence on crime trends and identify emerging risks to NHS Wales. An LCFS Training Forum was held in Mamhilad on 23rd September 2025 and presentations were conducted by the Home Office Enforcement section, Companies House, NHSCFA and CFS Wales. This was a successful and productive day with a high number of attendees. The next full LCFS forum will be held in April 2026 as the attendees at CFLG Meetings should cascade key information to LCFSs.

All counter fraud staff in NHS Wales are now routinely using Clue, the new Case Management System, which is a marked improvement on the old FIRST CMS system.

7 Five Year Operational Outcome Comparison

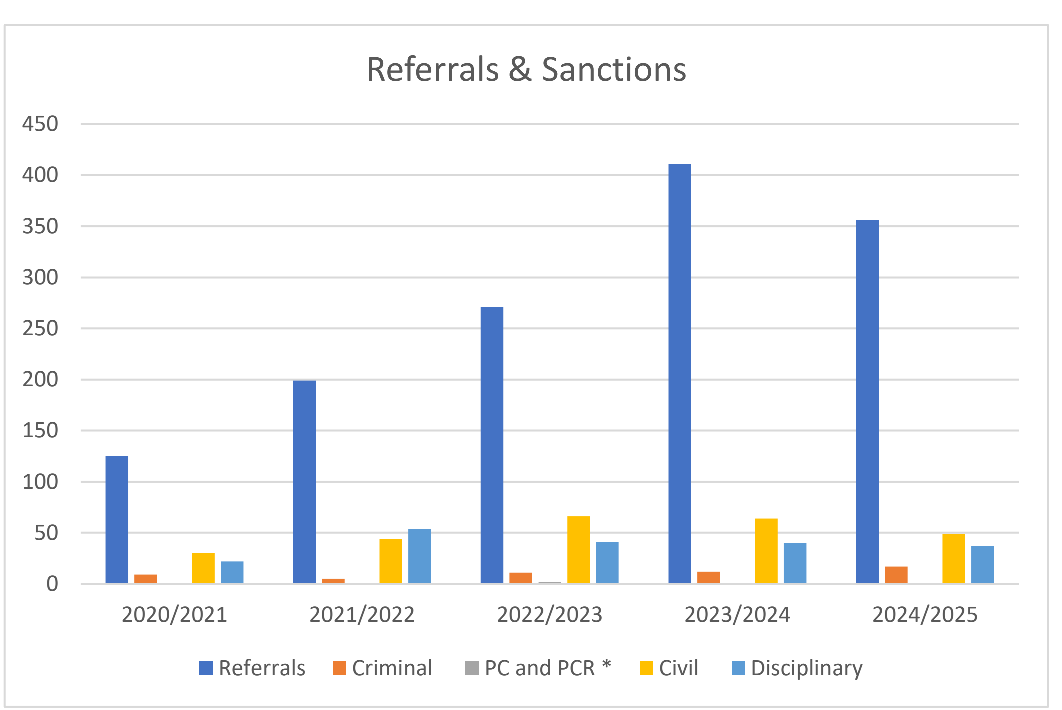
The following table and graph indicate the operational outcomes combined for CFS Wales and LCFS for the 5-year period 1st April 2020 to 31st March 2025.

A total of 1,362 referrals have been investigated in the five-year period which have led to 60 criminal sanctions (including PCRs*), 253 civil recoveries and 194 disciplinary outcomes which have secured £4,198,140 in financial recoveries for NHS Wales. The general increase in referrals received over the last five years reflects the increased focus on fraud awareness and prevention work. The number of referrals in 2023/24 (411) is the highest annual total in the last five years and has increased significantly from the low of 125 in the pandemic period of 2020/21.

The slight decrease in the number of referrals (356 in 2024/25: 411 in 2023/24) is noted but the significant 50% increase in criminal sanctions (18 in 2024/25 :12 in 2023/24) reflects the improvement in investigation work and the reduction in backlogs in the criminal justice system. The recoveries secured in 2024/25 increased (£780,537: £672,250) in 2023/24. There has also been a slight decrease in the number of civil sanctions (49:64) and disciplinary outcomes (37:40) secured under the parallel sanctions policy. This trend may partly reflect the increased focus on preventative work (LPEs and Risk exercises) rather than investigations by some LCFS teams.

	NHS CFS Wales and LCFS Sanctions April 2020 to March 2025					
	Referrals	Recoveries	Sanctions			
			Criminal	PC and PCR *	Civil	Disciplinary
2020/2021	125	£1,174,171	9	1	30	22
2021/2022	199	£592,993	5	1	44	54
2022/2023	271	£978,189	11	2	66	41
2023/2024	411	£672,250	12	1	64	40
2024/2025	356	£780,537	17	1	49	37
TOTAL	**1,362**	**£4,198,140**	**54**	**6**	**253**	**194**

* Police Community Resolution (PCR) was introduced in 2020/21 and included as a criminal sanction like a Police Caution (PC).


Referrals & Sanctions
450
400
350
300
250
200
150
100
50
0
2020/2021
2021/2022
2022/2023
2023/2024
2024/2025
Referrals
Criminal
PC and PCR *
Civil
Disciplinary

Summary of CFS Wales Cases Open at 30th September 2025

No.	Case No	Health Body	Case Start Date	Subject	Potential Offences
1	INV/25/02658	NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)	08/09/2025	NHS Manager	Abuse of Position
2	INV/25/01960	BETSI CADWALADR UHB	11/07/2025	Senior NHS Manager	Fraud by Abuse of Position/Bribery & Corruption
3	INV/25/01612	DIGITAL HEALTH CARE WALES	09/06/2025	NHS Employee	Fraud by False Representation, Fraud by Failure to Disclose, Money Laundering
4	INV/25/01506	SWANSEA BAY UHB	30/05/2025	Member of the Public	Conspiracy to Defraud & Fraud by Misrepresentation
5	INV/25/01501	CWM TAF MORGANNWG UHB	30/05/2025	NHS Employee	Abuse of Position
6	INV/25/01367	BETSI CADWALADR UHB	16/05/2025	Pharmacist	Dispensing Fraud
7	INV/25/01014	CWM TAF MORGANNWG UHB	01/04/2025	NHS Employee	Theft / Fraud
8	INV/25/00902	POWYS THB	24/03/2025	GP	Theft/ Fraud by False Representation
9	INV/25/00565	CARDIFF & VALE UHB	25/02/2025	NHS Employee	Computer Misuse & Fraud by Misrepresentation
10	INV/25/00482	ANEURIN BEVAN UHB	19/02/2025	GP Pensions	Fraud by False Representation
11	INV/24/03275	CWM TAF MORGANNWG UHB	01/06/2025	Pharmacy	Claiming out of pocket expenses
12	INV/24/03132	CARDIFF & VALE UHB	06/12/2024	NHS Employment	Fraud by False Representation
13	INV/24/02922	CWM TAF MORGANNWG UHB	15/11/2024	Estate staff	Bribery & Corruption
14	INV/24/02405	HYWEL DDA UHB	27/09/2024	NHS Pharmacy Contractor	Fraud by False Representation

15	INV/24/02035	SWANSEA BAY UHB	12/08/2024	NHS employee	Theft / Money Laundering
16	INV/24/01812	CWM TAF MORGANNWG UHB	16/07/2024	NHS Employee	Money Laundering
17	INV/24/01509	CARDIFF & VALE UHB	14/06/2024	Pharmacist	Fraud
18	INV/24/01395	SWANSEA BAY UHB	30/05/2024	NHS Dental Contractor	Fraud by False Representation
19	INV/24/00295	BETSI CADWALADR UHB	06/02/2024	NHS Manager	Fraud by Abuse of Position
20	INV/23/01736	CARDIFF & VALE UHB	17/08/2023	Health Care Support Worker (Ex employee)	Theft / Money Laundering
21	INV/23/01610	ANEURIN BEVAN UHB	02/08/2023	Nurse-failing to declare receipt of 2 salaries while on secondment	Theft & Money Laundering
22	INV/22/01725	HYWEL DDA UHB	21/11/2022	GP Practice Manager	Fraud by Abuse of Position /Theft/ Money Laundering
23	INV/22/00474	SWANSEA BAY UHB	01/04/2022	GP Practice Manager	Fraud by False Representation/Money Laundering
24	INV/21/00414	HYWEL DDA UHB	13/01/2022	Senior Nurse/Manager	Fraud by Failing to Disclose
25	WARO/18/00164	ANEURIN BEVAN UHB	15/11/2018	Dentist	Fraud by False Representation

Summary of NHS CFS Wales Cases Closed 1st July to 30th September 2025

No.	Case No	Health Body	Case Start Date	Subject	Potential Offences
1	INV/23/00355	SWANSEA BAY UHB	15/02/23 / 30/09/25	Practice Manager	Fraud by abuse of position / money laundering / theft
2	INV/25/02422	CARDIFF & VALE UHB	14/08/25 / 18/09/25	NHS Employees	Fraud by Abuse of Position
3	INV/25/02351	ANEURIN BEVAN UHB	06/08/25 / 27/08/25	Pharmacy	Fraud by Abuse of Position
4	INV/25/01322	BETSI CADWALADR UHB	13/05/25 / 18/09/25	NHS Employee	Fraud/theft
5	INV/24/03217	CWM TAF MORGANNWG UHB	16/12/24 / 05/08/25	Care Home Recruitment	Abuse of Position
6	INV/23/01970	POWYS THB	27/09/23 / 30/09/25	Health care support worker	Theft / Money Laundering

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Post Payment Verification (PPV) Mid-Year Report 2025-2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe – Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Legge Post Payment Verification (PPV) Manager

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specifications and relevant legislation.
The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The audit, risk & assurance committee is asked to note and take assurance of the contents of this report. This paper highlights PPV progress and how practices have been performing over the current Post Payment Verification (PPV) cycle. It also compares the overall performance of the Health Board against the national PPV visits.

Cefndir / Background

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).
Mid-year and end of financial year, the PPV Manager will prepare a report for Health Board Audit Committees, which should provide reasonable assurance that public monies are being appropriately claimed and that PPV continue to maintain an excellent level of PPV across all disciplines.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): From April 1st – September 30th in 2025/2026 out of 41 visits planned for Aneurin Bevan Board we have 16 in progress. We did not start this financial years planned work until July which was a national issue and is not specific to any individual Health Board.

We check 100% of the services that have been triggered for a revisit, and these take a long time to finalise. Unfortunately, last year we experienced unexpected absence in the team in a disproportionate number and are in progress of recovering.
In the first 2 months of this new financial year, we completed all outstanding routine visits that were overdue before we began the new visit plan.
We have begun to undertake the additional verification of Covid and RSV vaccines as requested by Welsh Government which are claimed on the Welsh Immunisations System.
General Ophthalmic Services (GOS): The visit plans for GOS 2025-2026 are progressing well, and as above we did not begin the new financial year until July. More contractors have transferred to electronic patient records so we can undertake the visit remotely, however we do have to carry out elements of physical visits for the contractors who do not have electronic patient records.
We also began verifying claims for an additional 2 services this year for WGOS 4 (Glaucoma and Medical Retina) and IPOS (Independent prescribing) 5 urgent claims.
General Pharmacy Services (GPS): In 2025/2026 we continue to PPV the Collaborative Working Scheme along with the Quality and Safety Scheme which we can undertake remotely.

Additional Services: We have progressed with our quarterly dispensing data checks and have introduced a robust service moving forward into the new financial year, which have resulted in financial recoveries. The results are included in our PPV reports for this year.
Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this year to align to the WGOS reform and the managing of clinical waste.
The PPV team also manage the Waste Management Audit programme on behalf of the Health Boards offering advice and support to GP Practices and Community Pharmacies in respect of Waste Management.
Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks.
We are continuing to investigate other avenues for savings from the provision of Clinical Waste services and produce a 'non-collection' report to all our Health Boards.
There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.
PPV training events will continue to be delivered to our Health Boards and contractors when required, including one-on-one training requirements, particularly for new practice staff within the Primary Care setting.

Argymhelliad / Recommendation

The reports provide the PPV overall progress of visits and narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving throughout the claiming process.
It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

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.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

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

Audit Report - 1st April to 30th September 2025 = Aneurin Bevan University Health Board

General Medical Services (GMS) for 2024 - 2025 | **ABuHB = 28 visits were completed with a total of recovery of £19,220.55** | **ALL WALES = 193 visits were completed with a recovery of £216,100.90**

GMS	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
	Routine	27	16	431	£13,156.83	£16,794.35	£29,951.18	103	65	£44,544.91	£57,371.51	£101,916.42
	Revisit	14	0	0	£0.00	£0.00	£0.00	148	0	£0.00	£0.00	£0.00
	TOTAL	**41**	**16**	**431**	**£13,156.83**	**£16,794.35**	**£29,951.18**	**251**	**65**	**£44,544.91**	**£57,371.51**	**£101,916.42**

General Ophthalmic Services (GOS) for 2024 - 2025 | **ABuHB = 18 visits were completed with a total of recovery of £1,976.15** | **ALL WALES = 100 visits were completed with a recovery of £16,316.67**

GOS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
	Routine	22	4	28	£759.24	164	39	£6,243.53
	Revisit	3	0	0	£0.00	11	0	£0.00
	TOTAL	**25**	**4**	**28**	**£759.24**	**175**	**39**	**£6,243.53**

General Pharmacy Services (GPS) 2024 - 2025 | **ABuHB = 42 visits were completed with a total of recovery of £10,745.90** | **ALL WALES = 238 visits were completed with a recovery of £48,153.27**

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	45	14	0	£0.00	232	86	0	£0.00
	TOTAL	**45**							

New Recovery process

DISPENSING	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy	Quarter 4 2024/25 (Jan to Mar 2025)	12	£3,447.16	64	Pending

GMS Summary

PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	% recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Routine		In Progress					
Practice 2	Routine	292	80	27.40%	£1,922.16	£130.39	£2,052.55	Asylum Seekers, Care Homes, Denosumab, Imms, NPT and Gonadorelins. Duplicate recoveries on Imms and Flu
Practice 3	Routine	471	22	4.67%	£985.01	£915.23	£1,900.24	Asylum Seekers, Care Homes and DOAC/R. Duplicate recoveries on Gonadorelin, Flu, NPT, DOAC/R, Pneumo and Unscheduled Vac Td/IPV/Booster
Practice 4	Routine	290	23	7.93%	£450.66	£0.00	£450.66	Imms, Lithium and Minor Surgery
Practice 5	Routine	416	17	4.09%	£706.94	£80.20	£787.14	DOAC/R. Duplicate recoveries on Flu and DOAC/R
Practice 6	Routine	1174	21	12.00%	£209.86	£78.19	£288.05	Imms and Pertussis. Duplicate recoveries on Pertussis
Practice 7	Routine	329	44	13.37%	£2,437.51	£1,614.23	£4,051.74	Care Homes, Flu, Minor Surgery and Pertussis. Duplicate recoveries on Pneumo, Flu and DOAC/R
Practice 8	Routine	310	48	15.48%	£1,289.34	£137.82	£1,427.16	Denosumab, Imms, Warfarin, DOAC/R and Gonadorelins. Duplicate recoveries on Gonadorelins, Flu and Rotavirus
Practice 9	Routine	189	15	7.94%	£459.00	£0.00	£459.00	Care Homes, Flu and Imms.
Practice 10	Routine	296	15	5.07%	£483.42	£1,301.67	£1,785.09	Denosumab. Duplicate recoveries on Contraceptive, Imms and Gonadorelins
Practice 11	Routine	161	2	1.24%	£127.30	£0.00	£127.30	Claim recovery under 10% per service
Practice 12	Routine	395	53	13.42%	£1,631.75	£22.22	£1,653.97	Asylum Seekers, Care Homes, Imms, Minor Surgery, DOAC/R and Ukrainian Refugees. Duplicate recoveries on Contraceptives
Practice 13	Routine	237	3	1.27%	£45.56	£0.00	£45.56	Claim recovery under 10% per service
Practice 14	Routine	368	18	4.89%	£576.85	£238.60	£815.45	Lithium, NPT and DOAC/R. Duplicate recoveries on Flu, Lithium and Pertussis
Practice 15	Routine	257	14	5.45%	£438.09	£275.42	£713.51	Care Homes, Flu and DOAC/R. Duplicate recoveries on Care Homes, Flu and Imms
Practice 16	Routine	332	56	16.87%	£1,393.38	£12,000.38	£13,393.76	Denosumab, Flu, Imms, Lithium, NPT, DOAC/R, Pertussis and Gonadorelins. Duplicate recoveries on Diabetes, Gonadorelins, Flu, DOAC/R, Substance Misuse and Warfarin

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers.
- All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed.
- The duplicate amount of recovery is due to the practice submitting certain addtional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors.
- The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns.
- PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise.
- Training/support is given to practices by PPV after their visit when requested.
- Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims.
- Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole.
- Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.

GOS Summary

PRACTICE	Routine or Revisit		Claim errors	% recovery	Value of recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Routine		4	3.88%	£176.00	Claim recovery under 10% per service
Practice 2	Routine		0	0.00%	£0.00	Claim recovery under 10% per service
Practice 3	Routine		In progress			
Practice 4	Routine		24	23.30%	£583.25	GOS 4 and EHEW claims

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers.
- As contractors are transitioning to electronic records, remote access and physical visits are progressing well

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic 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

The Strategic Risk Report provides the Committee with an overview of the key strategic risks facing the Health Board, aligned to the priorities and objectives within the 2025–28 Integrated Medium-Term Plan (IMTP).

It seeks to provide assurance that these risks are being identified, monitored, and managed effectively, with proportionate actions in place to mitigate potential impacts on service delivery, financial sustainability, and patient safety.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Committee with an assessment of the Health Board's strategic risk profile as at December 2025.

The overall strategic risk position remains broadly stable, although the operating environment continues to present significant pressures.

While challenges persist, particularly in relation to financial sustainability, workforce, and performance recovery, the Health Board continues to demonstrate a mature and proactive approach to managing risk through strengthened governance, robust assurance mechanisms, and sustained executive leadership focus.

Cefndir / Background

The Strategic Risk Register (SRR) is the principal mechanism through which the Board gains assurance over the management of strategic risks. It currently includes

nine principal risks and **21** associated sub-risks. Each risk has a designated Executive Director as lead, ensuring accountability for mitigation and oversight through relevant governance structures.

All strategic risks have been reviewed within the expected timeframe, and the overall control environment remains adequate. Where control gaps or assurance weaknesses have been identified, appropriate actions have been initiated to strengthen the relevant systems and processes.

Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Asesiad / Assessment

Current Risk Profile

The Health Board's strategic risk profile continues to reflect the scale and complexity of system-wide challenges. Most risks sit within the High category, particularly within Service Delivery and Compliance & Safety domains. These remain areas of sustained strategic focus and oversight.

Fewer risks are rated Extreme, but these represent the greatest potential threat to organisational resilience, patient safety, and delivery of IMTP objectives. These are subject to enhanced monitoring and reporting through the Executive Committee and relevant thematic committees.

The Heat Map, below, illustrates the current distribution of strategic risks and their relative severity.

Strategic Risk Landscape

Risk Level	People	Service Delivery	Financial Sustainability	Compliance and Safety	Transformation & Partnership Working
EXTREME	SRR 001D	SRR 011A	*SRR 001G	SRR 002 *A & *B	0
HIGH	SRR 001 A, B, C	SRR 005A SRR 006 A, B, & C	0	SRR *001I SRR 004 A & *B *SRR 010	SRR 007B
MODERATE	0	SRR 001 E, F	0	0	SRR 007A SRR 008A

Theme

Number of Risks: 0, 1, 2, 3, 4, 5

*RISKS OUTSIDE OF APPETITE

Risks outside of Appetite

The Table below sets out the **six** sub-risks that currently exceed the acceptable thresholds for their respective domains, all of which are under active management. Ongoing assessments are in place to monitor residual risk, ensuring that new threats and vulnerabilities are promptly identified and addressed.

Risk ID & Score Threshold	Sub Risk Description	Current Score	Management of the Risk
SRR 001G Score 12 and below	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	**20**	The residual risk is being **treated** through strengthened financial controls, while **opportunities are being taken** to redesign services for long-term sustainability.
SRR 001I Score 8 and below	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**	The residual risk is being **treated** and opportunities taken to strengthen services and accountability structures.
SRR 002A Score 8 and below	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**15**	The risk is being **tolerated** pending completion of remediation plans.
SRR 002B Score 8 and below	Due to significant levels of backlog maintenance and structural impairment.	**12**	The risk is being **treated** through proactive estate investment and maintenance planning.
SRR 004B Score 8 and below	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	**12**	The risk is being **treated** through the development, standardisation, and testing of business continuity and incident response plans.
SRR 010 Score 8 and below	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.	**12**	The risk is being **treated** through strengthening governance and **taking the opportunity** to enhance staff safety culture.

Linking Risk Appetite to Cross-Risk Dependencies and Collective Mitigation

The Health Board's Risk Appetite provides the overarching parameters within which all strategic risks, whether within or outside appetite, are assessed, prioritised, and managed. While identifying risks that currently sit outside appetite remains important, the primary purpose of the framework is to support balanced and informed decision-making across all strategic risks. This includes determining the level of exposure the Board is willing to accept, the pace and scale of required mitigation, and the allocation of resources across interdependent risk areas.

Applying risk appetite across the full strategic risk profile enables the Health Board to:

- Understand the relationships between risks, recognising that a change in one domain (e.g., financial sustainability) directly influences the ability to manage others (e.g., workforce, performance, infrastructure);

- Prioritise collective mitigation, ensuring that actions taken in one area do not unintentionally elevate risk elsewhere;

- Support proportionate decision-making, distinguishing where greater innovation or risk-taking is acceptable and where a cautious or highly controlled approach is required.

This approach is particularly relevant when viewed alongside the Health Board's IMTP, where interdependencies between financial sustainability, workforce capacity, service performance, and infrastructure resilience create a complex and mutually reinforcing risk landscape. The Board's risk appetite therefore plays a critical role in shaping the overall strategy for mitigating these interconnected risks.

By using risk appetite not only to flag risks that exceed accepted thresholds but also to guide collective action across the whole portfolio, the Health Board strengthens its ability to target mitigation where it will have the greatest system-wide impact. This ensures that areas such as financial balance, estate safety (including RAAC issues), business continuity, governance, and service performance are not managed in isolation but as part of an integrated, strategically aligned risk management approach. As a result, the management of strategic risks becomes more coherent, better integrated, and more closely aligned to IMTP delivery.

To provide assurance on how strategic risks are being managed over time, a risk dashboard is being developed. This dashboard will provide an at-a-glance view of the history of each strategic risk, showing whether exposure has remained stable, increased, or decreased since the risks were first identified in June 2023. This functionality will enable the Risk Team to triangulate information from various sources, to identify emerging patterns or trends and determine what actions are required to prevent further exposure. It will also support assessment of which types of controls require strengthening, as outlined in the table below.

Type of Control	Primary Purpose	How It Reduces Likelihood or Impact
Preventative Controls	Prevent the risk from occurring	Reduce the likelihood of a risk event by eliminating opportunities for error, failure, or inappropriate action
Detective Controls	Identify when a risk has occurred or is emerging	Reduce the impact by enabling early detection and timely intervention
Corrective Controls	Respond to and mitigate the impact after a risk materialises	Reduce the severity and duration of the impact, restoring operations and preventing recurrence
Directive Controls	Influence actions and guide desired behaviours	Reduce likelihood by setting expectations and reinforcing standards

Closing Position

As at December 2025, the Strategic Risk Register comprises **nine** high-level strategic risks and **21** sub-risks, of which **six** are operating outside their defined appetite levels. All risks continue to be actively monitored through the established governance framework, with particular focus on those presenting the greatest potential impact on service continuity, patient safety, or financial stability.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **CONSIDER** whether it has sufficient assurance that strategic risks are being appropriately managed and reviewed in line with the Health Board's governance framework;

- **NOTE** those risks that remain outside of the agreed appetite, recognising the ongoing work to strengthen controls and bring them within tolerance, and;

- **NOTE** the continued development of the Health Board's risk management and assurance framework as a key enabler of resilience, accountability, and sustainable service delivery.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

**Gwybodaeth Ychwanegol:
Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

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

Risk 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	●					◊		
			f) Due to unsustainable service models						X				●		◊		
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Finance						X			◊			●	
	Director of Strategy, Planning and Partnerships.		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 Aerated 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 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 an inability to recruit and retain staff across all disciplines and specialties.**	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings **Staff** • Non-compliance with safe staffing principles and standards. • Increased Workload **Organisation** • Operational Disruptions • Quality of Services • Reputational Damage • Financial strain – use of agency and bank staff	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Workforce & Organisational Development			
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			

SRR 001A

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score
Target Risk Score
Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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. • **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).	**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 MHLD 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. **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. **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 flexile retirement options from October 2023 and reduced break in service required following retire and return.
- Development of HCSW skills matrix and career framework has commenced.
- Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee.
- Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked**.** Further workshops planned until the end of the year.
- All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline.
- 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.

• 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 midwifes, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year. • Delivery of workforce planning training. **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers to WG as of 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. **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support.	

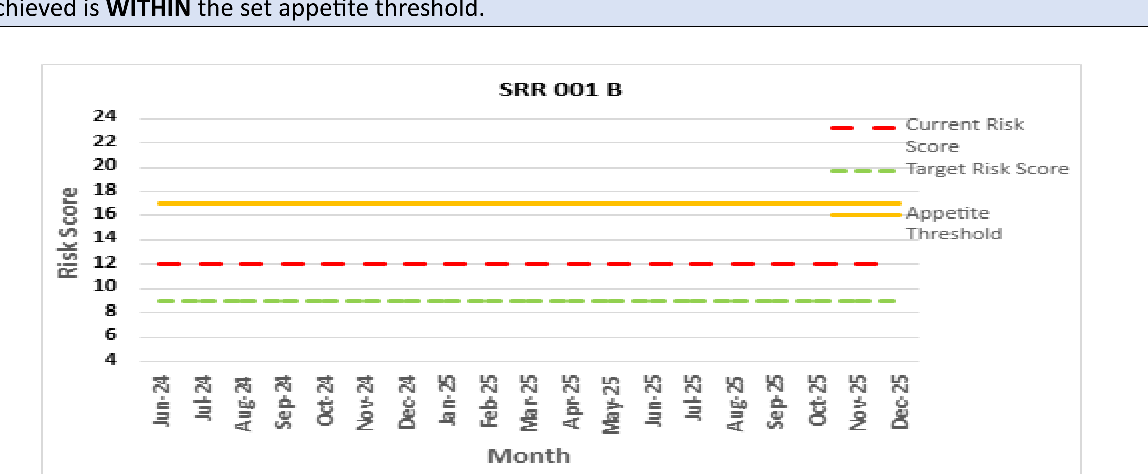
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls.	• Occupational Health and Wellbeing dashboards report KPIs. • Recruitment KPIs • Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB	• (Aneurin Bevan University Health Board) Staff Survey • Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board	• Governance processes • risk management input (register, risk assessment)	
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Internal Audit Reviews 2023 -24 • Long Term Sickness Absence Management (Q4) • Flexible Working (Q4) • External quarterly vacancy reporting to WG • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.	• External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • Workforce planning external audit action plan 2024 and Structured Assessment Response August 2025 • Resident Doctor Contract Reform	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

RISK THEME	PEOPLE					
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE					
Strategic - SRR 001 B	**There is a risk 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 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** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • High absence levels, with some sustained long periods • Non-compliance with safe staffing principles and standards	**Organisation** • Reputational damage to the health board as an employer • Work-related claims • Financial Implications	**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 • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority • Strategic Equality Plan • Rest and Facilities Charter – monitoring and compliance • Staff related policies • National Staff Survey and Health Board Employee Experience Survey • External Employee Assistance Programme • Speaking up Safely Action Plan • Race/LGBT groups • Wellbeing resources • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own • Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.	**General** • Increase wellbeing initiatives, 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.** • 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.

• 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 **Occupational Health** • Additional occupational health resources secured to reduce waiting times • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19 • Support equality and diversity of workforce • A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024 • Band 5 EDI Officer appointed and commenced in post at the end of March 2024 • Inclusive Leadership sessions embedded in the Leading People Programme • Reverse Mentorship Programme launched February 2024 **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed	• 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 **Staff Survey Action Plan** • 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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what's available.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and • Facilities		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

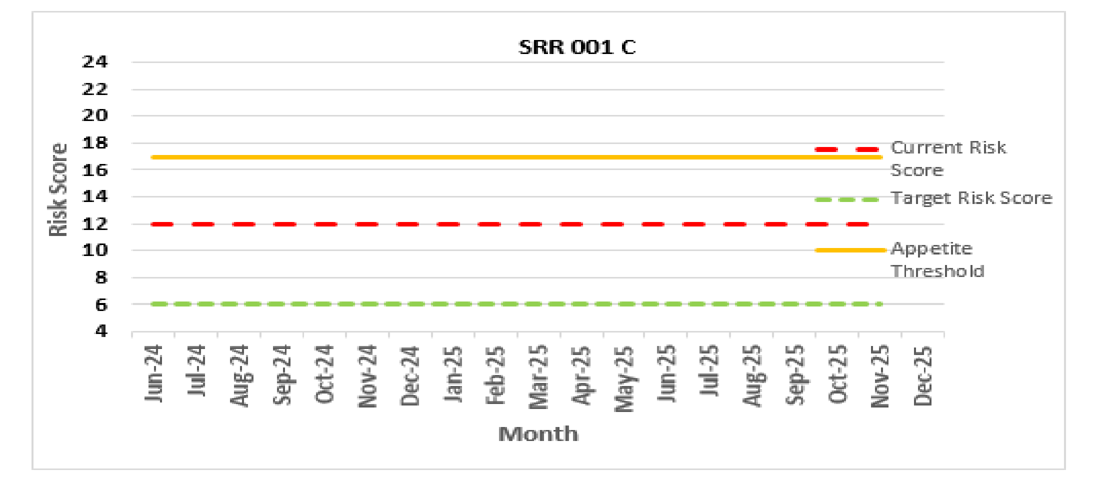
RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 C	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to insufficient and ineffective leadership levels throughout the organisation**				
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings;	**Staff** • Adverse impacts on staff recruitment and retention	**Organisation** • Failure to deliver health board priorities, required improvements and achieve sustainability; • Poor levels of accountability and delivery; • Reputational damage to the health board as an employer;		

Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

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)*
• 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 mangers, 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 ley 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.	**Talent and Succession Planning** • Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. • Development workshops being rolled across the Health Board, open for all leaders to attend. • Designated Talent and Management succession planning resources available on ABUHB intranet. **Development leadership capabilities** • Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes. • Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. • Working with HEIW to inform a national development programme for managers • Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England). • 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit Review • Talent and Succession Board		

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**POSITIVE**

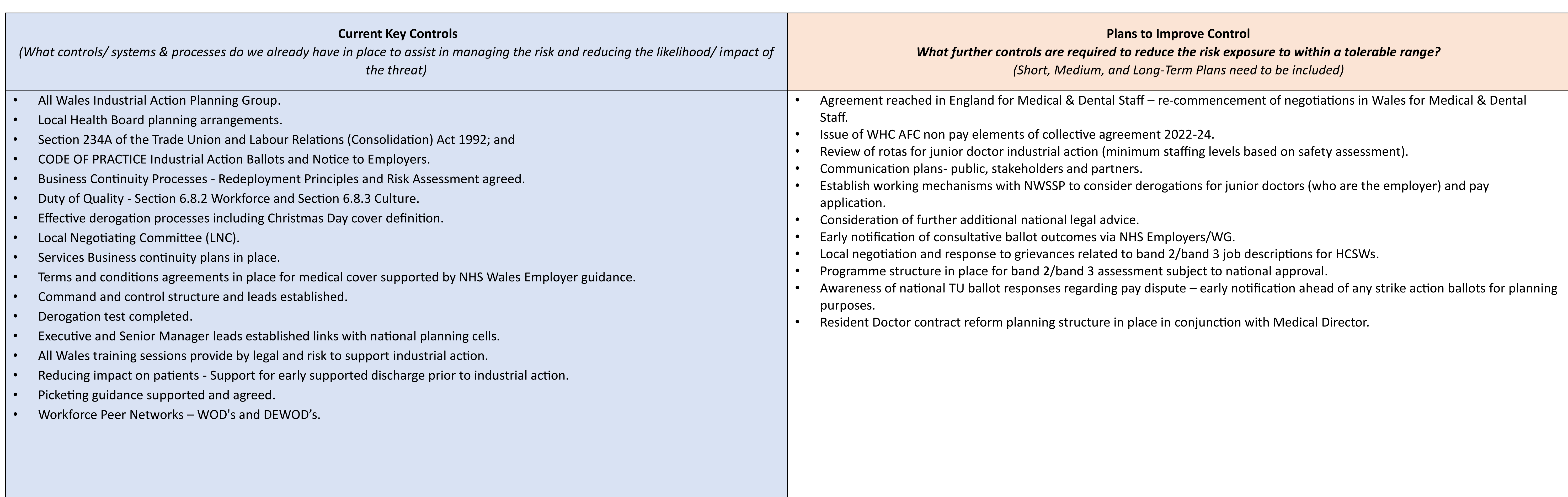
RISK THEME	PEOPLE				
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE				
Strategic - SRR 001 D	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level**			**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Non-compliance with safe staffing principles and standards	**Organisation** • Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence	**Risk Appetite Threshold - Score 17 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee / Group	People & Culture Committee	**Likelihood**	**4 (Likely)**	2 *(unlikely)*	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*	
Last Reviewed	01 December 2025	**Risk rating**	**= 16** ***(Extreme)***	**= 8** ***(Moderate)***	
Next Review (Monthly based on risk score)	01 January 2025				

SRR 001 D

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score; Target Risk Score; Appetite Threshold



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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.	• 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*

Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings • Established processes and tools used for previous industrial action.			Further industrial action
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required			
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action • Resident Doctor Contract Reform • Band 2/3 Implementation Framework – DRAFT, subject to Cabinet Secretary review/approval			

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

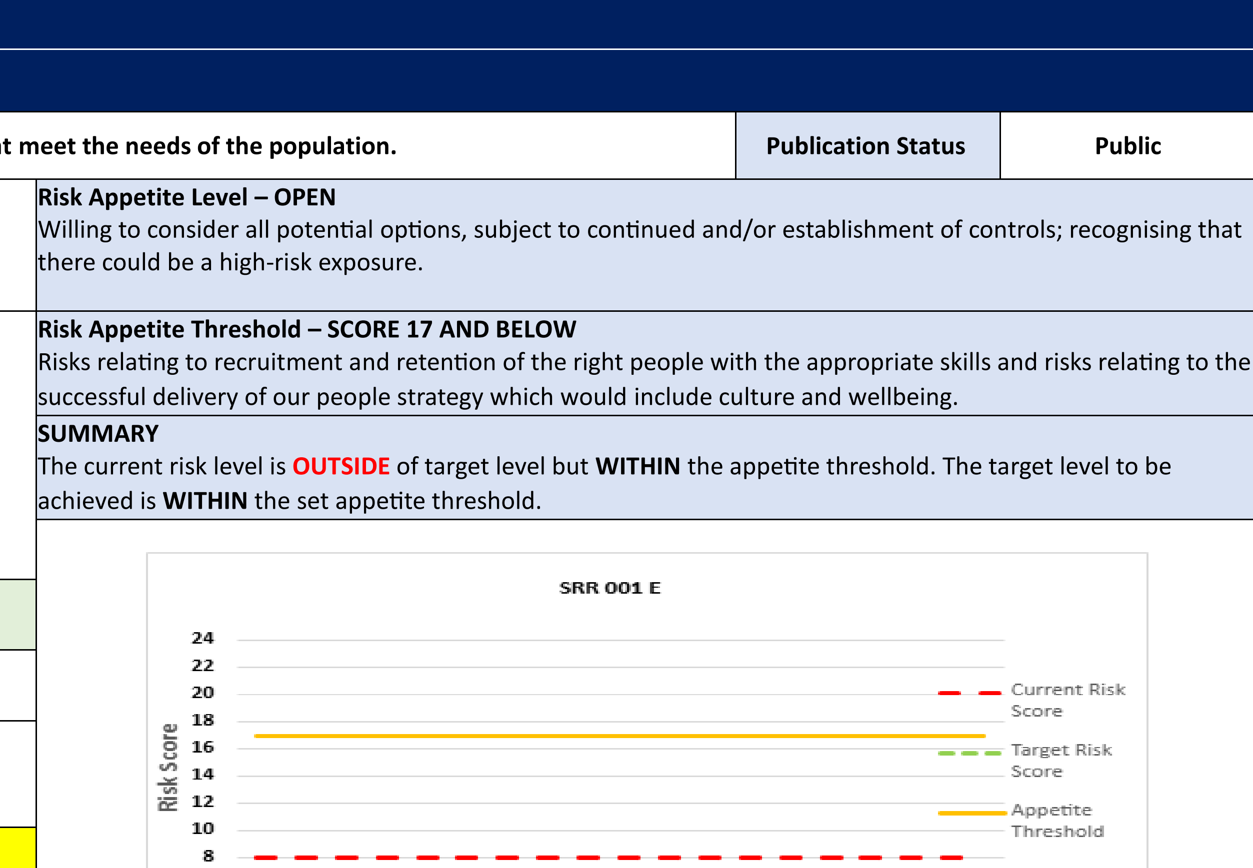
RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic/ Corporate Risk SRR 001 E	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			**Publication Status**	**Public**

Threat *(As a result of)*	**Due to inadequate strategic plans which respond to population health and socio-economic needs.**		**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Patient** • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff**	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence • Increased demand

Risk Appetite Threshold – SCORE 17 AND BELOW
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee	**Likelihood**	**2** *(Unlikely)* x	**2** *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Last Reviewed	01 November 2025	**Risk rating**	***= 8 (Moderate)***	***= 6 (Moderate)***
Next Review (Six monthly based on risk score)	01 May 2025			



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Qliksense – performance information • SFN – performance information		• Effectiveness of the plans in delivering improvements
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023-24 • IMTP Planning (Q1) Outcome – Reasonable Assurance **Internal Audit Reviews 2024-25** • Internal Audit Partnership Arrangements – **Limited Assurance**		• Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE					
Strategic Risk SRR 001 F	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to unsustainable Service Models**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes	**Staff** N/A	**Organisation** • Failure to train teams in multi-morbidity management • Failure to comply with the Wellbeing of Future Generations Act (Wales) • Reputational damage and loss of public confidence		**Risk Appetite Threshold – SCORE 17 AND BELOW** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	**Current Level**	**Target Level**		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x		
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**3** (Moderate)		
Last Reviewed	01 November 2025	**Risk rating**	**= 8 (Moderate)**	***= 6 (Moderate)***		
Next Review (Six monthly based on risk score)	01 May 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)*
• 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.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information		• Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews 2023-24 • IMTP planning Q1. Outcome – Reasonable Assurance. **Internal Audit Reviews 2024-25** • IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance • Partnership Arrangements. Outcome – Limited Assurance	• Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Implementation of the management responses to close off recommendations

Assurance Rating (*Overall Assessment of controls and assurances) Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	FINANCIAL SUSTAINABILITY				
LINK TO IMTP	SECTION 4: ENABLER - FINANCE				
Strategic - SRR 001 G	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat *(As a result of)*	**Due to the failure to deliver a sustainable financial position and longer-term financial plan.**			**Risk Appetite Level – CAUTIOUS** Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	
Impact *(Consequences of the threat)*	**Organisation** • Breach of statutory duty to breakeven over 3 years. • Instigation of NHS Wales Escalation & Intervention Arrangements. • Non–delivery of Health Board priorities, required improvements, and achieving longer-term sustainability. • Prioritisation and possible disinvestment in service delivery. • Reputational damage and loss of public confidence.			**Risk Appetite Threshold – Score 13 and Below** Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies. **SUMMARY** The current risk level is **OUTSIDE** of target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	**5 (Almost certain)** x	2 (Unlikely) x	
Initial Date of Assessment	June 2023	Impact	***4** (Major)*	**4** (Major)	
Last Reviewed	December 2025	Risk rating	**= 20 (Extreme)**	***= 8*** **(Moderate)**	
Next Review (Monthly based on risk score)	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)*

• 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	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance	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 *(Executed by risk management and compliance functions)*		
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	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.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		

Internal Audit • Annual Report • 2024/25 Financial Sustainability – **Reasonable Assurance** Sept 2025 • 2025/26 - Audit Reviews **External Audit Reports** • 2024 -25 – Annual Report • 2025/26 - Audit Reviews	**Welsh Government** • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government monthly • IMTP plan to WG end of March 2025	• Recommendations from audits	• Implement management actions to complete the recommendations from audit reports

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY			
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS	SECTION 4: ENABLERS – WORKFORCE & CULTURE		
Strategic Risk **SRR 001 I**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.**		**Publication Status**	**Public**

Threat *(As a result of)*	**Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.**			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact *(Consequences of the threat)*	**Patient** • Unintended Patient Harm. • Negative Public/Patient Experience.	**Staff** • Reduced Staff Morale leading to potential absence from work.	**Organisation** • Loss of patient/public trust and confidence. • Scrutiny from external organisations. • Adverse publicity. • Punitive Actions. • Financial implications.	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of target and the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

			Current Level	**Target Level**
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			

SRR 001 I

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score — Target Risk Score — Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Performance Management and Assurance Framework • Executive Accountability letters • Divisional Directors Accountability letters • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off • Reporting through to Finance and Performance Committee via Executives • Specific areas of focus are discussed at Value and Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. • External scrutiny via Welsh Government and NHS Executive • Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support	• 6-month review of Performance Management and Assurance • Alignment of internal mechanisms to national escalation • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Appropriate Business Partnering Support and analytical support • Realign capacity and/or redefine roles to provide explicit support

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

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY
LINK TO IMTP	SECTION 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.**

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	• Harm or injury to staff	• Litigation & Financial Penalties • Loss of estate

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.

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 December 2025	**Risk rating**	**= 15 (Extreme)**	**= 2 *(Low)***
Next Review (Monthly based on risk score)	01 Jan 2025			

SRR 002A

Risk Score / Month

Current Risk Score — Target Risk Score — Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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	• 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• 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	• Ongoing management of the issues.	N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor • risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment 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 *(Implemented by both auditors internal and external independent bodies)*		
• Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. • Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.	• Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements **Internal Audit 2024/25 Plan** • Implementation of the management responses to close off recommendations been concluded.

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES				
Strategic Risk SRR 002 B	**There is a risk that there will be significant failure of the Health Boards Estates**.			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to significant levels of backlog maintenance and structural impairment.**				
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients. • Adverse impacts on the delivery of care to patients across acute and non-acute settings.	**Staff** • Harm or injury to staff.	**Organisation** • Non-compliance with health and safety legislation. • Litigation and financial penalties. • Loss of estate		

Risk Appetite Level – MINIMAL
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – SCORE 8 AND BELOW
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of the target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

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 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)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants • A clear approach to compliance monitoring and escalation of AE reports has been implemented	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • 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.

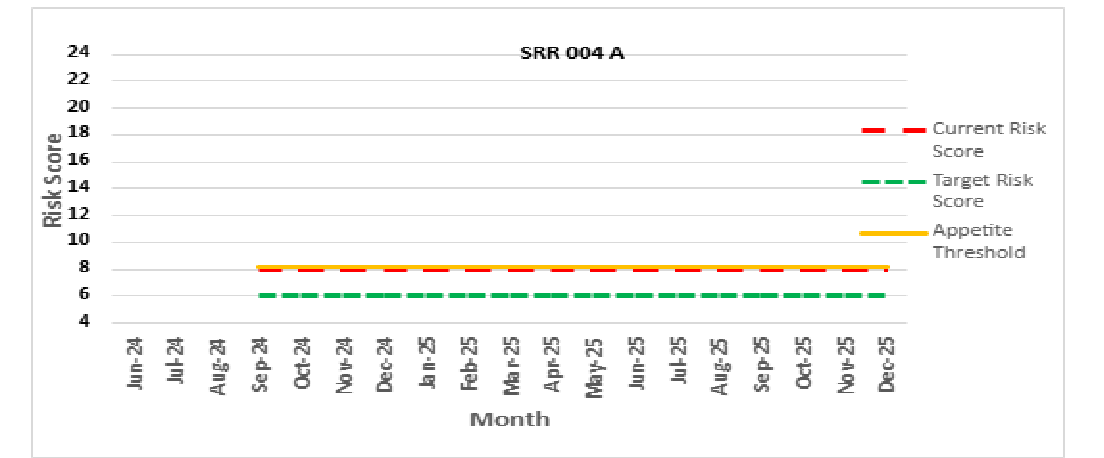
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness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

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY		
LINK TO IMTP	SECTION 3: SYSTEM CHANGE		
Strategic Risk SRR 004 A	**There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident**	**Publication Status**	**Public**

Threat *(As a result of)*	**Due to emergency planning arrangements at both the corporate and operational levels lacking the necessary robustness to ensure an effective response.**	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Impact *(Consequences of the threat)*	**Patient** • Adverse impacts on delivery of care to patients across acute and non-acute settings • Harm or injury to patients **Staff** • Inability to respond to a major incident to meet needs of those affected • Harm or injury to staff **Organisation** • Health Board breaches statutory duties under the Civil Contingencies Act 2004 • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning and Partnerships			
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	**Likelihood**	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 October 2025	**Risk rating**	**= 8 (Moderate)**	***= 6 (Moderate)***
Next Review (Six-monthly based on risk score)	01 May 2026			



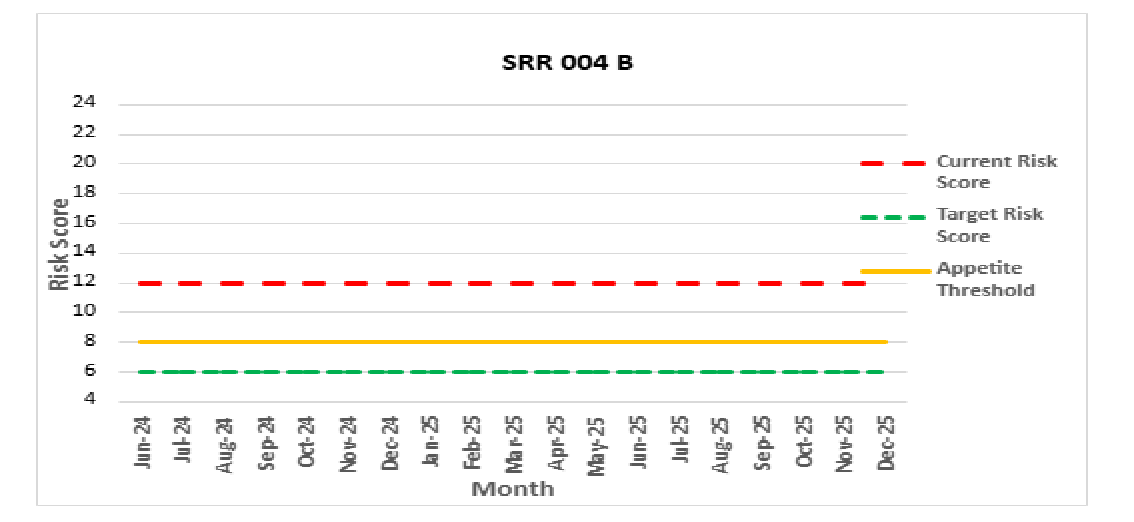
Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• 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	• Continue to deliver training programmes to support staff preparedness to response to an incident. • Additional 'local' team and intra team exercises to take place for areas to practice and embed their response to a major incident together • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • BCPs in place across all services. 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)

• LRF Pandemic Solaris undertaken	

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness	• EPRR Thematic Risk Register	• Develop an EPRR
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - **Reasonable Assurance** • Outcome and feedback from national exercises	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	• Implementation of the recommendations and subsequent management responses.

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	COMPLIANCE AND SAFETY					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE					
Strategic Risk SRR 004 B	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to Business Continuity incidents.				Publication Status	Public
Threat *(As a result of)*	• Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident				**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact *(Consequences of the threat)*	**Patient** • Harm or injury to patients • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Staff absence (injury, wellbeing) • Harm or injury to staff	**Organisation** • Operational flow if services fail to prepare BCPs against the 5 key themes • Loss of infrastructure; • Financial implications due to staff absence • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence		**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Likely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	Impact	*4 (Major)*	3 (Moderate)		
Last Reviewed	01 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)*
• 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 knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	• Ongoing support to develop business continuity plans. • 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.

• 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

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• 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.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness •	• EPRR Thematic Risk Register	• Develop an EPRR
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – **Reasonable Assurance** • Outcome and feedback from national exercise	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	• Implementation of the recommendations and subsequent management responses.

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY
LINK TO IMTP	SECTION 3: SYSTEM CHANGE

Strategic Risk SRR 005 A	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**	**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**		

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• 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.	• Increased workload • Fatigue & burnout	• Litigation & Financial Penalties • Reputational damage and loss of public confidence

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – OPEN SCORE 17 AND BELOW
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 December 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)*
• Escalation Policy. • Performance and Accountability Framework • Operational Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus	• New developments and pathways coming online into FY25/26 • New expanded transfer lounge o New ED extension and reconfiguration • Additional ED consultants coming onboard • Safety Flow agenda delivering wider developments and improvements

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee	• Effectiveness of the Operational Framework	• 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 *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits. -	None	N/A

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 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 *(As a result of)*	**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 *(Consequences of the threat)*	**Patient** • Unintended harm or Injury to Patients.	**Staff** • Unintended harm or injury to staff	**Organisation** • Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	*4 (Major)*	4 (Major)
Last Reviewed	01 October 2025	**Risk rating**	**= 12 (High)**	***= 8 (Moderate)***
Next Review (Quarterly based on risk score)	01 January 2025			

SRR 006 A

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Current Risk Score
Target Risk Score
Appetite Threshold

Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25

Month

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*

• Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. • Implement the recommendations from Templar report: • Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. • Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. • Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · • Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · • Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • ·Introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	• 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.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
• Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Single directorate risk registers now in place.		• None	• N/A
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. • Annual Senior Information Risk Owner report.		• None	• N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. • Oversight from NHS Wales Cyber Resilience Unit.	Internal Audit 2024/25	• None	• N/A

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY		
Strategic Risk SRR 006 B	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**	**Publication Status**	**Public**

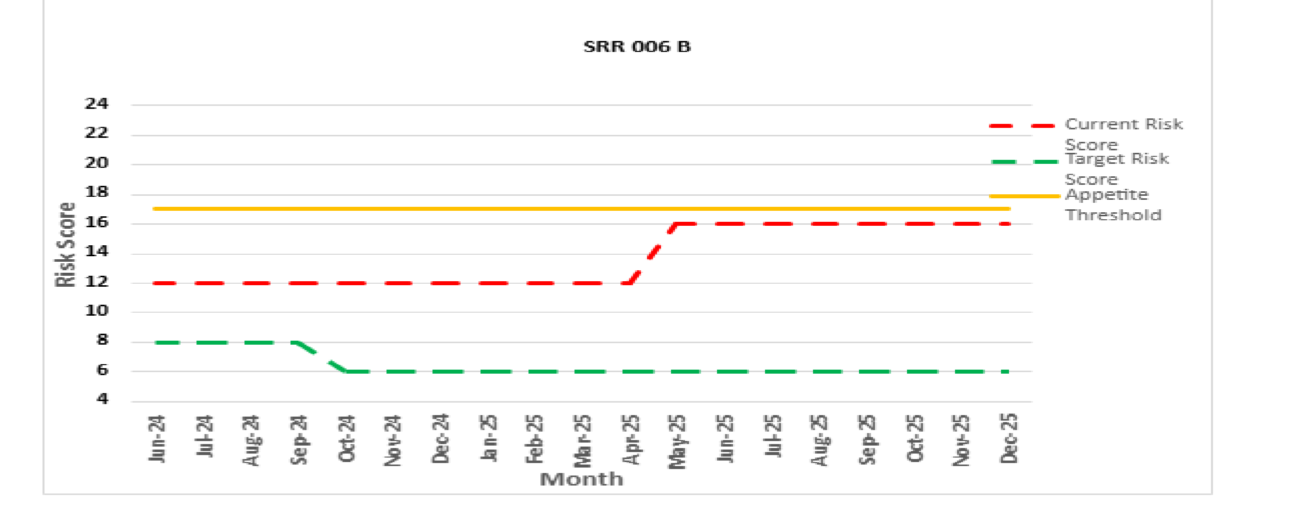
Threat *(As a result of)*	**Due to an adverse impact on service delivery in the implementation of new digital systems.**		
	Patient	**Staff**	**Organisation**
Impact *(Consequences of the threat)*	• Unintended harm or Injury to Patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings.	• Unintended harm or injury to staff	• Data Breaches • Litigation and Financial Penalties. • Reputational damage and loss of public confidence.

Risk Appetite Level – OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold – Score 17 and Below
Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

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 December 2025	**Risk rating**	**= 16 (Extreme)**	***= 6 (Moderate)***
Next Review (Monthly 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)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required. • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. • Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	• Additional governance being put in place with the Digital, Data and Technology 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*			
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board's Risk Framework		• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Welsh Government implementing stronger national governance for national project and programmes
Level 2 Organisational *(Executed by risk management and compliance functions)*			
• Regular Reporting to the Finance & Performance Committee		• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*			
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance	**Internal Audit 2024/25** • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	SERVICE DELIVERY
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY

Strategic Risk **SRR 006 C**	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**	**Publication Status**	**Public**

Threat *(As a result of)*	**Due to failure to develop digital solutions that are sustainable and for the future.**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact *(Consequences of the threat)*	**Patient** • Unintended harm or injury to patients. • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** • Unintended harm or injury to staff.	**Organisation** • Data breaches • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – Score 17 and Below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	**3** (Possible) x	**2** (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	**4** (Major)
Last Reviewed	01 October 2025	**Risk rating**	**= 12** **(High)**	***= 8*** ***(Moderate)***
Next Review (Quarterly based on risk score)	01 January 2025			

SRR 006 C

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Current Risk Score

Target Risk Score

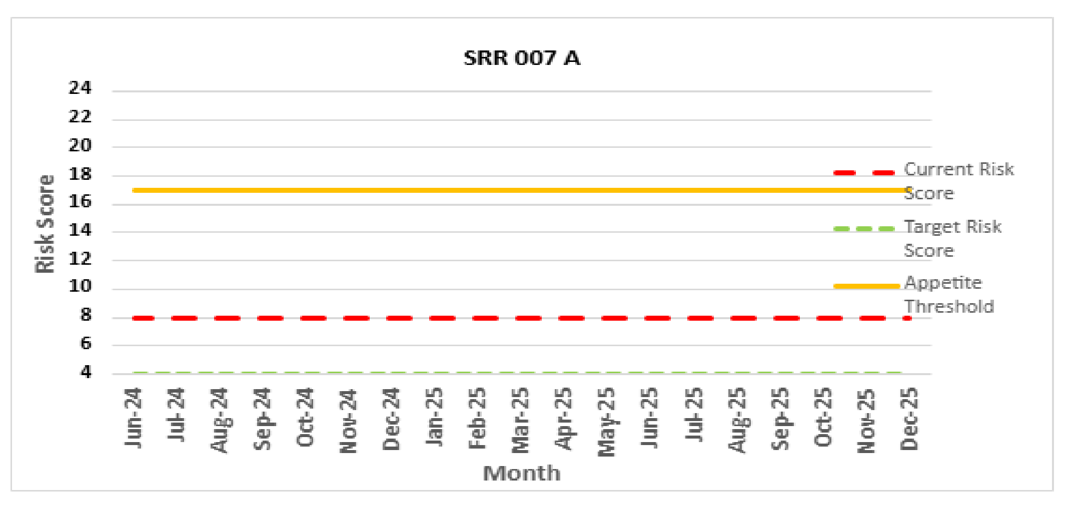
Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
○ New Digital Service Request process in place which provides governance in several key areas: ○ Automation of request process via 'Seren' the ICT Portal ○ Information Governance – ensuring new services have appropriate controls to keep patient information safe. ○ Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. ○ Patient Safety – ensuring services do not introduce any patient safety risks. ○ Records – ensuring new systems comply with the requirements of records management. ○ Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, ○ New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards ○ Annual operational plan completed and aligned with IMTP ○ Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place ○ Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	• Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, • Portfolio optimisation to ensure the resources of the service are aligned to key priorities • New Digital Request quarterly reporting to DDAT 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Quarterly reporting to DDAT Group	• If the NDSR process delivers anticipated improvements • The outcome of the EDRMS audit	• Monitor the performance of the NDSR process • Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular Reporting to the Finance & Performance Committee	• None	• Not Applicable
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2023/24 • LINC Programme– **Outcome Reasonable assurance** • Network Infrastructure (VPN) - **Outcome Reasonable assurance** **Internal Audit 2024/25** • Electronic document and records management solution - planned for Q4	• Recommendations identified through audit work	• Regular Reporting to the Finance & Performance Committee

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				SECTION 4: ENABLERS - REGIONAL PLANS	
Strategic Risk: SRR 007A	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**				**Publication Status**	**Public**
Threat *(As a result of)*	**Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient need resulting in harm	**Staff** N/A	**Organisation** • Ineffective use of combined resource Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence		**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	**Current Level**	**Target Level**		
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x		
Initial Date of Assessment	01 June 2023	**Impact**	**4** (Major)	**2** (Minor)		
Last Reviewed	01 November 2025	**Risk rating**	**= 8** **(Moderate)**	***= 4*** ***(Moderate)***		
Next Review (Six Months based on risk score)	01 May 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)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: • The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. • The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. • In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. • Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.

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

Assurance Rating (*Overall Assessment of controls and assurances*) Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			SECTION 4: ENABLERS – REGIONAL PLANS	
Strategic/ 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** • Unmet patient need resulting in harm • Adverse impacts on delivery of care to patients across acute and non-acute settings	**Staff** N/A	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence • Ineffective use of combined resources • • Delayed decision making	**Risk Appetite Threshold – SCORE 17 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy Planning and Partnerships			
Monitoring Committee / 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 November 2025	Risk rating	= 9 (High)	= 4 *(Low)*
Next Review (Quarterly based on risk score)	01 March 2025			

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. • The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. • Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. • Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. • 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.	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:- • 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. 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.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Service Divisions reporting to the Chief Operational Officer	• Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		

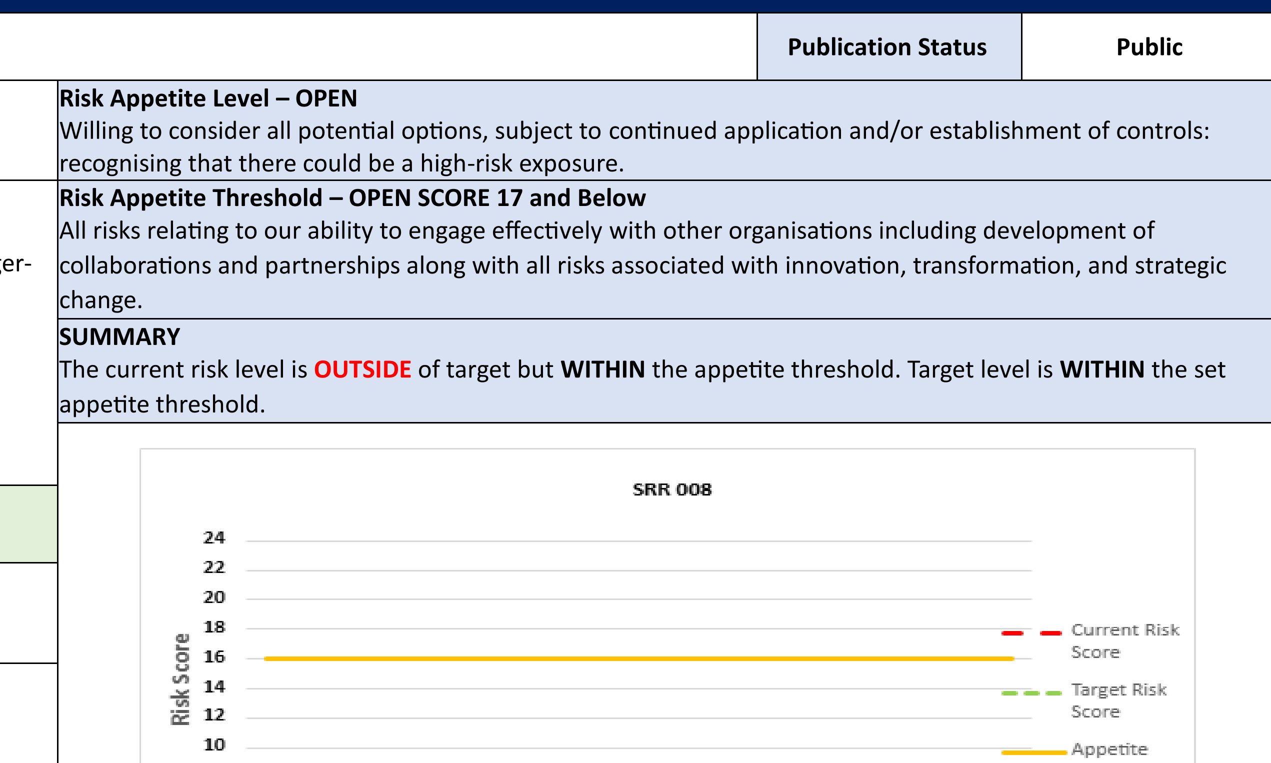
Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**REASONABLE**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	**SECTION 4: ENABLER - QUALITY**				
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**				
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress.	**Staff** Staff dissatisfaction Frustration Increased absence. Loss of confidence.	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence		
Lead Director	Director of Nursing	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety 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				

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – OPEN SCORE 17 and Below
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. • Bereavement survey built with CIVICA – Nov 2024 • CIVICA SMS launched 3rd March 2025 across ED and MIU'S	• Currently there is limited SMS provision to increase the number of surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.	• SMS provision for patient experience feedback 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 *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections • Advocacy reports	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable**

RISK THEME	COMPLIANCE AND SAFETY	
LINK TO IMTP SECTION 4: ENABLER	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 *(As a result of)*	**Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements**

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Unintended physical harm to patients • Psychological trauma	• Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	• Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.

Risk Appetite Level – MINIMAL
Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.

Risk Appetite Threshold – 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 September 2025	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	01 December 2025			

SRR 010

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score; Target Risk Score; Appetite Threshold

Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards	• 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	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S 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	• Thematic Risk Register	• Development of a thematic risk register
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • 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. Health and Safety Executive reviews/inspections.	• Recommendations from the 2024/25 Internal Audit	• Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report

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 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)** *This is common to all Health Bodies across the country.*	**Publication Status**	**Public**

Threat *(As a result of)*	**Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.** *(The effect of a failure to meet this target is on the wider environment.)*	**Risk Appetite Level – OPEN:** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure
Impact *(Consequences of the threat)*	**Organisation** • Failure to meet the target set on Welsh Health bodies for reducing carbon output • Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. • Reputational damage and loss of public confidence. • Opportunity cost of reduced energy costs	**Risk Appetite Threshold – SCORE 17 AND BELOW.** Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small. **SUMMARY** The current risk level is **OUTSIDE** of target level and WITHIN the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

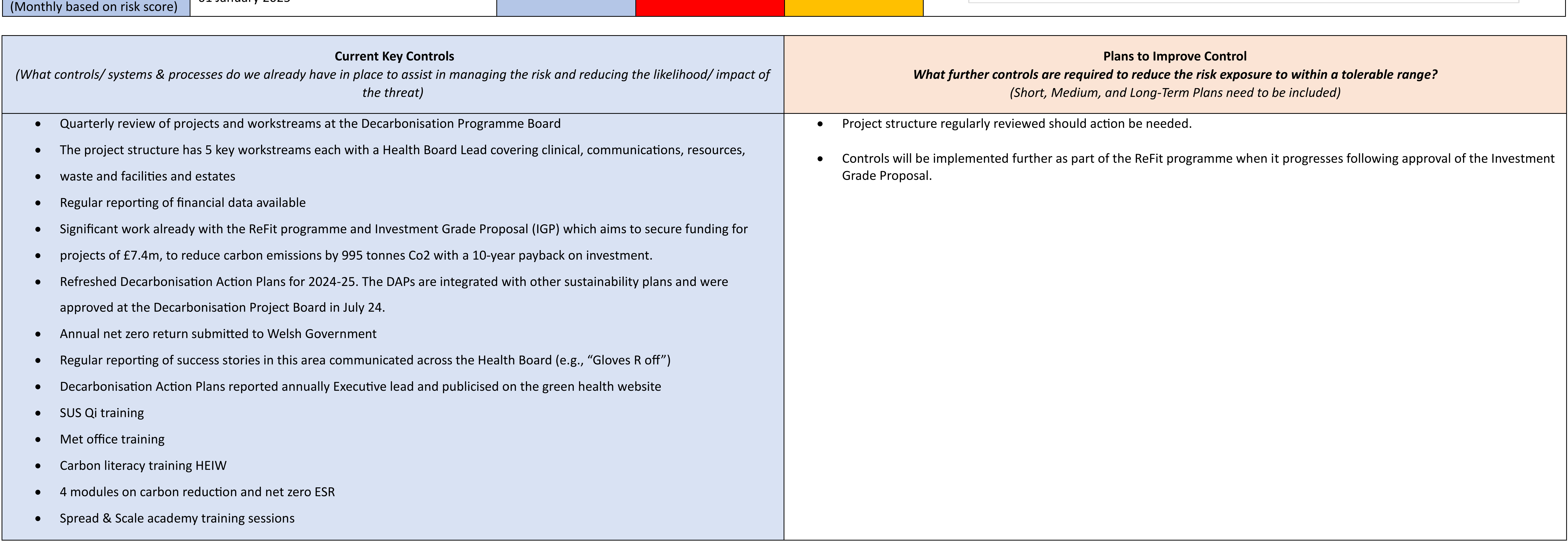
Lead Director	Director of Finance and Procurement	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee / Group	Finance and Performance Committee	**Likelihood**	5 (Almost Certain) x	**4** (Likely) x
Initial Date of Assessment	30 October 2024	**Impact**	***3*** *(Moderate)*	***3*** *(Moderate)*
Last Reviewed	01 December 2025	**Risk rating**	**= 15** **(Extreme)**	***= 12*** ***(Moderate)***
Next Review (Monthly based on risk score)	01 January 2025			

SRR 011

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25, Apr-25, May-25, Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25

Current Risk Score — Target Risk Score — Appetite Threshold



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Quarterly review of projects and workstreams at the Decarbonisation Programme Board • The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, • waste and facilities and estates • Regular reporting of financial data available • Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for • projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. • Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. • Annual net zero return submitted to Welsh Government • Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) • Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website • SUS Qi training • Met office training • Carbon literacy training HEIW • 4 modules on carbon reduction and net zero ESR • Spread & Scale academy training sessions	• Project structure regularly reviewed should action be needed. • Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Actions to Address Gaps *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Regular meetings of the subgroups to discuss position, monitor and new ideas • Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	• Detailed level metrics and measures are limited due to data capture equipment.	• All opportunities for funding will be optimised • Training opportunities will be maximised.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Six monthly updates to the Board • Executive Committee (Clinical Futures Board) updates – Quarterly • Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	• 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 *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Report in July 24. • Received "limited assurance" but not because of controls – the issues were largely around funding limitations. **External Audit Reports 2023 -24**Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	• Funding for a comprehensive ABUHB decarbonisation strategy is not available.	• As above - REFIT invest to Save capital opportunities being progressed.

Assurance Rating *(Overall Assessment of controls and assurances)* Guidance			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**NEGATIVE**

Capital Projects - Service Readiness

Final Internal Audit Brief

Aneurin Bevan University Health Board

Introduction

The Health Board receives an annual capital allocation from the Welsh Government to support discretionary schemes, alongside targeted funding from the All-Wales Capital programme and approved major projects. These investments are crucial in enhancing infrastructure, improving service delivery as well as supporting strategic transformation across the healthcare system.

As part of this audit, 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.

Scope, Risks & Approach

Scope	At a sample of projects, an evaluation will be undertaken on the preparedness of services for operational deployment, to ensure a timely commencement of the new / revised operations. Objectives of the area under review: 1. Assess whether plans are clearly defined/ documented pre-commissioning with clearly defined milestones, dependencies and resourcing requirements. 2. A working group and a lead have been assigned to oversee and co-ordinate between project board, service leads and operational units – sufficient time and staff resource has been assigned to ensure successful delivery. 3. Assurance on compliance with commissioning plans, this may include staffing plans, recruitment timescales, training programmes, familiarisation arrangements, equipment purchase/ transfer etc.
Associated risks	• Services may not be aligned with the operational goals or business case of the capital project. • Poor communication and training. • Requirements may not be met in time, delaying service. • Insufficient staff, budget or equipment can delay readiness.
Limitations to scope	The review will not consider the financial and/or programme performance of the delivery of the construction element of the project prior to user commissioning.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards: Quality Domains: Timely Quality Enablers: Workforce

	Effective Efficient Safe	Leadership Whole Systems approach

Contacts & Timings

Client contacts	Hannah Evans Hannah Capel Leanne Watkins	Director of Strategy, Planning and Partnerships Assistant Director of Strategic Capital Chief Operating Officer
Audit & Assurance contacts	Stephen Chaney Eifion Jones Rhian Gard	Head of Internal Audit Deputy Had of Internal Audit Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	November 2025 December 2025 February 2026
Brief agreement	Leanne Watkins, Chief Operating Officer (07.10.25) Hannah Evans, Director of Strategy, Planning and Partnerships (10.11.25)	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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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.

Directorate Review - CAMHS

Final Internal Audit Brief

Aneurin Bevan University Health Board

Introduction

Children and Adolescent Mental Health Services (CAMHS) deliver specialist mental health care through a range of services including neurodevelopmental assessments, crisis intervention, eating disorder clinics, and family therapy. Referrals are managed through many different avenues, via SPACE-Wellbeing, the Single Point of Access for emotional wellbeing and mental health of young people under 18 across the Gwent area, which includes Newport, Torfaen, Monmouthshire, Blaenau Gwent, and Caerphilly.

The service operates within a complex multi-agency environment, working in partnership with local authorities, education providers, third sector organisations, and primary care. These partnerships are essential to delivering integrated, person-centred care and are supported by legislative frameworks such as the Social Services and Well-being (Wales) Act 2014.

Scope, Risks & Approach

<table>
<tr><td>Scope</td><td>To ensure that appropriate arrangements are in place for the management of risk and performance within the CAMHS directorate.

Objectives of the area under review:
1. Review risk management processes within the directorate to see whether they are embedded and have clear escalation and assurance pathways.
2. Assess whether management have established robust performance metrics and reporting mechanisms within CAMHS to track quality, safety, and service outcomes, including the alignment to divisional dashboards with strategic priorities.
3. Governance arrangements are in place encompassing reporting and the monitoring of compliance with the statutory duties introduced under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</td></tr>
<tr><td>Associated risks</td><td>• Inconsistent risk management processes across service areas which may lead to unclear accountability and delayed mitigation / escalation.
• Incomplete, inaccurate or misaligned performance data could result in poor decision-making.
• Governance arrangements are ineffective, leading to non-compliance with legislative and regulatory requirements.</td></tr>
<tr><td>Approach</td><td>The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues.

Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.

Assurance opinions and action plan risk ratings</td></tr>
<tr><td>Link to Health & Care Quality Standards</td><td>This review may contribute towards assurance over the following Health & Care Quality Standards:
<table><tr><th>Quality Domains</th><th>Quality Enablers</th></tr><tr><td>Safe Care</td><td>Governance</td></tr></table></td></tr>
</table>

	Effective Care	Leadership
	Dignified Care	Workforce
	Timely Care	Information
	Individual Care	Engagement

Contacts & Timings

Client contacts	Leanne Watkins Sara Garland Kavitha Pasunuru Helen Morgan Deb Jackson	Chief Operating Officer General Manager Divisional Director Divisional Nurse Divisional Nurse
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	November 2025 T.B.C Tuesday, 16th December 2025
Brief agreement	Leanne Watkins, Chief Operating Officer 17.10.25	

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Occupational Health

Final Internal Audit Brief

Aneurin Bevan University Health Board

Introduction

The review of Occupational Health Services will be completed in line with the 2025/26 Internal Audit Plan for the Aneurin Bevan University Health Board (the 'Health Board').

The Occupational Health Service is a vital component in supporting staff wellbeing, managing sickness absence, and ensuring the safe and effective deployment of the workforce across the organisation. It plays a strategic role in maintaining employee health and capability, particularly in light of increasing demand and evolving workforce needs. The service provides a broad range of support, including health surveillance, immunisation, and wellbeing initiatives.

The Health Board's People Plan (2025–2030) identifies the sustainability of the Occupational Health Service as a key priority. The plan emphasises the importance of enhancing service accessibility, promoting prevention, and enabling early intervention. Given the significant financial and operational impact of sickness absence the Occupational Health Service is central to the Health Board's efforts to improve workforce resilience and overall organisational performance.

Scope, Risks & Approach

Scope	To provide assurance over the arrangements and controls in place for the management of the occupational health service. Objectives of the area under review: 1. The Health Board has approved policies and procedures in place for the Occupational Health Service and these are applied and implemented in practice; 2. Appropriate resources and processes are in place to ensure staff have timely access to the Occupational Health Service for referrals (both self and line manager); 3. Referrals are appropriately recorded, assessments are undertaken within required timescales, and managers are advised of the potential next steps; and 4. Appropriate KPIs are in place for the Occupational Health Service which are effectively monitored, reported and used to inform service improvement. Audit fieldwork will recognise the impact of external factors such as the national shortage of qualified Occupational Health professionals and the significant fluctuations in demand.
Associated risks	The main risk considered in this review is that the inefficient or ineffective provision of occupational health services to staff could negatively impact the Health Board's ability to provide safe and effective services to patients.
Limitations to scope	This audit focuses on the operational management of the Occupational Health Service and will not assess clinical effectiveness or individual outcomes. It is acknowledged that Occupational Health provides professional advice, and it is the responsibility of line managers to consider and act upon this advice in a reasonable and proportionate manner.

Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:

Quality Domains	Quality Enablers
Quality Domains – Safe, Timely, Effective, Efficient	Quality Enablers – Workforce, Whole Systems Approach

Contacts & Timings

Client contacts	Sarah Simmonds	Director of Workforce & Organisational Development
	Peter Brown	Assistant Director of Workforce & OD
	Ruth Badham	Head of Organisational Development
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Jonathan Jones	Audit Manager
Indicative timings	Fieldwork	November / December 2025
	Debrief meeting	December 2025
	Audit Committee	February 2026
Brief agreement	Director of Workforce & Organisational Development 7th November 2025	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	16 December 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 November and December 2025, the below items have been deferred to an additional committee meeting Scheduled for January 2026 to enable more comprehensive and meaningful reporting.

- To Receive the Local Corporate Clinical Audit Report
- To Receive a Six-Month Update on the National Clinical Audit Plan
- To Receive an Update on Job Planning Activity.
- To Receive a report on the progress against discharge Planning Audit Recommendations

Argymhelliad / Recommendation

The Committee is asked to:

- **Note** the status of Committee business, including completed business, amendments/changes, and forthcoming business.

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

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

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

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

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ANNUAL PROGRAMME OF BUSINESS 2025/26

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2024 and the Structured Assessment 2024 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders: The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.
The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings. The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by: ▪ independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales; ▪ advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further; ▪ Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and ▪ Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
Preliminary Matters									
Attendance and Apologies	**SI**	Chair	√	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2025/26	**An**	Chair & DofCG							√
Review of Committee Programme of Business	**SI**	Chair	√	√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	**An**	Chair & DofCG	√						
Committee Annual Report 204/25	**An**	Chair & DofCG	√						
Corporate Governance, Risk & Assurance									
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√		
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG	√						√
Compliance with Ministerial Directions	**BI**	DofCG	√						√
Compliance with Welsh Health Circulars (WHCs)	**BI**	DofCG	√**D**	√**D**	√**D**	√			√
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	**An**	DofCG							√
Compliance with regulatory requirements	**An**	DofCG							√
Audit Recommendations Tracking Report	**Qu**	DofCG		√**Q4**		√Q1	**D**√Q2	√Q2	√Q3
Annual Review of Risk Management Framework	**An**	DofCG	√						
Report on Risk Management Maturity	**BI**	DofCG					√		√

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
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Committee Risk & Assurance Report	**SI**	DofCG	√		√	√	√	√	
Financial Governance and Control									
Report of the use of Single Tender Action	**SI**	DofF&P	√			√	√	√	
Report of Losses and Special Payments *(May report will be included in the Accounts)*	**BI**	DofF&P	√	√			√		
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P	√		√	√	√	√	
Annual Report and Accounts									
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofCG							√
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√				
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√				
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√				
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√					
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√				
Final Annual Accounts Memorandum	**An**	AW					√		
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√				
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√				
Counter-Fraud									
Review of the Counter Fraud, Bribery and Corruption Policy *(Feb 2026)*	**3-Yearly**	DofF&P	-	-	-	-	-	-	√
Receive the Counter Fraud Annual Report	**An**	HofCF		√					

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Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th 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
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	18th Sept 2025	21st Oct 2025	16th Dec 2025	12th Feb 2026
Receive the 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

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√ **D**	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee