Audit, Risk and Assurance Committee - Additional Meeting

Thu 22 January 2026, 11:30 - 12:30

Agenda

1. PRELIMINARY MATTERS

1.0 ARAC 20260122 Agenda - Final.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Welcome and Introductions

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 16th December 2025

Attached *Chair*

ARAC 20260122 1.4 20251216 Minutes - Final.pdf (10 pages)

1.5. Committee Action Log and Matters Arising

Attached *Chair*

ARAC 20250122 1.5 ARAC 20251216 Action Log - Final.pdf (5 pages)

2. Items for APPROVAL/RATIFICATION/DECISION

2.1. To Approve the Local Corporate Clinical Audit Plan

Attached *Medical Director*

ARAC 20260122 2.1 SBAR Final ARAC Corproate Local Audit Plan 2026.27.pdf (6 pages)

ARAC 20260122 2.1a Corporate Local Audit Plan Final ARA Jan 2026.pdf (14 pages)

3. ITEMS FOR DISCUSSION

3.1. To Receive a Six-Month Update on the National Clinical Audit Plan

Attached *Medical Director*

ARAC 20260122 3.1 SBAR FINAL ARAC Six-Month Update on the National Clinical Audit Plan Jan 2026.pdf (6 pages)

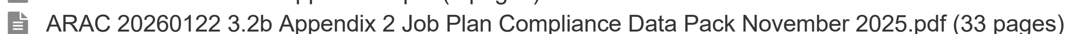
ARAC 20260122 3.1a FINAL ARA 6 month review - Clinical audit Activity 2025.2026.pdf (18 pages)

3.2. To Receive an Update on Job Planning Activity

Attached *Medical Director*

ARAC 20260122 3.2 ARAC 2026 01 - Job Planning Assurance Note FINAL.pdf (6 pages)

ARAC 20260122 3.2a Appendix 1.pdf (8 pages)


ARAC 20260122 3.2b Appendix 2 Job Plan Compliance Data Pack November 2025.pdf (33 pages)

- ARAC 20260122 3.2c Appendix 3.pdf (1 pages)
- ARAC 20260122 3.2d Appendix 4.pdf (1 pages)
- ARAC 20260122 3.2d1 Appendix 4.pdf (1 pages)

3.3. To Receive a report on the progress against discharge Planning Audit Recommendations

Attached *Director of Nursing*

- ARAC 20260122 3.3 Discharge Planning Assurrance Report.pdf (6 pages)
- ARAC 20260122 3.3a Appendix A_Discharge_Data_October_2025.pdf (21 pages)
- ARAC 20260122 3.3b Appendix B_Discharge Planning Audit Recommendation Analysis.pdf (7 pages)
- ARAC 20260122 3.3c Appendix C_Discharge Planning Revised Extension Requests.pdf (1 pages)

4. ITEMS FOR INFORMATION

4.1. Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

- ARAC 20260122 4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- ARAC 20260122 4.1a 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: Thursday 12th February 2026

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

AUDIT, RISK & ASSURANCE COMMITTEE AGENDA

Date and Time	**Thursday 22nd January 2026 at 11:30**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 16th December 2025	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve the Local Corporate Clinical Audit Plan	Attached	Medical Director
3	**ITEMS FOR DISCUSSION**		
3.1	To Receive a Six-Month Update on the National Clinical Audit Plan	Attached	Medical Director
3.2	To Receive an Update on Job Planning Performance	Attached	
3.3	To Receive an Assurance Report on Systems and Processes to Improve Discharge Performance, linked to Audit Recommendations	Attached	Director of Nursing
4	**ITEMS FOR INFORMATION**		

4.1	Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: Thursday 12th February 2026		

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

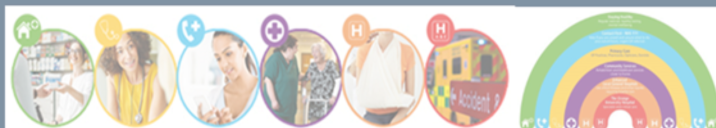
DATE OF MEETING	Tuesday 16 December 2025
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member Dafydd Vaughan - Independent Member Neil Patrick - Independent Member Helen Sweetland – Independent Member
IN ATTENDANCE	Rani Dash - Director of Corporate Governance Robert Holcombe – Executive Director of Finance and Procurement Robert Jones - Assistant Finance Director Peter Carr – Executive Director of Allied Health Professions (AHPs) & Health Science (Item 1.5.1) Lucy Windsor – Head of Risk and Assurance, Corporate Services (Item 2.1) Stephen Chaney - Senior Auditor, Internal Audit, NWSSP Eifion Jones – Deputy Head of Internal Audit, NWSSP Audit and Assurance Services Martyn Lewis – Senior Auditor, NWSSP Audit and Assurance Services (Item 3.2) Murray Gard - Senior Auditor, Internal Audit, NWSSP (Item 3.2) Gareth Lavington – Head of Counter Fraud Sara Utley - Performance Audit Lead, Audit Wales Amanda Legge - All Wales Post Payment Verification Manager *(Item 3.8)* Sara Jeremiah - Post Payment Verification Location Manager *(Item 3.8)* Danielle Jackson - Secretariat
OBSERVING	None to note
APOLOGIES	Julie Rees - Audit Wales Finance Audit Lead, Audit Wales

Minute Reference	Preliminary Matters
ARAC 1216/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
ARAC 1216/02	**Apologies for Absence** Apologies were noted.
ARAC 1216/03	**Declarations of Interest** There were no declarations of interest raised to record.
ARAC 1216/04	**Minutes of the previous meeting** The minutes of the meeting held on the 21 October 2025 were agreed as a true and accurate record.
ARAC 1216/05	**Committee Action Log** The Committee reviewed the Action Log and noted actions completed, in progress, or not yet due. It was reported that updates on Discharge Planning, Job Planning, and Clinical Audit were deferred due to Executive availability and would be considered at an extraordinary meeting on 12 January 2026. The Committee **AGREED** to remove completed actions and **NOTED** the deferred items.
ARAC 1216/06	**Update on the the Health and Safety governance structure and policy implementation** Peter Carr (PC), Executive Director of Allied Health Professions (AHPs) & Health Science confirmed that the Health and Safety Policy had been completed and ratified, with work ongoing to update remaining policies. It was reported that governance arrangements had strengthened, supported by revised Terms of Reference and operational sub-groups. Workplace inspections were reported as on track, with improved divisional engagement and escalation of identified risks. RIDDOR compliance had increased significantly following targeted actions, and additional oversight mechanisms had been introduced. While further improvement was required, robust monitoring and reporting arrangements were confirmed to be in place. The Committee **NOTED** progress in implementing the Health and Safety Policy and strengthening governance arrangements.
	ITEMS FOR APPROVAL / RATIFICATION / DECISION

DRAFT

ARAC 1216/07	**Reviewed and Updated Financial Control Procedures.** Robert Jones (RJ), Assistant Finance Director, presented the report on Financial Control Procedures (FCPs). It was confirmed that there were no new Financial Control Procedures requiring approval during the reporting period and that all existing procedures remained current and compliant. The forward plan indicated that scheduled reviews remained on track for the February meeting. Two technical accounting updates issued by Welsh Government were highlighted: adjustments relating to AME impairment and DEL depreciation impact, and guidance on strategic cash requests, which the Health Board had submitted by the required deadline. Assurance was provided that the Finance team had reviewed the updates and was satisfied that compliance requirements could be met. It was also reported that no payments exceeding £100,000 had been made during the period and that work was underway to update procurement and grant funding policies for presentation at the next meeting. The Committee **NOTED** the report.
ARAC 1216/08	**Quarter 2 Audit Recommendation Tracking report and Approve closing position.** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Audit Recommendation Tracking Report for Quarter 2 (July–September). It was reported that 74 audit recommendations had been completed during the quarter and that revised deadlines were proposed for 19 recommendations. Following approval, 88 live recommendations would remain within the agreed extension threshold, with 11 recommendations remaining outside the threshold. These primarily related to long-standing digital audits. New graphical analysis from the Internal Audit dashboard was presented, illustrating trends and patterns in recommendation closure. It was confirmed that future reports would include expanded trend analysis to strengthen assurance. Members raised concerns regarding overdue digital actions and queried the realism of some revised deadlines. A request was made for a deeper review of digital audit recommendations, and it was agreed that a further update would be brought to the next meeting. **ACTION: Head of Corporate Risk and Assurance**



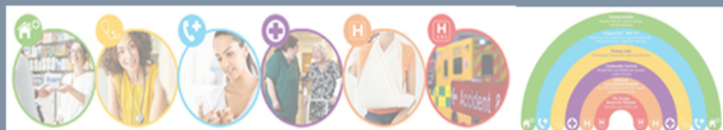
DRAFT

	It was also agreed that revised deadlines relating to discharge planning and job planning should be deferred until the extraordinary meeting in January, where these areas would be considered in detail. The Committee **NOTED** the completion of 74 recommendations and **APPROVED** revised deadlines for 19 recommendations, excluding those deferred to January.
ARAC 1216/09	**Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report. It was reported that planning for the 2026/27 audit cycle had commenced, with a draft plan expected shortly. Delivery of the 2025/26 audit plan remained on track, with several audits ongoing and several nearing completion. Several reports were expected to be finalised and presented to the Committee at its February meeting. The Committee **NOTED** the Internal Audit Progress Report.
ARAC 1216/10	**Internal Audit Review Reports** Stephen Chaney (SC), Head of Internal Audit, presented several internal audit reports, detailed below. **Standing Orders Compliance audit** concluded with substantial assurance, confirming that appropriate arrangements were in place. A minor issue relating to legacy advisory groups was noted and was being addressed. **Business Continuity Planning audit** provided reasonable assurance. While plans were in place and aligned with statutory requirements, none of the sampled services had tested their plans. Improvements were recommended in relation to action cards and awareness training. The Committee expressed concern that the lack of testing might be more widespread and agreed that further assurance should be sought through the Partnerships, Population Health and Planning Committee. **Action: Committee Secretariat** **Public Health arrangements,** an advisory review, highlighted positive achievements, including leadership in addressing health inequalities, while identifying opportunities to strengthen governance, planning, and risk management.

DRAFT

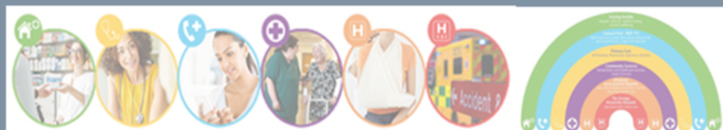
	Welsh Intensive Care Information System lessons learned audit provided substantial assurance, confirming that risks had been managed appropriately following the pausing of the programme. One improvement was recommended to embed a structured approach to applying lessons learned across all programmes. **Cyber Security audit** concluded with reasonable assurance. Strengths included the establishment of a dedicated cyber team and an improvement plan. Key issues were identified, and the Committee was informed that plans were in place to remediate the issues. Dafydd Vaughn (DV), Independent Member, requested that the report be presented the Partnerships, Population Health and Planning Committee (PPHPC). **ACTION: Committee Secretariat** **Royal Gwent Hospital Central Decontamination Unit audit** provided reasonable assurance, recognising strong governance and financial controls, while highlighting the need for formal sign-off of derogations and improved contract strategy and advisor performance monitoring for future projects. The Committee **NOTED** all reports and **AGREED** the associated management actions.
ARAC 1216/11	**To Receive External Audit Progress Report 2025-26** Sara Utley (SU), Audit Wales, presented the External Audit Progress Report for 2025/26. It was reported that external audit work was ongoing across several areas, including Digital GP Managed Contracts, an Estates Deep Dive which had recently commenced, and a Cancer Services review which was currently in the scoping phase. The Committee was informed that the external audit programme was progressing in line with plan and that Audit Wales continued to engage regularly with the Health Board to discuss emerging risks, priorities, and areas of focus. The Committee **NOTED** the External Audit Progress Report.

DRAFT



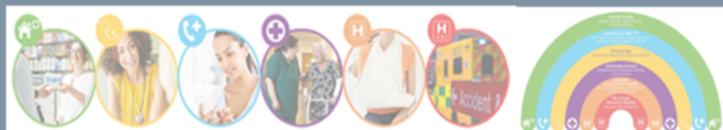
ARAC 1216/12	**To Receive the 2025 Structured Assessment** Sara Utley (SU), Audit Wales, presented the 2025 Structured Assessment report. It was confirmed that the assessment had considered the Health Board's governance arrangements, risk management, performance oversight, financial management, and progress in implementing previous audit recommendations. The overall position was reported as positive. The Health Board was described as continuing to demonstrate effective governance and strong financial oversight. Improvements were noted in risk management arrangements, with the corporate risk register nearing completion, and the recent approval of a long-term strategy was highlighted as providing clear organisational direction. The Committee was advised that the Health Board had maintained a good track record in delivering savings, although the ongoing deficit position continued to present a challenge. The report included six recommendations, all of which had been accepted by management. These related to: • Improving reporting on declarations of interest and compliance • Increasing the use of staff stories at Board level • Formalising reporting of actions arising from patient safety leadership walkarounds • Strengthening oversight of local clinical audit • Enhancing Committee reporting arrangements • Improving the tracking of recommendations from external bodies, including Healthcare Inspectorate Wales It was confirmed that a management response had been agreed and that the Structured Assessment would be presented to the Board in January 2026 alongside the Annual Audit Summary. The Committee **NOTED** the 2025 Structured Assessment report.

DRAFT



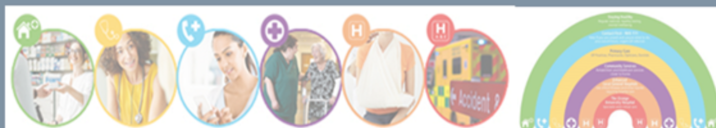
ARAC 1216/13	**Audit Wales 2026-27 Audit Fees Consultation** Sara Utley (SU), Audit Wales, presented the Audit Wales 2026–27 Audit Fees Consultation outcome. The Committee was informed that following the consultation the proposed increase for 2026–27 had reduced to 5.3%, which was lower than initially anticipated. It was reported that responses received during the consultation process had been considered and summarised within the report. The Committee was advised that the proposed fee would be referred to the Health Board's Finance Committee for further consideration and confirmation. The Committee was also informed that Audit Wales continued to explore opportunities for efficiency and innovation, including the potential use of artificial intelligence tools to support audit processes. A query was raised regarding collaboration with other public sector audit bodies on AI developments, and it was agreed that an update would be provided outside the meeting. The Committee **NOTED** the Audit Wales 2026–27 Audit Fees Consultation.
ARAC 1216/14	**Report of the use of Single Tender Action** Robert Jones (RJ), Assistant Finance Director, presented the report on the use of Single Tender Actions (STAs) during the reporting period. It was confirmed that one STA request had been submitted and approved. The request related to goods and services, including maintenance, associated with the upgrade of CCTV, door access, and control systems. The annual value of the contract was reported as £89,589.90 excluding VAT. The Committee was advised that the report included a new graphical representation showing the volume of STAs from November 2024 to the current period. This had been introduced in response to an internal audit recommendation to improve transparency and oversight. It was noted that the overall volume of STAs remained low, with a slight increase typically observed toward the end of the financial year. The Committee **NOTED** the report.

DRAFT



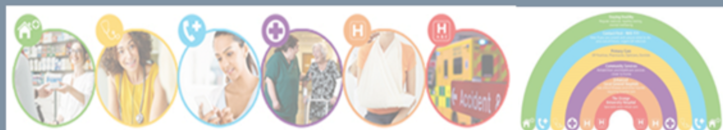
ARAC 1216/15	**To Receive a Quarterly Report on Counter Fraud Activity** Gareth Lavington (GL), Head of Counter Fraud, presented the quarterly report on counter fraud activity covering the period from 01 September to 14 November 2025. It was reported that all targets set by the Counter Fraud Authority had been met during the period and that the Health Board continued to strengthen its fraud risk assessment arrangements. Risk assessments had been rolled out to relevant stakeholders, and the approved process was now embedded across the organisation. The report included a summary of completed and ongoing risk assessments, alongside benchmarking data from the Counter Fraud Service Wales national report. The Committee was advised that the Health Board compared favourably with other health boards in relation to performance and compliance. The Committee noted that a significant proportion of referrals related to staff working elsewhere while on sick leave. It was explained that such cases rarely met the evidential threshold for criminal fraud and were more appropriately managed through workforce and employment policies. A breakdown of these cases and outcomes would be included in future reports. It was also confirmed that mandatory counter fraud training compliance remained high compared to other health boards, reflecting the decision to make the training mandatory. The Committee **NOTED** the Counter Fraud Activity report.
ARAC 1216/16	**Mid-Year update in respect of Post-Payment Verification Activity** Amanda Legge (AL), Post-Payment Verification Manager, presented the mid-year update on Post-Payment Verification (PPV) activity. It was confirmed that work for the current financial year had commenced in July, following completion of outstanding visits from the previous year. The Committee was advised that the team had made a strong start and had enhanced the reporting format to provide greater detail, in response to feedback from audit committees across Wales. Key developments were highlighted, including:

DRAFT



	• The introduction of duplicate claim checks, which had identified high volumes in some practices and prompted discussions on system validation and potential pre-payment checks • Additional training and support provided to practices to reduce errors and improve compliance • Inclusion of new recovery data for dispensing practices, to be reported every six months • Expansion of PPV activity to cover additional services, including COVID-19, RSV, and flu vaccinations claimed via the Welsh Vaccination System, as well as optometry services for glaucoma and retinal reviews and independent prescribing urgent services It was noted that planned visits across Wales remained behind schedule due to the impact of previous years; however, recovery activity was ongoing. The Committee was advised that collaboration continued with counter fraud colleagues to share learning and address any concerns arising from PPV findings. The Committee **NOTED** the mid-year update on Post-Payment Verification activity.
ARAC 1216/17	**Committee Risk & Assurance Report** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the Committee Risk & Assurance Report. It was reported that the report continued to reflect the current strategic risk position and provided assurance regarding the governance arrangements in place. The Committee was advised that, following recent announcements, a review of strategic risk assessments would be undertaken after the Christmas period. This review would ensure that risk controls and mitigating actions remained appropriate and effective and would involve engagement with Executive leads to validate risk scoring and confirm that controls were operating as intended. The Committee **NOTED** the Committee Risk & Assurance Report and confirmed that no changes had been made since the previous submission.
4	**ITEMS FOR INFORMATION**

DRAFT



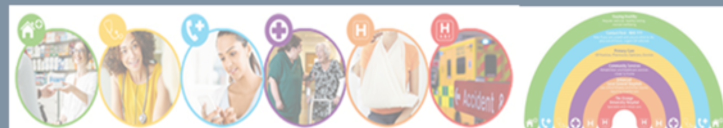
ARAC 1216/18	**Internal Audit Briefs** The Committee received, for information, internal audit briefs relating to audits due to commence. These covered the following areas: • **Capital Projects**: **Service Readiness** – assessing readiness for service commencement and the adequacy of governance arrangements for major capital projects. • **CAMHS Directorate Review -** reviewing governance, risk management, and operational controls within the Child and Adolescent Mental Health Services Directorate. • **Occupational Health** – examining compliance, governance, and the effectiveness of occupational health arrangements across the Health Board**.** The Committee **NOTED** the internal audit briefs.
ARAC 1216/19	**Committee Programme of Business 2025/26** The Committee **NOTED** the Programme of Business for 2025/26 for information.
	Other Matters
ARAC 1216/20	**Items to be Brought to the Attention of the Board and Other Committees** • **Business Continuity Plan Audit Report** - to be presented to the Partnerships, Population Health and Planning Committee (PPHPC) to consider assurance on testing of business continuity plans across the organisation. • **Cyber Security Audit Report** - to be presented the Partnerships, Population Health and Planning Committee (PPHPC) to consider the testing of the Cyber Incident Response Plan, as highlighted in the audit findings. • **Audit Wales 2026-27 Audit Fees Consultation –** to be presented at the Finance and Performance Committee.
ARAC 1216/21	**Any Other Urgent Business** • Nothing reported.
ARAC 1216/22	**Date of the next meeting:** • **Monday 22nd January 2026** 11:30-12:30 (Extraordinary) • **Thursday 12th February** 09:30 – 12:00

DRAFT

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	**Completed** Included within the January 2026 Extraordinary Committee Meeting
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	**Completed** Included within the January 2026 Extraordinary Committee Meeting
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

DRAFT

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		Circulate a concise note clarifying Committee roles	Director of Corporate Governance	16 December 2025	**Completed** Email circulated to relevant members.
		Review Terms of Reference alignment to ensure outputs from reports are routed through the appropriate Committees		May 2026 Included as part of the annual review of ToRs	**Not Due**
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**
December 2025	**ARAC 1216/08** To Receive the Audit Recommendation	Conduct a deep dive into all live digital related audit recommendations to	Head of Corporate Risk and Assurance	February 2026	**Not Due**

DRAFT

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Tracking report and Approve closing position.	ensure timelines are realistic.			
December 2025	**ARAC 1216/10** Internal Audit Reports	Partnerships, Population Health and Planning Committee (PPHPC) should receive the Standing Orders Compliance audit report and seek further assurance on Business Continuity Plan testing across the organisation.	Committee Secretariat	January 2026	**Completed.** **Transferred to another Committee**
December 2025	**ARAC 1216/10** Internal Audit Reports	Partnerships, Population Health and Planning Committee (PPHPC) to receive the Cyber Security Internal Audit Report for information	Secretariat	January 2026	**Completed**

DRAFT

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION LOG

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

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

DRAFT

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 January 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Local Corporate Clinical Audit Plan 2026-27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

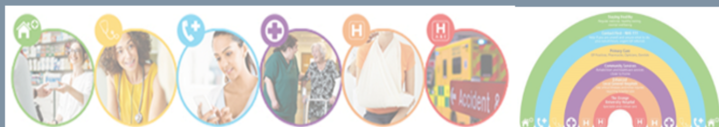
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe, effective, and high-quality care to the population of Gwent. Clinical Audit is a critical mechanism for providing assurance that services are meeting guideline-defined standards of care. Where audits identify opportunities for improvement, these are translated into SMART action plans, reviewed by divisional and directorate leadership teams, and formally signed off by the Clinical Standards and Effectiveness Group (CSEG).

Historically, the Health Board has undertaken a range of Corporate Local Audits each year. However, these audits have not been part of a formal Annual Audit Plan. Instead, they have been coordinated by the Medical Director's Audit Team and presented to the relevant governance group to inform improvement planning.

To strengthen assurance and governance, the Health Board uses AMaT (Audit Management and Tracking) to monitor recommendations from corporate audits,



record levels of service assurance, assess risk, and store evidence of completed SMART action plans.

For 2026–2027, the Corporate Audit Team is realigning and formalising the process for undertaking corporate audits. The introduction of a Corporate Local Audit Plan for the year will:

- Provide robust, corporate-level assurance on organisational priorities.
- Drive continuous quality improvement across services.
- Ensure compliance with national and local standards.
- Align with the Health Board's strategic priorities and respond to both internal and external audit requirements.

This structured approach will embed audit as a cornerstone of governance, offering clear visibility of progress and assurance to the Board, regulators, and the public.

Cefndir / Background

Between 2023–2025, corporate audits have focused on high-risk areas including DNACPR, consent, NG tube placement, case note quality, VTE risk assessment, heparin chart use, safe storage of medicines, and mortality reviews. The current corporate audit programme incorporates audits mandated by external agencies, those required for the Annual Quality Report, and audits addressing key organisational risks.

For 2026–2027, a formal Corporate Local Audit Plan will be developed by the Medical Director's Quality & Patient Safety Team**,** working collaboratively with directorates and divisions. This plan will align with the Clinical Audit Strategy 2022–2025 and the Health Board's Quality Strategy, ensuring a strong focus on evidence-based care, risk management, and continuous improvement.

Key features of the plan include:

- Executive Leadership delegated to the Medical Director, providing clear accountability.
- Assurance embedded within the Quality Management Framework, ensuring audits are structured around six pillars of quality:
    - Patient and staff experience, complaints, concerns and compliments
    - Incident reporting
    - Clinical effectiveness
    - Health, safety, and security
    - Infection prevention and control
    - Safeguarding

Escalation and assurance processes will be robust: audit results requiring further scrutiny will be escalated through the appropriate governance group, reported to

the Quality Management Group (QMG), and onward to the Patient Quality and Safety Outcomes Committee (PQSOC). This ensures corporate audit performance is monitored, improvement plans are developed, and progress is tracked.

All corporate local audits will be recorded and managed through AMaT (Audit Management and Tracking), which supports:

- Building audit proformas
- Capturing data and producing results
- Developing and monitoring SMART action plans within a single platform

Clinical audit remains a cornerstone of the Health Board's commitment to delivering the Duty of Quality, as mapped to the Health and Care Quality Standards**.** Establishing a formal Corporate Local Audit Plan will strengthen governance, support sustainable improvement, and contribute to a resilient health and care system.

Asesiad / Assessment

The introduction of a Corporate Local Audit Plan for 2026–2027 will establish a formal, standardised process for prioritising and delivering audits that provide clear organisational assurance. Key elements include:

- **Structured Audit Programme**

Approximately 10 corporate audits per year, selected based on risk, strategic alignment, and potential impact. Topics will be drawn from the corporate risk register, serious incidents, investigations, and areas for improvement.

- **Governance and Accountability**

All audits will be recorded and monitored through AMaT. Robust escalation pathways will ensure that any significant findings are reported to the Quality Management Group (QMG) and the Patient Quality and Safety Outcomes Committee (PQSOC) for scrutiny and assurance. This process also provides a clear reporting line to the Audit, Risk and Assurance Committee (ARAC).

- **Alignment with Strategic Priorities**

The plan supports delivery of the Clinical Audit Strategy and the Health Board's Quality Strategy, embedding audit within the six pillars of quality.

- **Patient-Centred and Evidence-Based**

Audits will incorporate patient involvement, professional development, and compliance with regulatory standards, ensuring findings drive measurable improvements in care.

- **Collaborative Approach**

Directorates and divisions will submit audit requests linked to clinical priorities, e.g. incidents, complaints, or risks. The Medical Director's Audit Team will provide methodological support, benchmarking against national standards, and develop SMART improvement plans in collaboration with clinical leads.

- **Continuous Monitoring and Escalation**

AMaT will enable real-time tracking of progress, deadlines, and completion of action plans. Governance structures will ensure timely escalation of issues relating to participation, improvement, or risk identification to the Executive Board.

- **Learning and Future Planning**

Results will be triangulated across audits to inform future planning and shared widely to embed learning. The next audit activity report will review how feedback loops can strengthen improvement at clinical level.

Learning from audits will be actively shared across the Health Board to promote improvement and organisational learning. Key mechanisms include:

- Learning and Improvement Forum – a platform for Health Board-wide discussion of audit findings and best practice.
- Audit Bulletin – a regular publication summarising key outcomes and improvement actions.
- Learning Repository – concise audit summaries uploaded to the central repository, accessible via the Health Board intranet (SharePoint), ensuring staff can easily reference and apply learning.

This approach ensures transparency, supports continuous improvement, and embeds audit learning into everyday practice.

By formalising processes and strengthening governance, the Corporate Local Audit Plan will deliver robust assurance, support compliance, and drive continuous quality improvement across the Health Board. To maintain relevance and responsiveness, a Corporate Local Audit Activity Plan will be reviewed and updated annually, ensuring alignment with emerging risks, strategic priorities, and regulatory requirements.

This plan is designed within current resource constraints and will remain flexible to adapt to emerging risks, incidents, and external requirements.

Further details on previous Corporate Local Audits and the execution approach for the Corporate Local Audit Plan are provided in the attached appendices. The proposed Audit Registration Form is also included as an appendix for reference.
Argymhelliad / Recommendation Approve the proposal for the Corporate Local Audit Plan 2026–2027 as the formal framework for delivering evidence-based, risk-prioritised, and strategically aligned clinical audits. This plan will provide clear organisational assurance, support compliance with national standards, and drive continuous improvement across the Health Board.

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):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise

	areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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.

Corporate Local Audit Plan 2026 - 2027

Driving Quality Improvement Through Evidence-Based Audits

Medical Director's Quality & Patient Safety Team

Leeanne Lewis, ***Assistant Director for Quality and Patient Safety***

Anita Goff, ***Lead Nurse H&C Stds Pt. Quality & Safety***

Alla Rybak, ***Coordinator Quality and Patient Safety***

Introduction

The Corporate Local Audit Plan aligns with the Health Board's strategic priorities, incorporating audits requested or mandated by external agencies, and those scheduled for reporting within the Health Board's Annual Quality Report.

The Corporate Local Audit Plan sets out a prioritised programme of clinical audits designed to support the delivery of evidence-based care in alignment with national, local and professional policies and recognised standards of care.

The Corporate Local Audit Plan will define key expectations and timelines for each audit, developed in collaboration with relevant stakeholders and underpinned by core standards and evidence-based practice e.g. NICE Quality Standards.

All clinical audits and service evaluations are delivered by the relevant directorates and divisions in accordance with the Health Board's Clinical Audit Policy. The corporate audit team provides leadership for corporate audits and offers methodological support and guidance to directorates and divisions, enabling them to undertake their own audit activities effectively and independently.

When selecting an audit topic, it is essential to consider the potential benefits for clinical services and patient outcomes, alongside the resources and time available. Audits should be directly linked to the quality of patient care and include a clearly defined quality improvement objective. The plan also provides assurance to ABUHB by addressing key organisational risks and gaps through a structured and coordinated approach.

Aligning Clinical Audit Strategy with Corporate Local Audit Plan

Aneurin Bevan University Health Board's Clinical Audit Strategy 2022-2025 has four priorities:

This strategy can be read in conjunction with the Health Board's Health Board's Clinical Audit Policy and The Quality Strategy.

Together, these documents demonstrate how clinical audit will be developed, delivered, and outcomes put into practice through service improvement.

The Corporate Local Audit Plan 2026-2027 is developed to align closely with this strategy. Our approach ensures that corporate audit activities support and complement the four strategic priorities, providing focused assurance and driving quality and safety improvements across the organisation.

Pillars of Quality

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit can support and drive improvements in our Pillars of Quality Programme:

Patient and Staff Experience, Complaints, Concerns, and Compliments:	Clinical audits place patient and staff experiences at the heart of care, ensuring services remain truly person-centred while fostering a supportive environment for healthcare teams. This focus is vital for delivering compassionate, high-quality care, with audits providing a structured way to measure and drive improvement. By actively engaging with feedback, the Health Board can identify opportunities for change and replicate best practice. In doing so, we strengthen trust and accountability, demonstrating a clear commitment to listening and responding to the experiences of patients, families, and staff.
Incident Reporting:	Systematically monitoring incidents such as falls, pressure ulcers, medicines management, and mortality enables clinical audits to uncover patterns, tackle systemic issues, and prevent recurrence. This proactive approach drives continuous improvement in care practices, enhancing patient safety and ensuring that standards are consistently evaluated and raised.
Clinical Effectiveness:	Clinical effectiveness ensures that care is evidence-based, outcomes-focused, and delivered to the highest standards. Clinical audits play a vital role in this by systematically reviewing practice against national guidelines and best practice benchmarks. Through regular measurement and feedback, audits identify gaps, highlight successes, and drive continuous improvement—ensuring that interventions are not only safe but also effective in achieving the best possible patient outcomes.
Health, Safety and Security:	Clinical audits safeguard patients, staff, and visitors by ensuring that facilities and processes consistently meet the highest standards. Through regular evaluation and improvement of safety protocols, audits create a secure environment for care delivery and reinforce a culture of safety across the organisation.
Infection Control and Prevention:	By making infection control a dedicated focus, clinical audits strengthen practices that minimise healthcare-associated infections. This commitment ensures infection prevention measures are consistently applied and effective, leading to safer care and better patient outcomes.
Safeguarding:	Embedding safeguarding as a core pillar within clinical audits ensures that vulnerable individuals receive the protection and support they need. This approach upholds ethical standards and legal responsibilities, while guaranteeing that safeguarding practices are routinely reviewed, strengthened, and improved.

Historical corporate local audits undertaken (2023-2025)

The Medical Director's Audit Team has adopted a risk-based approach to corporate audits over the past three years, prioritising areas of high risk areas to maximise impact and assurance. The table below summarises audits completed during this period, demonstrating the breadth of work achieved under the current resource allocation. Audit findings are reported to the most relevant group or forum, ensuring alignment with the audit's subject matter. This approach enables improvement plans to be owned and driven locally, rather than the corporate team.

Annual Audit	Driver / Purpose of Audit
DNACPR	A recent review by Health Inspectorate Wales highlighted deficiencies in DNACPR form completion.
Consent	Significant negligence claims prompted Welsh Risk Pool to request a national review of consent standards. This is now audited every 6 months.
NG tube	The audit was triggered by a Regulation 28 Prevention of Future Deaths report following a serious incident involving incorrect nasogastric tube placement.
Quality of case notes	The Coroner requested assurance on the quality of clinical documentation following cases where poor note-keeping impacted investigations and learning. This led to a renewed focus on audits of patient records.
Venous thromboembolism-completion of risk assessment tool	Welsh Risk Pool identified a rise in clinical negligence and redress claims linked to missed VTE risk assessments and inadequate thromboprophylaxis.
Heparin chart – administration, prescribing and monitoring	Audit of refinement of the heparin anticoagulant chart to incorporate learning from two patient deaths and serious incident investigations.
Safe storage of medicines	Assess compliance with Patient Safety Notice PSN055: The Safe Storage of Medicines: Cupboards.
Medication Administration Record – in patient medication chart	Reviewing compliance of the medicines chart ahead of EPMA.
Mortality reviews	Supporting the Learning from Death report and the learning and improvement from the referred cases by the Medical Examiner Service (MES).
Treatment Escalation Plans	Assessing compliance with the All Wales updated TEP form.
Health Technology Wales	Adoption of HTW guidelines by the Health Board.

Corporate Audit Request Process

To reinforce governance and ensure alignment with Health Board priorities, for 2026-2027, the Medical Director's Audit Team will introduce a formal request process for corporate audit proposals. Key features of the process include a Standardised Audit Request Form: Departments and services will submit proposals to the Corporate Audit Team using a structured form capturing essential details such as scope, objectives and anticipated impact.

We will aim to deliver 10 corporate audits annually, creating a balanced and achievable programme that supports strategic goals and drives quality improvement.

Audit requests will be assessed using the following criteria:

- Alignment with the Health Board strategic priorities
- Impact on patient safety and clinical effectiveness
- Regulatory and compliance requirements
- Potential for quality improvements and resource optimisation
- Feasibility within available capacity and timelines

Timeline: This request process will be launched via Divisional Triumvirate Structures and Executive Teams in January 2026, enabling development of the Corporate Audit Plan for the period April 2026 to March 2027.

Next Steps:

- Develop a risk-prioritisation matrix to rank audit topics based on severity, likelihood and regulatory drivers.
- Align with Quality Strategy Year 3 priorities (e.g., avoidable harm, staff engagement).
- Engage stakeholders early, including the Executive Directors, Corporate Risk Team, and Patient Safety leads.

Aim - To provide robust corporate-level assurance for the Health Board by evaluating organisational priority areas driving quality improvement through a consistent, structured and evidence-based audit process.

Objectives

Quality Improvement:

Drive organisational level enhancements in patient care by identifying gaps against best practice within corporately selected audit topics and implementing targets changes to align with recognised clinical standards.

Clinical Effectiveness:

Ensure that corporately reviewed clinical interventions are evidence based, aligned with current guidelines, and reflect the Health Board strategic priorities – delivering care that is both safe and effective.

Patient Safety:

Proactively identify and address risks within corporate audit areas to minimise the chance of errors and adverse events, ensuring a safe environment for patients and staff.

Professional Development:

Deliver actionable feedback from corporate audit findings to healthcare professionals, fostering learning, reflection and continuous professional growth

Accountability:

Demonstrate organisational accountability to ABUHB, regulatory bodies, and stakeholders by regularly reviewing clinical and driving improvements at the corporate level- ensuring transparency, compliance and trust.

Resource Optimisation:

Identify inefficiencies and areas of waste within corporate audit priorities to enable smarter resource allocation, improve cost effectiveness, and support sustainable service delivery.

Compliance:

Ensure adherence to local, national, and international healthcare standards and guidelines across all governed audit topics – reinforcing regulatory compliance and best practice.

Patient Involvement:

Actively engage patients in corporate audit processes to capture their perspectives and experiences, ensuring improvements that strengthen patient-centred care and shared decision-making.

Principles of the Corporate Local Audit Plan

In developing the Aneurin Bevan University Health Board Annual Corporate Local Audit Plan, the following approach has been applied to date and will continue to underpin the principles for the 2026-2027 Audit Plan:

Purpose of Corprate Local Clinical Audits:

- Ensure the quality of care for specific conditions or pathways aligns with best evidence.
- Understand variations in care outcomes and assess good practice.

Participation and Compliance:

- Provide evidence-led care in line with National, Local, and Professional Policies and Standards of Care.
- Implement and audit NICE guidance and HTW adoption, subject to external review.
- Service evaluation and re-audit should be conducted following changes in practice.

Audit Management:

- Register all corporate clinical audit activities and manage audit requests received via the formal Clinical Audit Registration Form from directorates and services.
- Collaborate with clinicians, managers, and audit staff to meet all clinical, statutory, regulatory, commissioning, and Health Board requirements.
- Enable healthcare professionals to participate in audits for revalidation and professional development.
- Aim to undertake approximately ten corporate audits annually, prioritised according to organisational needs and available resources.

Support and Review:

- Ensure resources, governance, and structures support audit engagement at the corporate level.
- Establish a formal process for reviewing audit performance and implementing improvements.
- Escalate significant issues to the executive board when necessary.
- Maintain a clear process for risk identification and mitigation following audit findings.

Governance & Reporting:

- Outcomes from the Corporate Local Audit Plan will be regularly reported to the Audit, Risk and Assurance Committee (ARAC) to support Board-level assurance.
- Audit results will be triangulated with complaints, incidents, and risk registers to inform organisational priorities and enhance quality and safety.

Identifying Audits

When determining which corporate audits to undertake, the Corporate Local Audit Plan will prioritise areas informed by the corporate risk register, serious incidents, ongoing investigations, and opportunities to enhance patient care. Directorates and Divisions are encourages to submit audit requests for corporate delivery, particularly where significant risks have been identified or additional support is required. We will also consider how to align regionally (across South East Wales and through closer collaboration), while ensuring compliance with both local and national requirements.

Risk-Based Audit Prioritisation Process

- **Map Corporate Risks**: Review the Health Board's risk register to identify high-scoring risks (e.g., patient safety, workforce, financial sustainability).
- **Link to Strategic Objectives**: Align audit activity with risks that could impact the delivery of the Quality Strategy and organisational priorities.
- **Apply Scoring Matrix:** Use severity x likelihood approach to prioritise audits where failure would have the greatest consequence.
- **Collaborate with Corporate Risk Team:** Map proposed audits against risks.

Incorporate Serious Incidents (SI)

- **Analyse Themes and Trends**: Review aggregated data from SI reviews, mortality reviews, and complaints to identify recurring issues (e.g., handover failures, medication errors).
- **Target High-Risk Pathways**: Prioritise audits in areas where incidents cluster around specific services or conditions (e.g., maternity, sepsis management).
- **Evaluate Action Plan Implementation:** Assess the effectiveness of improvement measures introduced following previous incidents, such as escalation protocols and duty of candour compliance.

Align with Ongoing Investigations

- **Avoid Duplication**: Where external bodies (e.g., HIW, WRP) are conductive investigations, ensure audits complement rather than replicate their scope.
- **Re-audit for Compliance:** Conduct follow up audits to confirm implementation of recommendations from previous investigations and assess sustained improvement.
- **Maintain Dynamic Updates**: Keep the audit plan flexible, enabling rapid audits or deep dives in response to emerging investigations or newly identified risks.

Integrate National and Local Requirements

- **NHS Wales Audit Priorities**: Incorporate all mandatory audits required at national level.
- **Local Quality Goals**: Align audit activity with Year 3 priorities outlined in the Quality Strategy Implementation Plan to support Health Board objectives.
- **Stakeholder Engagement**: Engage Directorates and Divisions to request audits for corporate delivery, particularly where risks are significant or additional support is required.
- **External Bodies:** Ensure compliance with external requirements and national priorities (i.e. HIW standards).

Structure of Corporate Local Audit Plan

No.	Audit Title	Audit type	Clinical Area/ Directorate	Reason for Inclusion	Priority/ Risk Level	Audit Objective	Last Audited / Date of Previous Audit	Lead Department Team	Audit Lead	Involved Departments / Teams	Resources, Person-Days	Expected Completion Date (Report & Presentation)	Reporting Committee / Group	Expected Outcomes/ Key Performance Indicators (KPIs)	Status / Comments
1	The full or concise title of the audit topic. For example: Documentation or Compliance with NG Tube Insertion Standards	Indicates whether the audit is part of the annual corporate cycle (planned) or initiated due to an event, complaint, or external requirements (unplanned)	The clinical specialty or area the audit relates to – for example, Surgery, Outpatient Services, or Patient Documentation	A brief explanation of why the audit is being conducted; based on organisation, internal or external requests, regulatory requirement, or corporate priority	Reflects the importance of the topic to the organisation (high, medium, low) rated on a scale (e.g., 1–5). May be determined by the corporate risk register	This section should clearly state the purpose and intended outcomes of the audit. Must align with the audit aims to achieve improvements in adequacy and effectiveness, ensure compliance with guidelines, and evaluate operational performance. Including a review of previous audits ensures that the audit scope and testing are aligned with the organisation's priorities	Shows when the audit was last carried out (this topic) including planning frequency and duplication	The main department responsible for coordinating the planning and the report	The person responsible for overseeing the audit and engagement	Other departments or teams involved in data collection, analysis, or implementation of recommendations	An approximate estimate of the time required – e.g., 1 person × 30 days or 3 person-days. Helps assess workload and resource allocation needs	The anticipated date when the audit will be completed and findings presented, for example: March 2017 or 10.03.2017	The forum where the results will be presented, e.g., Clinical Standards and Effectiveness Group, Executive team, AHAG	What is expected as a result of the audit: improved compliance with standards, enhanced documentation quality, reduction in incidents, etc.	Current status of the audit within the plan. Examples: New (audit planned for the first time), Recurring, Carried forward (audit carried over from previous year)

Smart **M**easurable **A**ttainable **R**ealistic **T**imely

Governance, Monitoring & Reporting

All local clinical audits and service evaluation must be registered with the relevant Directorate Clinical Lead, and formal approval must be obtained before commencement.

Each audit included in the plan will have an identified clinical lead and be aligned to the most relevant governance group. This structure ensures that priority clinical audits are embedded within the Health Board's strategic priorities and governance processes. In turn, this approach supports audits in driving meaningful improvement.

The clinical directorate, together with those names on the Clinical Audit Programme is/are responsible for managing priority clinical audits and clinical services. Where audits span multiple service areas, Clinical Directors – drawing on their knowledge of local priorities – must collaborate to ensure audits are managed in a timely coordinated manner.

All local audits, and service evaluations must produce a report that includes the methodology, findings and recommendations. Each report must be accompanied by a SMART Action plan. Local audits should be shared with the appropriate Directorates. Corporate audits will be shared with the Clinical Standards and Effectiveness Group (CSEG) and relevant stakeholders.

The Corporate Audit team will work collaboratively with projects leans involved in clinical audits to ensure they are completed to ah high standard and within agreed timeframes and support attended at CSEG.

The Corporate Audit team will maintain an electronic database of all clinical audit projects registered with them. The database will be used to monitor project progress, track implementation of recommendations and report activity. Findings and outcomes from audits and evaluations will be shared with governance groups and the Quality Management Group. Examples of good practice will be acknowledged and disseminated via the Learning and Improvement Forum.

Recommendations from Clinical Audit Reports

The Clinical Standards and Effectiveness Group (CSEG) is focused on reviewing audit data, identifying risks to clinical effectiveness and patient safety, and promoting improvements in care. This group ensures clinical audit findings are discussed in a system-wide context, facilitating shared learning and cross-divisional alignment.

The Patient Quality, Safety, and Outcomes Committee (PQSOC) looks at audit outcomes and the improvements made as a result.

1. Clinical Audit reports and outcomes identify recommendations for service.
2. Improvement and Quality Improvement (QI) work where data shows variation from standard of care.
3. Local audit recommendations are reviewed by the ABUHB Clinical Leads.
4. Risks are identified by clinical leads/teams, to ensure risks are escalated and recorded on risk register.

Specific	✓ Try and make your goal as precise and defined as possible
Measurable	✓ Establish a criteria to measure your progress ✓ How will you know when you are on your way?
Accountable	✓ Determine a person who will help you and keep you responsible for your goals
Reachable	✓ Set reachable goals that you will be able to attain (high expectations are good) ✓ Set small goals toward bigger goals
Time Specific	✓ Create a timeline ✓ Having an end time will help you stay accountable to your goals

Medical Director's Quality and Patient Safety Clinical Audit Team - Role & Responsibilities for Corporate Audit

Role: The team is responsible for leading and managing the Corporate Local Audit Programme. This includes supporting clinical healthcare professionals and working collaboratively with clinical and managerial leads on corporate audits. The role demands strong leadership, project management and communication skills, alongside expertise in audit methodology and data analysis.

Leading and Managing Corporate Clinical Audit – responsible for developing, implementing and overseeing corporate clinical audit plans, programmes and initiatives to ensure alignment with Health Board priorities and standards.

Providing Expert Advice and Support – offering specialist guidance on audit methodology, data collection, analysis and reporting to staff and stakeholders, ensuring audits are robust, accurate and aligned with best practice.

Ensuring Compliance and Governance – co-ordinating the Health Board's clinical audit and effectiveness strategies, ensuring adherence to national and local standards, and contributing to quality improvement plans across services.

Facilitating Collaboration and Communication – working closely with clinicians, managers and other healthcare professional to identify audit topics, share information and promote collaborative audit projects that drive quality improvements.

Monitoring and Evaluating Progress – tracking the progress of corporate clinical audits, analysing data and reporting on the effectiveness of implemented changes to ensure continuous improvement and accountability.

Driving Continuous Improvement – identifying areas for improvement based on audit findings and collaborating with relevant stakeholders to implement necessary changes, monitor impact and sustain progress over time.

Plan for corporate local audits April 2026- March 2027

The Medical Director's Audit Team will review existing audits that currently take place annually and assess whether they should continue each year or move to a rolling programme every three years, enabling improvements to be tracked over time. For audits managed by other teams, the Corporate Audit Team will focus on supporting actions and improvements and clarifying ownership.

Rolling Annual Audit	**Plan for 2026-27**
Mortality reviews	Delivered by Medical Director's team, this involved ongoing Learning from Death report and MES reviews.
Health Technology Wales	Adoption of HTW guidelines by the Health Board, supported by AMaT. HTW produce associated reports.
DNACPR	Currently undertaken by Resus Group, with links to End of Life Care Board for reporting.
Consent	Reports presented to Directorates, ambitions for areas to undertake peer reviews- outlined by W*elsh Risk Pool.* This will require support from the Corporate Audit Team.
NG tube	Action Plan finalised by Nutrition and Hydration Group. Re-audit would not take place until actions have been implemented.
Quality of case notes	Determine whether there is an ongoing requirement to provide assurance to The Coroner through audits of patient records.
Venous thromboembolism	Await the release of the 3-year *Welsh Risk Pool* report, which provides recommendations for HB actions and improvements.
Safe storage of medicines	Handed over to Medicines Safety Group (MSG).
Heparin chart	Working with EPMA Group to implement agreed actions. Future audits will be instantly available via EPMA - discussed at MSG.
Medication Administration	No longer needed as EPMA.
Treatment Escalation Plans	Assessing if needed to review compliance with the All Wales updated TEP form.
Early Warning Systems	A new audit for 2026.27 will focus on deteriorating patients and sepsis – this is being scoped.

The final Corporate Local Audit Plan for the 2026-2027 will be developed once requests have been received from Directorates and Services. This process will determine which audits need to be delivered as corporate audits and undertaken by the corporate audit team and which can be manged locally, with support from Corporate Audit Team where required.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN** **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 January 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Six-Month Update on the National Clinical Audit Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Joanne Stimpson, Quality and Patient Safety Lead for National Clinical Audit

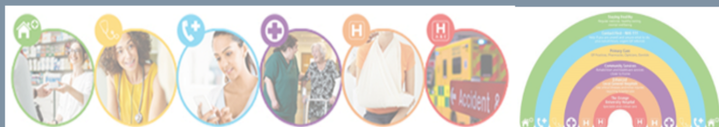
Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board is committed to delivering safe, effective, and high-quality care, with clinical audit serving as a cornerstone of its assurance framework. Clinical audit provides robust, evidence-based assurance by systematically measuring how well services meet the standards set out in local and national guidelines. Where audits identify areas for improvement, these are addressed through SMART action plans, which are rigorously reviewed by leadership teams and formally approved by the Clinical Effectiveness Group. This ensures that improvement actions are not only identified but also implemented and monitored for impact.

National audit results are a standing item at Patient Quality and Safety Operational Committee (PQSOC) meetings, ensuring that assurance and learning are embedded at the highest levels of governance. The ABUHB Clinical Audit Six-Month Activity Report (April–September 2025/2026) provides a comprehensive



mid-year overview of progress against the Health Board's Clinical Audit Plan, in alignment with the National Clinical Audit Programme. The report highlights key achievements, ongoing challenges, and the Health Board's compliance with the National Clinical Audit & Outcome Review Plan (NCAOPR), as required of all Welsh Health Boards and Trusts. This structured approach underpins the Board's assurance that clinical standards are being met and that continuous improvement is actively pursued.

Cefndir / Background

National Clinical Audits are fundamental to benchmarking and driving improvements in healthcare services. They underpin compliance with standards, foster professional development, reinforce accountability, and support a culture of continuous quality improvement. Within Aneurin Bevan University Health Board, audit reports are rigorously reviewed by the Clinical Standards and Effectiveness Group (CSEG), which provides assurance to the Patient Quality and Safety Operational Committee (PQSOC) that standards are being met and that improvement actions are both identified and implemented.

Participation in all audits listed in the National Clinical Audit & Outcome Review Plan (NCAOPR) is a statutory requirement for the Health Board. The insights and data generated from these audits directly inform service design and delivery, ensuring that care remains evidence-based and patient-centred.

The Medical Director's Clinical Audit team continues to work closely with Divisions, standardising audit report templates and enhancing the scrutiny of action plans. The Health Board utilises the Audit Management and Tracking System (AMaT) to monitor audit recommendations, assurance levels, risk ratings, and to store and track SMART action plans, providing a transparent and auditable trail of improvement activity.

Clinical audit remains a cornerstone of the Health Board's commitment to fulfilling its Duty of Quality, as set out in the Health and Care Quality Standards. The establishment of a formal Corporate Local Audit Plan will further strengthen governance, support sustainable improvement, and contribute to a resilient and high-performing health and care system.

Asesiad / Assessment

Aneurin Bevan University Health Board has established a robust process for scrutinising National Clinical Audit Reports, ensuring that assurance and improvement are at the heart of its clinical effectiveness agenda. Following publication, all National Clinical Audit Reports are presented to the Clinical Standards and Effectiveness Group (CSEG). Clinical Leads are notified in advance

of report due dates and are provided with locally developed, standardised proformas to present local performance against national benchmarks. Improvement plans, aligned with national recommendations, are developed and tracked through the Audit Management and Tracking (AMaT) system, providing a transparent and auditable record of progress.

The six-month review of clinical audit activity highlights both significant achievements and ongoing challenges, offering a clear direction for future improvement. As part of Pillar Three—Clinical Effectiveness—there is a renewed emphasis on the outcomes and actions arising from clinical audits. This approach has strengthened escalation and assurance processes: audit results requiring further scrutiny are escalated through the appropriate governance groups, reported to the Quality Management Group (QMG), and, where necessary, onward to the Patient Quality and Safety Outcomes Committee (PQSOC). This ensures that corporate audit performance is closely monitored, improvement plans are developed, and progress is systematically tracked.

The 2025/26 Annual Clinical Audit Plan, approved by PQSOC in April 2025, has been implemented throughout the year. The schedule of published reports for April and September 2025 has been aligned to CSEG dates, with all audits due for publication from September 2025 to March 2026 forecasted for presentation in line with the Clinical Audit Plan.

The report also transparently highlights audits in which the Health Board did not participate (two in total), with reasons for non-participation explored and documented with the relevant teams:

- National Respiratory Audit Programme (NRAP): While participation has improved with this audit, it remains limited due to multi-site data complexities and operational constraints. Data accuracy and acquisition, continue to pose risks such as double counting and misattribution of care. Engagement with national audit providers has not yet resolved these systemic issues. All audits are being undertaken except for COPD, where resource constraints have made data acquisition challenging for the Directorate.
- National End of Life Care Audit (NACEL): Gaps in clinical leadership have hindered the development of cohesive improvement plans in this area. The Audit team are engaging with other Health Boards to gain insight into their approach to delivering NACEL.

AMaT has now been widely adopted across the Health Board, enabling all audit actions to be tracked and followed up by the Medical Director's team to ensure completion. The system records assurance levels for completed audits, aligning with the Health Board's risk management framework and providing a clear line of sight from audit findings to assurance and improvement. The audit team are ensuring actions are reviewed every six months and aims for completion within

12 months. An escalation process is in place and being refined to provide assurance and address overdue actions promptly.

To address ongoing challenges and build on current momentum, the Clinical Audit team is focusing on several key areas:

- Finalising and implementing an updated Clinical Audit Policy and Standard Operating Procedures, including robust frameworks for outlier management and reporting.
- Prioritising the resolution of data acquisition and accuracy issues—especially for multi-site audits—and collaborating with national providers to overcome systemic barriers.
- Supporting and ensuring there are clinical leads for all audit areas, increasing engagement across divisions, maintaining transparent communication through regular updates and newsletters, and ensuring divisional accountability.
- Continued robust oversight via CSEG will help ensure timely completion of actions and the effective embedding of audit findings into service redesign and quality improvement initiatives.

Aligning audit outcomes with value-based healthcare metrics and patient experience data will enable more effective benchmarking and strategic planning, ensuring that improvements are both evidence-based and patient-centred.

Argymhelliad / Recommendation

Note the assurance provided by the clinical audit team in developing an ongoing clinical audit programme. A clinical audit activity report is being updated annually.

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):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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.

Six-Month Clinical Audit Activity *(Quarter 1 and Quarter 2, 2025–2026)*

Prepared in Conjunction with the 2025–2026 Clinical Audit Plan

ARAC January 2026

Medical Director's Quality & Patient Safety Team

Leeanne Lewis, ***Assistant Director for Quality and Patient Safety***

Jo Stimpson, ***Quality and Patient Safety Lead for National Clinical Audit***

Introduction

Welcome to the Health Board's Clinical Audit Six-Month Activity Report (April–September 2025). This report provides an overview of progress against the Health Board's Clinical Audit Plan, aligned to the National Clinical Audit Programme, highlighting mid-year achievements and addressing current challenges.

Health Boards and Trusts in Wales are mandated to fully participate in all audits and outcome reviews listed in the National Clinical Audit & Outcome Review Plan (NCAOPR) which is commissioned by Health Quality Improvement Partnership (HQIP).

National Clinical Audits provide a vital source of information for measuring and benchmarking improvements in healthcare services across Wales.

The audit datasets help assess the quality and effectiveness of care delivered by Health Boards and Trusts. When combined with targeted improvement actions, these insights can significantly influence how services are designed and delivered.

At Aneurin Bevan University Health Board, reports are reviewed through the Clinical Standards and Effectiveness Group (CSEG) and provide onwards assurance to Patient Quality and Safety Operational Committee (PQSOC).

Core objectives of National Clinical Audit:

Objective	Details
Improve Patient Care and Outcomes	✓ Identify and analyse gaps between current practice and evidence-based standards using robust audit data. ✓ Drive targeted improvements that enhance safety, effectiveness and patient-centred care, ensuring alignment with national priorities. ✓ Evaluate and sustain impact through continuous monitoring, feedback loops and shared learning across teams.
Ensure Compliance with Standards	✓ Systematically assess alignment of clinical practice with national guidelines (e.g., NICE), local policies, or specialty-specific standards. ✓ Identify and prioritise non-compliance risks, proving clear recommendations and practical support for correct aim. ✓ Embed compliance monitoring into routine practice to maintain standards and reduce variation.
Support Professional Development	✓ Promote reflective practice by enabling clinicians to review performance and identify leaning opportunities. ✓ Provide robust evidence to inform appraisal, revalidation and continuous professional development (CPD). ✓ Foster a culture of lifelong learning through feedback and shared best practice.
Promote Accountability and Transparency	✓ Provide clear evidence that services are delivered safely, effectively and in line with agreed standards. ✓ Offer assurance and build trust with patients, regulators, commissioners and the wider public through transparent reporting. ✓ Demonstrate organisational responsibility by sharing outcomes and improvement actions openly.
Drive Continuous Quality Improvement	✓ Ensure changes are data-driven and measurable; supporting ongoing evaluation and refinement. ✓ Leverage audit insights to inform service redesign, optimise care pathways, and guide resource allocation for maximum impact. ✓ Embed a culture of learning and improvement across teams through collaboration, feedback & shared best practice.
Support Risk Management and Patient Safety	✓ Use audit findings to identify and mitigate risks, ensuring services are safe, reliable and resilient. ✓ Inform service redesign and pathway optimisation to reduce harm and enhance patients safety. ✓ Embed a proactive safety culture through shared learning, multidisciplinary collaboration, and continuous improvement.
Inform Strategic Planning and Commissioning	✓ Provide robust, actionable data to support business cases, service development, and commissioning decisions. ✓ Align audit priorities with organisational objectives and national programme, ensuring resources are targeted where they deliver the greatest impact. ✓ Enable evidence-based planning that drives sustainable improvements and meets population needs.

Progress against 2025/26 Objectives

Key objectives for 2025/2026	Achievements April - September 2025
Develop local audit plans with Divisions	Corporate local audits completed, e.g., NG Tubes and thromboprophylaxis for VTE, with plans for Bowel Cancer audit.
Embed AMaT and deliver training; raise audit awareness	AMaT usage continues to expand; additional staff training delivered to strengthen audit capability.
Strengthen governance and reporting within AMaT	Governance and reporting structures are progressing and improving, ensuring robust oversight.
Implement process for tracking audit results and actions	Actions monitored at Corporate and Ward level; findings from national and local audits informing organisational learning.
Triangulate learning from audits and other sources	Mechanisms through CSEG regularly reviewed to ensure integration of insights for service improvement.
Collaborate with value-based healthcare team on measures	Ongoing work to align audit outcomes with value-based healthcare metrics for benchmarking.
Review patient experience and involvement in audit	Consideration underway on how to triangulate CIVICA and patient experience data to strengthen audit impact.
Review audit team structures and gap analysis	QPS team working with Health Board colleagues to ensure full participation in NCAOPR and address resource gaps.

NCAORP Schedule in line with National Clinical Audit Plan for 2025/2026 with CSEG dates

The schedule via Healthcare Quality Improvement Partnership (HQIP) is updated monthly, the CSEG plan can change with each publication, as the report publication dates can change. The plan is accurate at the time of reporting.

During 2025/2026 HQIP have published **36** national reports relevant to Aneurin Bevan University Health Board services.

Group	Report No.	Comments
CSEG May 2025	1	CSEG reviewed four audits. Of these, three were published in 2024/25 and one in 2025/2026, ensuring compliance with reporting requirements.
CSEG Sep 2025	2	CSEG reviewed three audits. Of these, two were published within 2025/2026. One was published in 2024/2025.
CSEG Nov 2025	7	All Published in 2025/2026
CSEG Jan 2026	8	All Published in 2025/2026
CSEG Mar 2026	5	All Published in 2025/2026
CSEG May 2026	2	All Published in 2025/2026
Stroke Board	1	The SSNAP report was presented at the Sep 2025 CSEG meeting, where the new metrics were discussed. This current publication follows too soon after that presentation for findings to be reported at this stage.
Cancer Board	9	Proposal for presentation at the Cancer Board: NATCAN included 10 cancer audits. Nine were published in 2025/26, with the Lung Cancer (NLCA) scheduled for publication in April 2026.
In Patient Falls Group	1	To be discussed regarding presenting at CSEG.
Grand Total	36	

National Clinical Audit - Limited Participation

National Respiratory Audit Programme (NRAP) – COPD, Adult Asthma, Pulmonary Rehabilitation)
Participation Update and Ongoing Challenges

Current Position
The Health Board has re-established participation in most NRAP audits, with activity concentrated at Grange University Hospital (GUH). This represents positive progress; however, achieving full compliance across all sites remains difficult due to structural and operational constraints. The only outstanding audit is COPD, which the directorate is reviewing for participation.

Key Issues and Risks

Multi-Site Model Challenges
- Risk of Double Counting: Patients transferred between sites may appear in multiple datasets, inflating numbers, impacting results and distorting audit outcomes.
- Misattribution of Care: Audit findings may be incorrectly attributed to the wrong site. For example, a patient admitted to GUH but later registered at Nevill Hall Hospital (NHH) for discharge planning, could result in management being recorded under NHH, rather than GUH.
- Increased Workload: Logging into multiple databases for separate site submissions adds significant administrative burden.

Data Acquisition and Accuracy Issues
- NRAP mandates hospital-level data, current rules prevent amalgamation of sites.
- Persistent discrepancies between PEDW extracts and local coded lists, including incorrect coding, inclusion of non-admitted patients, and duplication when patients move between wards or sites. PEDW is the national administrative dataset for Wales that records all inpatient and day-case episodes in NHS hospitals. It includes patient demographics, diagnoses, procedures, and hospital identifiers. PEDW is used by NRAP to validate case ascertainment, making accuracy critical for compliance.

Engagement with NRAP
Despite repeated offers from the Health Board to collaborate on solutions, NRAP has not provided a clear pathway to address these systemic challenges. This limits opportunity for improvement and assurance.

Impact on Assurance
- Continued risk of non-compliance with NRAP requirements.
- Potential reputational and quality assurance implications for the Health Board.
- As audits are retrospective, the Health Board will remain an outlier for the past 12 months and until COPD data is fully captured and validated.

National Clinical Audit - Limited Participation

National Audit of Care at End of Life (NACEL) 2024 – published Aug 2025

Current position

The Health Board has participated in the NACEL audit each year commencing in 2019. The audit comprises several elements, these are:

- **Organisational Survey** – relating to HB policies and guidelines & service models
- **Case Note Reviews** – Acute and Community settings - these are completed by Health Board clinical staff with experience of treatment care planning, 40+ questions
- **Quality Surveys** – these are to be completed by the bereaved carers of the deceased in relation to the end-of-life care received (online or on telephone)
- **Staff Surveys** – to be completed by any staff who are most likely to encounter dying patients and those important to them

Engagement in NACEL

- Given the scale of the NACEL audit and the inclusion of Mental Health Services in the latest audit round, alongside the delivery of end of life care across multiple sites and specialities, securing consistent clinical leadership has been challenging.
- Historical, the Health Board's Palliative Care team provided the primary input for data collection. However, they have indicated that while they maintain high standards of end of life care, the audit requires broad Health Board involvement to ensure a comprehensive perspective. Requests have been made for wider clinical participation, particularly in complete case note reviews.
- Data entry for patients across multiple hospital sites has proven complex, impacting compliance and participation. The audit required significant coordination by the Clinical Audit team and participation has been challenging.
- Previous audit findings have been presented to the End of Life Care Board, however the absence of a designated Clinical lead has hindered the development of a cohesive, overarching improvement plan. Strengthening leadership and broadening participation remain critical to delivering sustainable improvements in end of life care. We are engaging with other Health Boards to gain insight into their approach to delivering NACEL.

The Health Board is actively participating in the **NACEL 2025 Mental Health Spotlight Audit,** with several components still in progress.

Audit Actions across the Health Board 2025/2026

National Clinical Audits are registered within the relevant Clinical Area on AMaT. Actions arising from national recommendations, as well as any local recommendations identified by the clinical lead, are recorded in AMaT and monitored by the QPS Clinical Audit Team.

Actions may be short or long term. Some are fully within the Health Board's control, while others depend on external bodies, such as other Health Boards providing services to Aneurin Bevan University Health Board residents. The audit team ensures actions are reviewed every six months and aims for completion within 12 months. An escalation process is in place and being refined to provide assurance and address overdue actions promptly.

Since introducing the recording National Clinical Audit actions in AMaT (over three years ago) the Health Board has **FULLY COMPLETED 118** actions.

Audit/Project Title	CSEG Date	Assurance Level	Risk Level	Financial year	Actions	Comments
National Lung Cancer Audit (NLCA) - State of the Nation report 2025	May 2025	Significant	None	2025/2026	Total 7 (Fully complete-2, Partially complete-2 Overdue-3)	The Clinical Lead has been contacted to provide an update, and this will be monitored by the QPS Clinical Audit Team.
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People – Annual report 2024	Sep 2025	Limited	Major	2025/2026	Total 2 (Fully complete-1, Unable to complete-1)	Unable to complete the recommendations as they require the appointment of additional clinical posts and funding has not been secured. The clinical lead has been advised to escalate the issue by placing on the risk register.
National Heart Failure Audit (NHFA) annual report 2025	Sep 2025	Significant	Minor	2025/2026	Total 16 (Fully complete-1, ongoing-13, Overdue-2)	The Clinical Lead has been contacted to provide an update, and this will be monitored by the QPS Clinical Audit Team.

Audit Actions across the Health Board

These 4 audits were presented on the first 6 months of 2025/2026 however the publication date fell in 2024/2025

Audit/Project Title	CSEG Date	Assurance Level	Risk Level	Financial year	Actions	Comments
National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation	May 2025	Significant	Minor	2024/2025	No actions as first round of this audit.	
National Paediatric Diabetes Audit (NPDA)- State of the Nation Report (Year 3)	May 2025	Significant	Minor	2024/2025	1 • Overdue	The Clinical Lead has been contacted to provide an update, and this will be monitored by the QPS Clinical Audit Team
National Clinical Audit of Psychosis (NCAP) - State of the Nation report	May 2025	Significant	Minor	2024/2025	16 • 1 Fully complete • 13 ongoing • 2 Overdue	The Clinical Lead has been contacted to provide an update, and this will be monitored by the QPS Clinical Audit Team
Sentinel Stroke National Audit Programme (SSNAP)- State of the Nation 2024	Sep 2025	Significant	Minor	2024/2025	No actions as new metrics introduced in October 2024 with significant changes which will need time to embed into daily working practices.	

National Clinical Audit & Outcome Review Annual Plan(NCAORP) Schedule for 2025/2026

The schedule is subject to a structured monthly review and update process to ensure accuracy and alignment with current reporting requirements.

The CSEG plan is dynamic and may be adjusted following publication, as report release dates can vary. The version presented reflects the most accurate position available at the time of reporting.

CSEG meeting dates may occasionally become oversubscribed due to the Group's operational limit of six presentations per session. While every effort is made to adhere to the published schedule, factors necessitate changes.

For example, clinical leads may be unable to attend on their allocated date, in which case an alternative slot will be agreed to maintain continuity.

To minimise disruption to clinical duties, clinical leads are offered the flexibility to attend only for their scheduled 20-minute presentation slot.

Following the cancellation of the July 2025 meeting, the schedule has been impacted. To address this, additional meetings may be convened or sessions extended to ensure all outstanding audits are scheduled and delivered.

NCAORP Schedule in line with National Clinical Audit Plan for 2025/2026

HQIP Ref.	Name	Report	Publication Date	CSEG Date (if applicable)
519	NLCA	National Lung Cancer Audit - State of the Nation report (England & Wales)	10/04/2025	CSEG May 2025
NICOR	NICOR	National Heart Failure Audit (NHFA)	01/04/2025	CSEG Sep 2025
576	EP12	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	11/07/2025	CSEG Sep 2025
580	NNAP	National Neonatal Audit Programme - State of the nation report 2026	09/10/2025	CSEG Nov 2025
545	NMPA	National Maternity and Perinatal Audit - State of the nation report	14/08/2025	CSEG Nov 2025
NICOR	NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)	01/04/2025	CSEG Nov 2025
NICOR	NICOR	Myocardial Ischaemia National Audit Project (MINAP)	01/04/2025	CSEG Nov 2025
581	MNI	Perinatal Mortality Surveillance 2025 - State of the nation Report	12/06/2025	CSEG Nov 2025
578	MNI	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	CSEG Nov 2025
577	FFFAP	National Hip Fracture Database (NHFD) - State of the Nation 2025 report	11/09/2025	CSEG Nov 2025

NCAORP Schedule in line with National Clinical Audit Plan for 2025/2026

HQIP Ref.	Name	Report	Publication Date	CSEG Date (if applicable)
574	NVR	National Vascular Registry - State of the Nation 2025 report	13/11/2025	CSEG Jan 2026
551	NRAP	National Respiratory Audit Programme - Asthma Secondary Care Secondary care outcomes report	09/10/2025	CSEG Jan 2026
616	NRAP	National Respiratory Audit Programme - State of the Nation report - Children and young people's asthma: Elements of care received by children admitted with near-fatal asthma	12/06/2025	CSEG Jan 2026
605	NELA	National Emergency Laparotomy Audit Year 10 - State of the Nation report	09/10/2025	CSEG Jan 2026
583	NEIAA	National Early Inflammatory Arthritis Audit - State of the Nation Report 2026	09/10/2025	CSEG Jan 2026
552	NCEPOD	ICU Rehabilitation report	12/06/2025	CSEG Jan 2026
618	NCEPOD	Blood sodium report	11/09/2025	CSEG Jan 2026
617	NCEPOD	Emergency paediatric surgery	11/12/2025	CSEG Jan 2026
546	NMPA	National Maternity and Perinatal Audit - Induction of labour snapshot report	13/11/2025	CSEG Mar 2026

NCAORP Schedule in line with National Clinical Audit Plan for 2025/2026

HQIP Ref.	Name	Report	Publication Date	CSEG Date (if applicable)
NICOR	NICOR	National Audit of Cardiac Rhythm Management (NACRM)	01/04/2025	CSEG Mar 2026
701	NCISH	Suicide - Mental Health Clinical Outcome Review Programme - State of the Nations report	12/02/2026	CSEG Mar 2026
699	NCAP	National Clinical Audit of Psychosis - State of the Nation report 2026	12/02/2026	CSEG Mar 2026
641	FFFAP	Fracture Liaison Service Database (FLSDB) - State of the Nation Report	08/01/2026	CSEG Mar 2026
659	NPDA	National Paediatric Diabetes Audit (NPDA) Annual Core State of the Nation Report (2026)	12/03/2026	CSEG May 2026
702	NMPA	National Maternity and Perinatal Audit - Multiple Births Report	12/03/2026	CSEG May 2026
631	NATCAN	National Primary Breast Cancer Audit (NAoPri)	11/09/2025	Cancer Board
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe)	11/09/2025	Cancer Board
633	NATCAN	National Ovarian Cancer Audit (NOCA)	11/09/2025	Cancer Board
634	NATCAN	National Pancreatic Cancer Audit (NPaCA)	11/09/2025	Cancer Board
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA)	11/09/2025	Cancer Board

NCAORP Schedule in line with National Clinical Audit Plan for 2025/2026 Continued

HQIP Ref.	Name	Report	Publication Date	CSEG Date (if applicable)
636	NATCAN	National Kidney Cancer Audit (NKCA)	11/09/2025	Cancer Board
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA)	11/09/2025	Cancer Board
638	NATCAN	National Prostate Cancer Audit (NPCA)	11/09/2025	Cancer Board
639	NATCAN	National Bowel Cancer Audit (NBOCA)	09/10/2025	Cancer Board
650	SSNAP	Sentinel Stroke National Audit Programme - State of the Nation Report	13/11/2025	Stroke Board
588	FFFAP	National Audit of Inpatient Falls (NAIF) State of the Nation report 2025	09/10/2025	IP Falls Group

Clinical Standards and Effectiveness Group - Processes:

Healthcare Quality Improvement Programme (HQIP) Provide regular updates on when reports will be published. Often dates will change. QPS will inform the Clinical lead and the Divisional Triumvirate of these planned dates and of any amended dates and invite to present the Health Board data at the most appropriate CSEG.

Once the report is published, QPS will insert local data into a PowerPoint document and organise a meeting with the presenter to ensure its accuracy and to ensure that AMaT is reflective of the data.

Meeting Summary Logs:

- The meetings notes have developed over recent months into meeting summary logs, which are more succinct in terms of text, however the audit presentations are included in a slide deck for further audit information. All relevant documents are available for all Health Board staff on the Quality and Patient Safety (QPS) intranet page, here.
- QPS liaise with the Clinical Lead or Divisional/Directorate Management prior to CSEG to ensure all actions are based on the report recommendations and to detail any local actions which are S.M.A.R.T. and these are given a six-month review date.
- New procedure applications are discussed with within the CSEG forum, and to date **FIVE** applications have been approved:

	Application Name	Presenter	CSEG Date	Outcome
1	Impella use in GUH	Dr Hussain, Consultant Cardiologist	May 2025	Approved
2	Conduction System Pacing	Dr Charles Lawson, Consultant Cardiologist	May 2025	Approved
3	RefluxStop procedure	Mr Haritharan Nageswaran – Consultant UGI Surgeon	Sep 2025	Approved
4	Cytosponge	Dr Joshi – Consultant Gastroenterologist	Sep 2025	Approved
5	Capsule Colon	Matthew Evans - ADM Medicine & Dr Joshi – Consultant Gastroenterologist	Sep 2025	Approved

What's Next?

The QPS team will monitor and request action updates at a 6-month point review with the relevant person(s) which will be added to the appropriate CSEG meeting as an update. All national audits should be signed off before or around the time of new publications – an audit cannot have more than one report ongoing. When a report is not annual, a 12-month review by QPS will take place

The processes have developed to ensure better communications while streamlining processes and remain being fit for purpose. The above pathway is being updated in the Clinical Audit Policy which is currently being reviewed for submission to the Clinical Standards Policy Group (CSPG).

What actions have been implemented under the National Clinical Audit Outcome Review Plan within ABUHB?

Audit Name	Recommendation	What we did
National Clinical Audit of Psychosis - State of the Nation Report 2024	Access and waiting time needs to be improved in line with target of 60% being seen within 14 days of referral	QI project completed to improve awareness of target within the team and change process of screening and allocating referrals - Achieved. (Data from last 6 months show 64% allocated within 2 weeks and 85% within 4 weeks.)
National Non-Hodgkin Lymphoma Audit- State of the Nation Report 2024	Commenced a new MDT proforma for all haematology MDT discussions, to try and improve recording of staging	This has already been initiated within Haematology for all patients, and our aim is for 100% of patients with NHL to have staging and PS accurately recorded at the time of MDT
National Lung Cancer Audit - State of the Nation 2025	Goal 3: Increase the proportion of people receiving SACT and reduce variation in access	Audit standard being achieved - Ongoing refinement of pathways according to threats
Fracture Liaison Service Database (FLS-DB) Annual report	Appropriate identification and monitoring post fracture	Full FLS business was presented at PIP on 8th November 2024 and Exec Committee on Monday 10th March - Fracture Liaison Service business case by Dr I Singh - FLS business case option 3 (full business case) was approved
National Respiratory Audit Programme (NRAP) - Wales Primary Care Clinical Audit Report	Spirometry Hubs in process of setup with plan to commence April 2025	Referrals into spirometry hubs commenced April 2025, Spirometry testing hub running in each of the 5 localities.

What actions have been implemented under the National Clinical Audit Outcome Review Plan within ABUHB?

Audit Name	Recommendation	What we did
Breathing well - An assessment of respiratory care in England and Wales - PAEDIATRIC ASTHMA	Meeting planned with Primary Care to discuss pathways	1hr webinar with interest from All Wales Primary Care with Prof Forton to present so consistent with the Welsh approach. Scheduled for 11th June at 1pm, also invited Welsh Paediatric trainees to the link and generate an output in terms of learning
National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2022/23	Awareness of the symptoms of onset of Type 1 Diabetes should be raised to reduce presentation with diabetic ketoacidosis (DKA)	Taking action to Wales wide via CYPDNW meeting 13th June 2025
National Vascular Registry - State of the Nation Report	Appoint a data clerk to capture and enter NVR data on all index cases. Developing a complex EVAR service	Clerk now in post
National Audit of Dementia (NAD) Care In General Hospitals 2022-23 Round 5	Improve compliance in completing the Estimated Discharge Date (EDD)	EDD and definition to a ward discussed and completed on board rounds in MAU everyday
	Improve nursing attendance and engagement with Delirium training – SQID, 4AT	Delirium champions allocated for each ward. Plan to deliver training on 4AT and SQID assessment for the nursing staff
	Continuing with Delirium teaching every 8 weeks– target audience doctors, staff nurses, HCSW	Training ongoing

Overdue actions are for ALL National Clinical Audit are monitored and discussed with the Clinical Leads and Directorate Management teams.

Further Work

Assurance Update – National Clinical Audit Governance

Clinical Audit Policy

The Health Board's Clinical Audit Policy has been updated to strengthen governance and includes Standard Operating Procedures for:

- National Clinical Audit Reporting and Monitoring
- National Clinical Audit Outlier Management
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – National Clinical Audit and Outcome Review Plan (NCAORP)

Governance Framework

The Terms of Reference for the Clinical Standards and Effectiveness Group (CSEG) are under review to reflect process changes following HIW recommendations.

Divisional Engagement

Divisions are regularly informed of actions within their areas, including overdue items, to ensure accountability and timely completion. Meet with Chief Operating Officer to strengthen engagement with audit actions and implement plans aimed at reducing overdue items, while enhancing oversight of audits and associated improvement initiatives.

Medical Director's Clinical Audit QPS Team Oversight

- Continuously monitors updates from HQIP to maintain compliance.
- Maintains and updates all information relating to the National Clinical Audit Outcome Review Plan.
- Engages directly with national audit providers (e.g., NACEL, NRAP – delivered by the Royal College of Physicians under HQIP contract) to ensure participation and adherence to standards.
- Progressing the National Clinical Audit Plan and undertaking compliance checks across all divisions.
- The team are ensuring actions are reviewed every six months and aims for completion of all actions within 12 months. An escalation process is in place and being refined to address overdue actions promptly.

Communication and Transparency

The Team are developing divisional newsletters detailing audit activity.

Aneurin Bevan University Health Board

Health Board Committee Assurance Note

Item:	Job Planning Progress Update
Date:	August - December 2025
Executive Lead:	Medical Director
Reporting to:	Audit, Risk & Assurance (ARA) Committee

Summary

This assurance note outlines the progress on implementing Consultant Job Planning, providing an update on data from the previous report along with any new developments.
At the February 2025 meeting the Committee noted that the compliance target within the Welsh Government's new IMTP framework, had increased from 85% to 90%. At the September meeting, the Health Board's compliance rate was reported at 59%, an increase from 33.54% in February. As of 30 November 2025, the overall compliance rate stands at 53.7%, with consultants at 55.4%, reflecting a decrease of 3.6% since September.

There are several factors which prevented an improvement in the compliance rate. The leading factor has been the expiry of a cluster of existing job plans within directorates. Other known factors are job plans awaiting signatures, staff absence (sickness, maternity etc), job plans within the formal dispute and appeals process and the impact of winter service needs on the workforce.

As noted in previous reports, achieving 90% compliance is highly challenging when sickness absence is around 8% and several formal appeals and review processes are ongoing. However, it is important to note that including legitimate non-compliance reasons, such as sickness absence, into the numerator then this would raise compliance by 17.9%, bringing the overall rate to 71.6%.

To improve compliance, the Health Board will implement a schedule of priority actions focused on areas where immediate improvements can be achieved by targeting compliance categories rather than specific service divisions. This includes completing plans awaiting sign-off and, where possible, agreeing job plans for staff on long-term absence, such as, parental leave, before they return.

However, it is noted that even with full engagement and timely sign-off from all consultants who are available and not affected by appeals or legitimate absence, the Health Board cannot exceed 73.1% compliance; which is considered the operational ceiling for compliance at this time.

Background

An update report was received by the ARA Committee in September 2025. A full report was presented to the Workforce implementation project on 18th September 2025. The ARA Committee requested a further update in January 2026.

Assessment

Audit Action Plan (highlights):

The action plan was intended to assist with the completion of the Job Planning process and achieving the 90% completion target set by Welsh Government. A fuller update to the action plan is included as Appendix 1 (Action Plan).

- Fifteen (15) out of nineteen (19) of the actions are considered complete. Three of the remaining four are reliant on L2P undertaking work and one is dependent upon the Health Board achieving a high level of compliance.
- Vacant consultant posts continue to not be filled until all the medical team has an up-to-date job plan; this has helped to improve compliance in some directorates.
- In September 2024 the Medical Workforce e-Systems team put on hold the implementation of the medical e-Rota to support job plan compliance. However, this could not be continued and the e-Systems Team is again undertaking an implementation programme.
- Drop-in training workshops were offered (since Spring 2024), however, uptake was low and these have been discontinued. Training remains available on request.
- Service specific training packs have been developed to assist each Division achieve compliance.
- Monthly compliance reports continue to be provided to the Divisional management teams.
- Communication via Divisional Directors to consultants, prompting staff to use core SPA time for job planning activities.

Electronic Job Planning system configuration & training:

The L2P job planning system has been configured to the Amendment to the Consultant Contract (Wales (2003) and the Health Board's Job Planning Procedure. The L2P system is an intuitive application and can be used with minimal training. However, training has been offered and 69% of staff completing this. The totals for each Division are:

	August Total Required	No trained (August 2025)	Nov Total Required	No trained (Nov 2025)	% trained
Surgery	189	132	189	132	70
Family & Therapies	109	98	110	101	92
Medicine	137	46	139	73	53
Clinical Support Services	174	110	174	110	63
MH & LD	53	41	57	43	75
Urgent Care	36	23	36	23	64
Primary & Community Care	51	43	52	43	83
Total	749	493	757	525	69

Job Planning:

As at 30th November there were 388 job plans completed or uploaded out of a total of 722 at a rate of 53.7%. This total includes Consultants, SAS drs etc. Of these, the number of completed Consultant job plans were 313 out of a total of 565 at a rate of 55.4%.

As at 1st August 2025 there were 419 job plans completed or uploaded out of a total of 708 at a rate of 59.2%. Of these, the number of completed Consultant job plans were 325 out of a total of 551 at a rate of 59%. The number of completed consultant job plans has reduced due to the expiry of several of them and some are yet to be reviewed and signed off by the Directorate. It is noted that this figure will regularly change due to the anniversary of review.

The numbers of job plans referred back, awaiting signature (sign-off), in-progress and non-compliant (with legitimate reason) remains static. Whilst the number of job plans to be started has increased by 46 from 16 to 62 – primarily due to the number of expired plans that require to be "restarted".

The following table provides a breakdown of Consultant totals in each of the categories:

Category	Total (August 2025)	%	Total (Dec 2025)	%
Completed / Uploaded The job plan has been completed and signed by all required signatories in the L2P system / compliant paper job plan has been uploaded and is compliant until the expiry date of that job plan.	419	59.2	388	53.7
Referred Back The job plan has been signed by the Clinician and or the Clinical Manager but one of the signatories has reverted the job plan back as changes needed to be made	13	1.8	11	1.5
Awaiting Signature The job plan has been signed by the Clinician and or the Clinical Manager but not the final signatory (non-medical manager).	61	8.6	59	8.2
In progress A new job plan has been started in the L2P system	127	17.9	132	8.6
Non-compliant (with legitimate/unavoidable reason)* Reasons include maternity, long term sickness absence, grievance	72	10.2	70	9.7
To be started New job plans to be started in the L2P system	16	2.3	62	8.6
Total	708		722	

*The total for the category "Non-compliant (with legitimate reason)" excludes the number of job plans that are currently being worked through in the system and will not show as officially 'closed' (Non-compliant with legitimate reason).

The status by division is included in further detail as Appendix 2.

There are 13 consultant job plans (2.3%) that are non-compliant for legitimate and unavoidable reasons such as sickness absence and maternity leave.

A further 139 consultant job plans (24.6%) are currently in formal appeals or escalated divisional assurance processes across Anaesthetics, Paediatrics, Trauma & Orthopaedics, and Respiratory.

These delays are primarily linked to out of contract local agreements and issues with recording complex rotas.

If these categories were also included within the compliance calculation, the overall compliance rate would rise to 82.3%.

However, its believed that even with full engagement and timely sign-off from all consultants who are available and who are not affected by appeals or legitimate absence, the organisation cannot exceed 73.1% compliance until the appeals backlog is resolved, and the L2P-related delays are cleared. Therefore, this figure is considered the operational ceiling for compliance at this time.

Deep Dive:

Deep Dives were undertaken with the Divisions in order to achieve the Welsh Government target of 90% compliance. These proved somewhat successful in improving the compliance rate. However, since these were discontinued post the Welsh Government date, the compliance rate has fallen. A new round of Deep Dives is scheduled for January and February 2026 and will continue until compliance is met and is embedded in the Divisions.

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

Challenges:

- Winter pressures – Winter pressures require staff to be available and this has put additional strain on the staff time to complete job planning.
- Formal appeal process – A number of job plans are under discussion as the interpretation of the current consultant's contracts is different for the various individuals and staff groups. This creates inconsistencies within and across staff groups and delay in job plan completion.
- Job plans awaiting signature – this creates backlog.
- Staff tend to not use their SPA time to manage their job planning and other administrative obligations. The reasons for this are varied and complex and include where staff may be requested to work during this allocated session due to staff shortages (and winter pressures) or perhaps they don't consider job planning as a priority and a potential lack of engagement between the staff and the MWES team.

Recovery Actions:

- Deep Dives - A new round of Deep Dives is scheduled for January and February 2026 and will continue until compliance is met and is embedded in the Divisions.
- Ensure that the job plans awaiting sign-off signature are signed-off. This would create an immediate increase in compliance of 8%. The Medical Workforce e-Systems Team will chase job plans awaiting signatures on a monthly basis and will escalate to Divisional Directors if waiting longer than 1 month for signature.

- Where job plans have expired these will be reviewed to determine if these can simply be "rolled over" on a time-limited basis i.e. if the activities have not changed then the job plan can be copied into the new year, requiring minimal input.
- Ensure that staff use their SPA time to manage their job planning obligations (as this is one of the contractual expectations of core SPA sessions).
- Longer term, the job plans will need to be linked to the Health Boards IMTP cycle to ensure that the service needs are met.
- Ensure that the L2P job planning system sends automatic email reminders to clinicians 1 month before their job plans are due to expire and every week for 12 weeks once the job plans has expired.
- Medical Workforce E-Systems teams will showcase job planning data to each directorate, highlighting areas of improvement and identifying where practice may not fully align with contractual agreements. This work commenced in December with Urology and will continue during 2026. By demonstrating the additional benefits of completing job plans and the insights that can be drawn from them, it is anticipated that this will encourage greater compliance across services. During these sessions, the Directorates can share the efficiencies they have identified, in order to capture and share the opportunities throughout the Health Board.

Recommendation

The Committee is asked to receive the report as assurance that the Health Board recognises the challenges it faces and that actions are in place to recover and improve compliance with a target of March 2026.

In addition, it is asked to note that if the sign-off process is completed for those job plans requiring a final signature and the numbers of "non-compliant with legitimate reasons" is included in the total compliance rate then this would immediately provide an increase of 18% which would create an overall compliance rate of 71.6%.

Appendix 1 – Action Plan as at December 2025

ARAC%202026%200
1%20-%20Job%20Pl

Appendix 1: Action Plan Update - Dec 2025

Appendix 2 – Job Planning Data – Division Status

Job Plan Data
Status by Division N

Appendix 3 – Job Plan In-Progress Status Summary by Division as at December 2025

Job Plan In
Progress Status Sum

Appendix 4 – Consultant Job Planning System and procedure training

Training Figures -
Consultants...

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated December 2025

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

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

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
REF IA/25	**1. JOB PLANNING COMPLIANCE**				
R1/A1	1.1	Discuss accountability for progress to achieving 90% compliance in the bi-annual Divisional Performance reviews. Ensuring actions to address the compliance are captured in the Executive summary of these meetings	Immediate & on-going	Chief Operating Officer	Completed December 2025 Job planning compliance is discussed and updated at every monthly divisional assurance meeting. The bi-annual are full Executive attendance chaired by the Chief Executive Officer.
R1/A2	1.2	The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with Medicine.	July 2025	Medical Director Deputy Medical Director (SE)	Completed December 2025 Deep Dives were undertaken with Medicine; Family & Therapies; Mental Health, Urgent Care, Clinical Support Services and Primary Care & Community. Whilst this supported completion by the target date, these are seen as useful and are being established in January and February 2026.

R1/A3	1.3	Vacant consultant posts will not be replaced until the whole team have an up-to-date job plan.	Process in place June 2025 On-going	Finance Director / Director of Workforce & OD	Completed August 2025 This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. The Job planning e-Systems project officer has been added to the authorisation process in trac such that the job planning status of the team can be established before sign off. Where the requirement for the whole team to have an up-to-date job plan has not been met this will be escalated to the MD/DMD Medical for discussion with the DD/GM.
R1/A4	1.4	No positive pay impacting changes will be made unless accompanied by an up-to-date-job plan.	June 2025	Finance Director / Director of Workforce & OD	Completed August 2025 This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. Monthly retrospective reports are being analysed to ensure compliance with the requirements and action will taken if breaches are identified.
R1/A5	1.5	Financial support for study leave will be withheld for consultants who do not have an up-to-date job plan. A process to facilitate this will be developed.	June 2025	Finance Director / Director of Workforce & OD	Completed August 2025 This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7. Monthly retrospective reports are being analysed to ensure compliance with the requirements and action is taken if breaches are identified.
R1/A6	1.6	Accountability arrangements will be strengthened to ensure the Directorate Manager has oversight and is responsible for ensuring job planning takes place within the directorate.	June 2025	Medical Director / Chief Operating Officer	Completed August 2025 This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7.

R1/A7	1.7	A communication will be sent from the Medical Director and Chief Operating Officer to each consultant reminding them of their contractual obligation and specifying the organisational approach to achieving 90% compliance.	May 2025	Medical Director/Chief Operating Officer	Completed August 2025 The Medical Director has sent a letter to all consultants. In addition, the Medical Director, Director of Workforce and Chief Operating Officer have sent a communication jointly to all General Managers and Divisional Director to share with their management team. Both communications explain the organisational approach and the actions that need to be taken to improve compliance. This has been reinforced at the divisional deep dives.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated December 2025

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
	2. QUALITY OF APPROVED JOB PLANS				
R2/A1	2.1	The e-sytems team will work with L2P to establish whether the outcome section can be a mandatory field, preventing sign off until such time as this section is completed.	Dependent on ability of the L2P system and any additional cost, review October 2025	Director of Workforce & OD	Update December 2025 (No change) This requirement was not part of our original contract with L2P however they have agreed in principle to include this in the systems development. The timescales for this are unclear at present due to other priorities. The Medical E systems team will provide updates following their regular meetings with L2P
R2/A2	2.2	The Service outcome section in L2P will be activated once all consultants have an up-to-date job plan on the system and have identified personal job planning outcomes	Review October 2025	Medical Director / Director of Workforce & OD	Update December 2025 (No change) Personal outcomes are based on the individual doctor's needs (career development etc) and the service needs are discussed at the job plan review meeting. The service outcomes in the L2P system can be activated with minimal notice once all consultants have an up-to-date-job plan in preparation for the next round of job planning. Preparatory work will need to be undertaken with divisions and corporate team to identify the outcomes that need to be included in the system.
R2/A3	2.3	A reminder to complete the outcome section with SMART objectives will be included in the communication referred to in action R1/A7, to the consultant and the Directorate Managers.	June 2025	Medical Director / Chief Operating Officer	Completed August 2025 The requirement is included in the job planning training which all consultants have been asked to undertake previously. It has also been included in the communication to all consultants, and management teams referenced in R1/A7.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION PLAN FOR JOB PLANNING – Updated December 2025

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR LOCAL LEAD	STATUS AND MILESTONES
	3. ESR RECONCILIATION				
R3/A1	3.1	The Medical Systems team will work with L2P to establish whether the current alert can be used to provide a reminder that a change form needs to be completed and submitted to pay roll. It may also be possible to add a link to the Change form.	Dependent on ability of the L2P system and any additional cost. Review June 2025	Director of Workforce & OD	Update December 2025 (No change) An alert icon is already available on the L2P system that identifies a sessional change in the job plan. L2P however has agreed in principle to include this request in the systems development. The timescales for this are unclear at present due to other priorities. However, the requirement may vary when SMA is rolled out for medical staff.
R3/A2	3.2	Once all job plans are on the L2P system for a directorate it will be possible for Directorate Managers and BPAs to easily identify job planned session in L2P and compare with ESR. Monthly comparisons for completed job plans will be undertaken within the directorate.	Review June 2025	Chief Operating Officer / Director of Finance	Update December 2025 (No change) Cannot be achieved until 90% compliance with Job planning in the system.
R3/A3	3.3	The reminder to complete change forms to ensure sessions in job plans are paid accurately will be included in the communication to Directorate Managers	June 2025	Chief Operating Officer/Director of Finance	Completed August 2025 This requirement has been included in the communication to all consultants, and management teams referenced in R1/A7.

		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
	4. OPERATIONAL FORUMS				
R4/A1	4.1	The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor.	July 2025	Medical Director Deputy Medieval Director	Completed December 2025 Deep Dives were undertaken with Medicine; Family & Therapies; Mental Health, Urgent Care, Clinical Support Services and Primary Care & Community. Whilst this supported completion by the target date, these are seen as useful and are being established in January and February 2026.
R4/A2	4.2	The terms of reference for the Job Planning Consistency Group will be reviewed and include identification of when to stand down a meeting and what action to take for persistent non-attendance. Good practice and key issues sections will be included in the agenda going forward.	July 2025	Medical Director Deputy Medical Director	Completed August 2025 The Terms of reference have been reviewed and agreed with the Job Planning Consistency Group. The decision to stand down a meeting with be the Deputy Medical Director's based on representation by the relevant clinical leaders. Lack of representation from the divisions is being addressed. Key issue highlighted from the job planning process and good practice sharing have been established as core agenda items.
R4/A3	4.3	The Chief Operating Officer and Divisional Directors will escalate strategic issue highlighted through Performance meetings to the Deputy Medical Director. Operational issues will be dealt with within the division.	July 2025	Chief Operating Officer / Divisional Directors	Completed December 2025 Issues where support is required is escalated, e.g. Anaesthetic dispute – Divisions and Chief Operating Officer are clear on who is accountable for what and understand the escalation process to implement.

R4/A4	4.4	Regular performance reports will be submitted to Performance Oversight Committee section of the Executive Committee.	Bi- Annually	Medical Director / Director of Workforce & OD	Completed August 2025 Job planning performance and compliance will be included in the monthly Workforce Performance report. Next report 18th September.

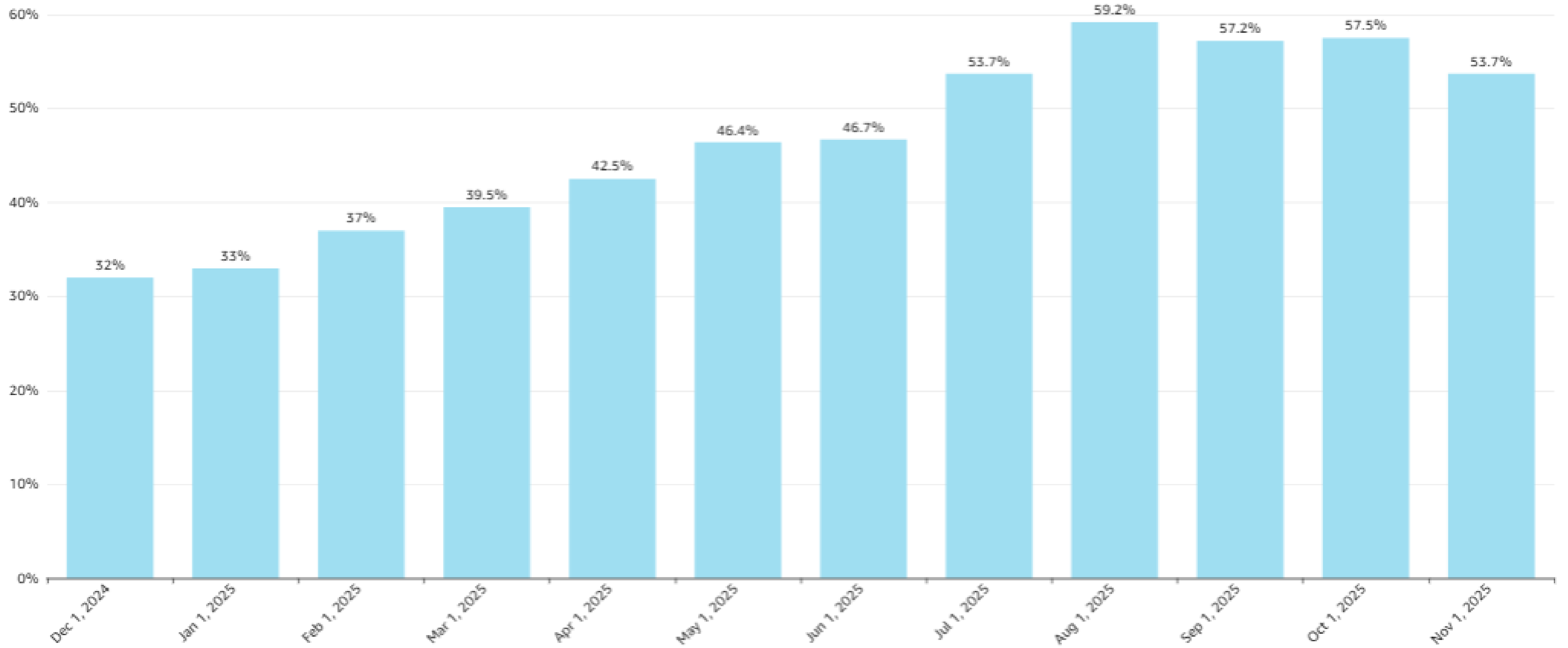
		OBJECTIVES	ACTION REQUIRED BY	RESPONSIBLE DIRECTOR	STATUS AND MILESTONES
	5.RISK REGISTER				
R5/A1	5.1	In discussion with the Director of Corporate Governance the appropriate risk register for job planning compliance to be included in will be identified	June 2025	Medical Director / Chief Operating Officer	<u>Completed August 2025</u> Non compliance with 90% target has been included in the corporate risk register in the workforce & culture section.
R5/A2	5.2	Risk related to compliance will be included in divisional risk registers	June 2025	Chief Operating Officer	<u>Completed December 2025</u> Request has gone out to Divisions to include.

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

L2P

Job Plan Compliance Data Pack November 2025 Aneurin Bevan UHB

Overall Monthly Compliance %



Health Board Job Plan Compliance + Status by Division

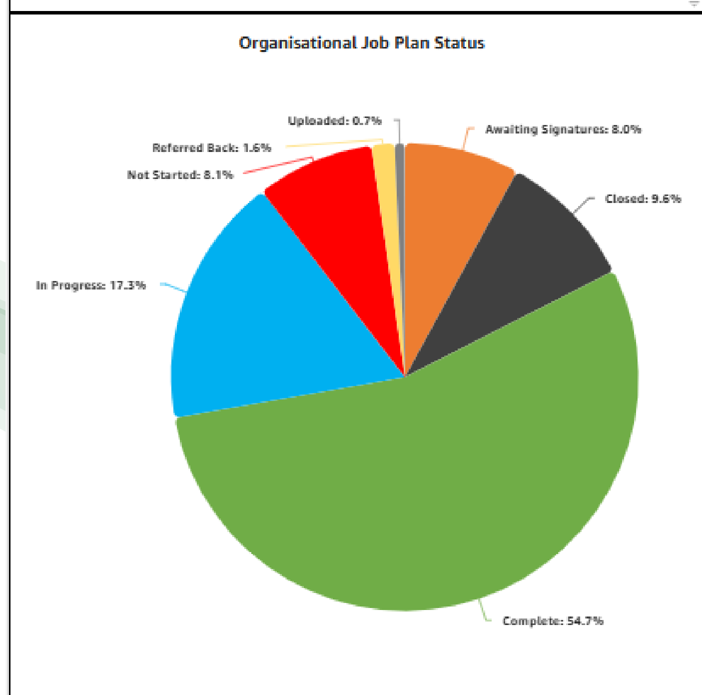
Total count	722
Total job plans completed *(In-date L2P and/or Uploaded)*	388
Total compliance	53.7%
Difference from previous Month	-3.8%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	381	52.8%
	Uploaded	7	1.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	11	1.5%
	Awaiting signature(s)	59	8.2%
	In progress	132	18.3%
	Not started	62	8.6%
	Non-compliant with reason	70	9.7%
	Grand total	722	100%

Consultant : Health Board Job Plan Compliance + Status by Division

Total count	565
Total job plans completed *(In-date L2P and/or Uploaded)*	313
Total compliance	55.4%
Difference from previous Month	-3.2%

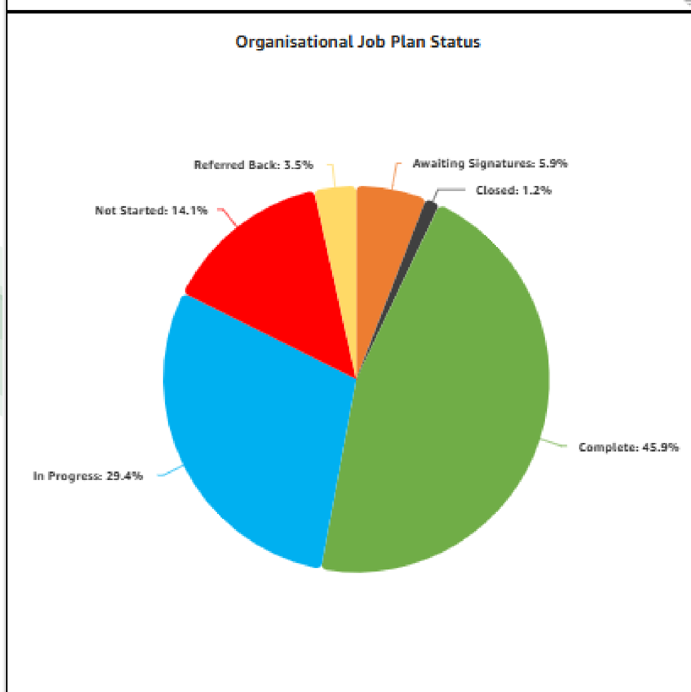


Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	309	54.7%
	Uploaded	4	0.7%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	9	1.6%
	Awaiting signature(s)	45	8.0%
	In progress	98	17.3%
	Not started	46	8.1%
	Non-compliant with reason	54	9.6%
	Grand total	565	100%

Consultant: Job Plan Compliance + Status by Division for **Family & Therapies**

Total count	85
Total job plans completed *(In-date L2P and/or Uploaded)*	39
Total compliance	45.9%
Difference from previous month	0%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	39	45.9%
	Uploaded	0	0.0%

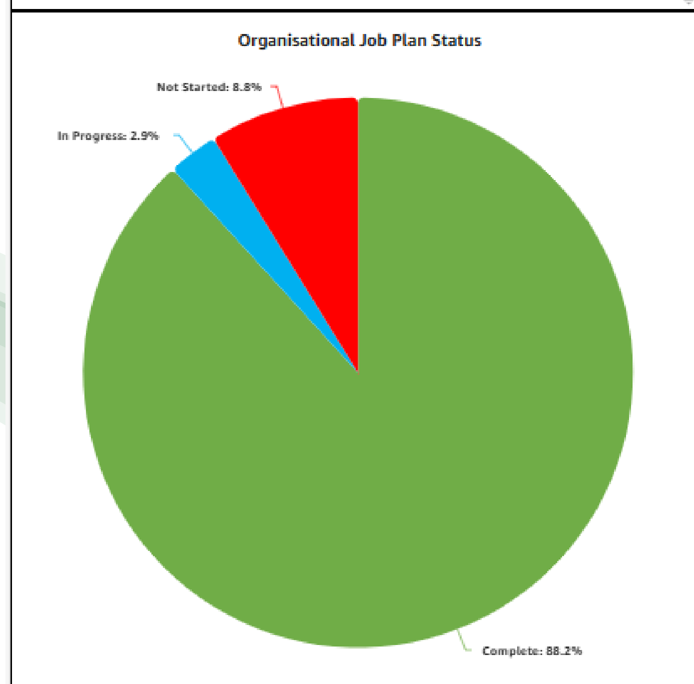
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	3	3.5%
	Awaiting signature(s)	5	5.9%
	In progress	25	29.4%
	Not started	12	14.1%
	Non-compliant with reason	1	1.2%
	Grand total	85	100%

Consultant: Job Plan Compliance + Status by Division for **Family & Therapies**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
CAMHS	10	0	90.9%	0	0	1	0	0
Community Paediatrics	7	0	70.0%	2	0	1	0	0
Neonates	11	0	100.0%	0	0	0	0	0
Obs & Gynae	2	0	8.0%	3	1	7	12	0
Paediatrics	2	0	9.5%	0	2	16	0	1
Sexual Health	7	0	100.0%	0	0	0	0	0
Total	39	0	45.9%	5	3	25	12	1

Consultant: Job Plan Compliance + Status by Division for **Mental Health**

Total count	34
Total job plans completed *(In-date L2P and/or Uploaded)*	30
Total compliance	88.2%
Difference from previous month	+2.9%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	30	88.2%
	Uploaded	0	0.0%

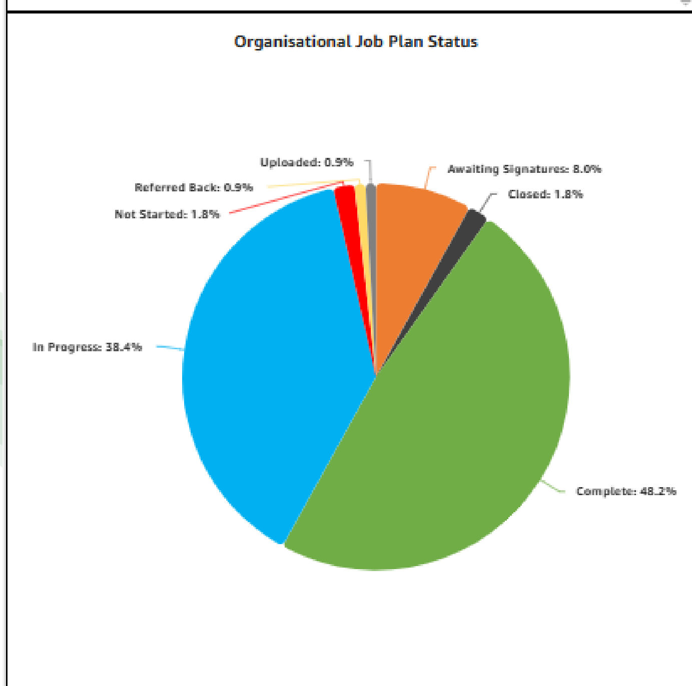
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	0	0.0%
	In progress	1	2.9%
	Not started	3	8.8%
	Non-compliant with reason	0	0.0%
	Grand total	34	100%

Consultant: Job Plan Compliance + Status by Division for **Mental Health**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
General Adult Psychiatry	16	0	94.1%	0	0	1	0	0
Learning Disabilities	5	0	100.0%	0	0	0	0	0
Older Adult	9	0	75.0%	0	0	0	3	0
Total	30	0	88.2%	0	0	1	3	0

Consultant: Job Plan Compliance - Status by Division for Medicine

Total count	112
Total job plans completed *(In-date L2P and/or Uploaded)*	55
Total compliance	49.1%
Difference from previous month	-1.4%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	54	48.2%
	Uploaded	1	0.9%

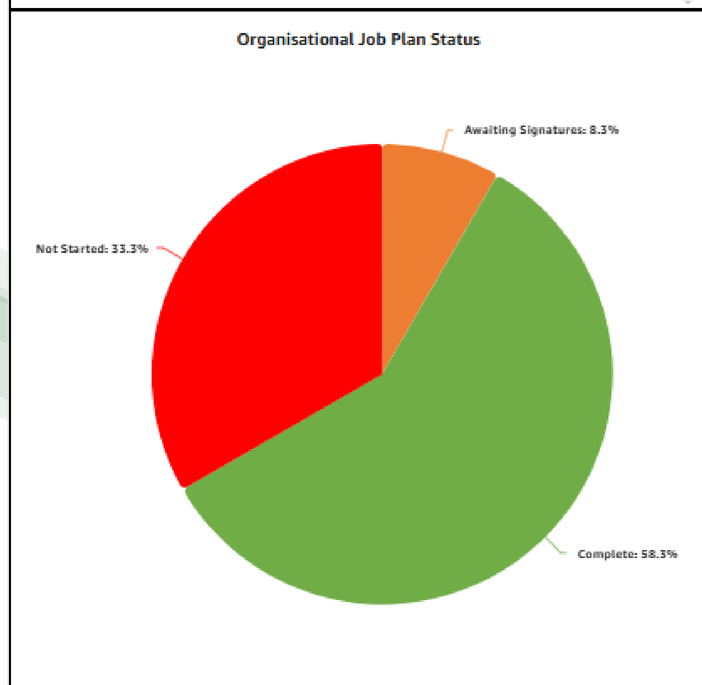
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	1	0.9%
	Awaiting signature(s)	9	8.0%
	In progress	43	38.4%
	Not started	2	1.8%
	Non-compliant with reason	2	1.8%
	Grand total	112	100%

Consultant: Job Plan Compliance + Status by Division for **Medicine**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Acute Medicine	1	0	8.3%	5	0	6	0	0
COTE	13	0	68.4%	2	0	1	2	1
COTE YYF	3	0	42.9%	1	0	2	0	1
Cardiology	7	0	46.7%	0	0	8	0	0
Endocrinology Diabetes	3	1	40.0%	1	0	5	0	0
Gastroenterology	13	0	76.5%	0	0	4	0	0
Nephrology	0	0	0.0%	0	0	1	0	0
Neurology	9	0	81.8%	0	0	2	0	0
Respiratory	0	0	0.0%	0	1	14	0	0
Stroke	5	0	100.0%	0	0	0	0	0
Total	54	1	49.1%	9	1	43	2	2

Consultant: Job Plan Compliance + Status by Division for **Primary Care**

Total count	12
Total job plans completed *(In-date L2P and/or Uploaded)*	7
Total compliance	58.3%
Difference from previous month	-16.7%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	7	58.3%
	Uploaded	0	0.0%

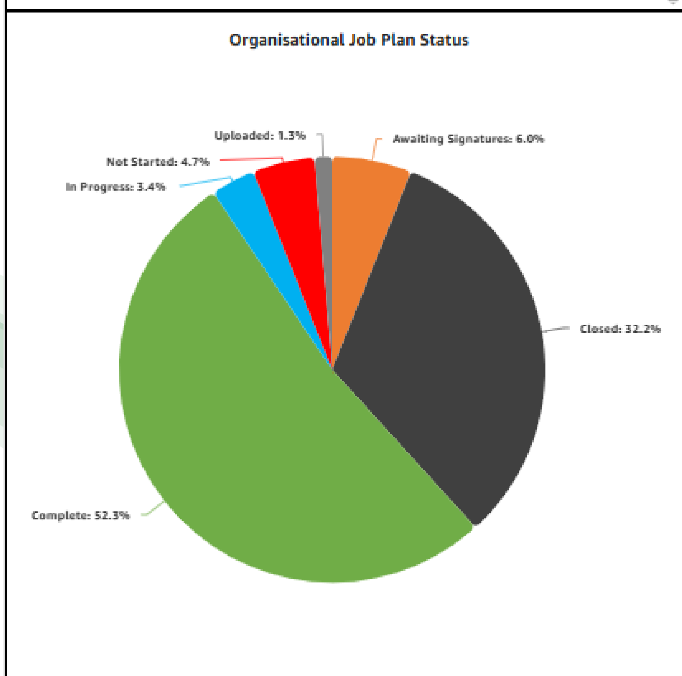
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	1	8.3%
	In progress	0	0.0%
	Not started	4	33.3%
	Non-compliant with reason	0	0.0%
	Grand total	12	100%

Consultant: Job Plan Compliance + Status by Division for **Primary Care**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Dental	2	0	66.7%	0	0	0	1	0
Frailty	1	0	25.0%	1	0	0	2	0
Palliative Care	4	0	80.0%	0	0	0	1	0
Total	7	0	58.3%	1	0	0	4	0

Consultant: Job Plan Compliance + Status by Division for Clinical Support Services

Total count	149
Total job plans completed *(In-date L2P and/or Uploaded)*	80
Total compliance	53.7%
Difference from previous month	-3%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	78	52.3%
	Uploaded	2	1.3%

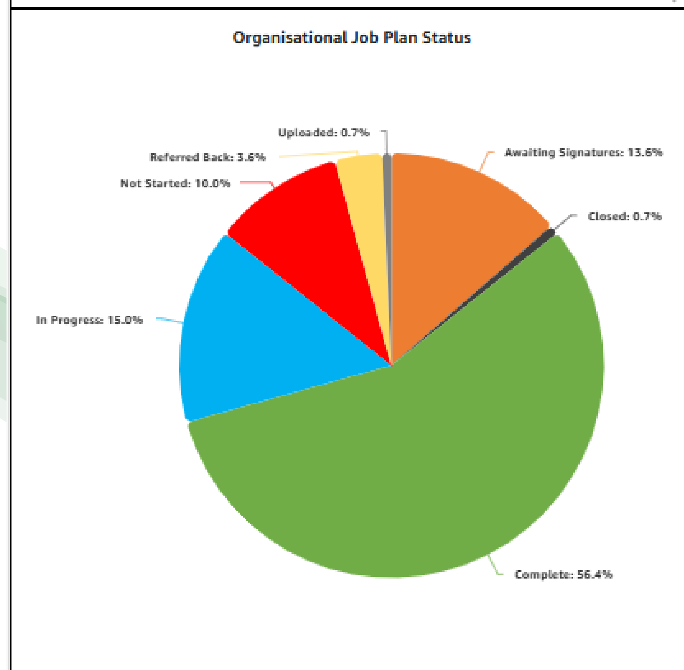
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	9	6.0%
	In progress	5	3.4%
	Not started	7	4.7%
	Non-compliant with reason	48	32.2%
	Grand total	149	100%

Consultant: Job Plan Compliance + Status by Division for **Clinical Support Services**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
PACCT - Anaesthetics	19	1	28.2%	4	0	0	0	47
PACCT - Critical Care	12	0	63.2%	2	0	1	4	0
PACCT - Pain	1	0	50.0%	0	0	0	1	0
Pathology - Cell Path	11	0	84.6%	0	0	2	0	0
Pathology - Chemical	0	0	0.0%	0	0	1	0	0
Pathology - Micro	7	1	88.9%	0	0	0	1	0
Radiology	28	0	82.4%	3	0	1	1	1
Total	78	2	53.7%	9	0	5	7	48

Consultant: Job Plan Compliance + Status by Division for **Surgery**

Total count	140
Total job plans completed *(In-date L2P and/or Uploaded)*	80
Total compliance	57.1%
Difference from previous month	-5.8%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	79	56.4%
	Uploaded	1	0.7%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	5	3.6%
	Awaiting signature(s)	19	13.6%
	In progress	21	15.0%
	Not started	14	10.0%
	Non-compliant with reason	1	0.7%
	Grand total	140	100%

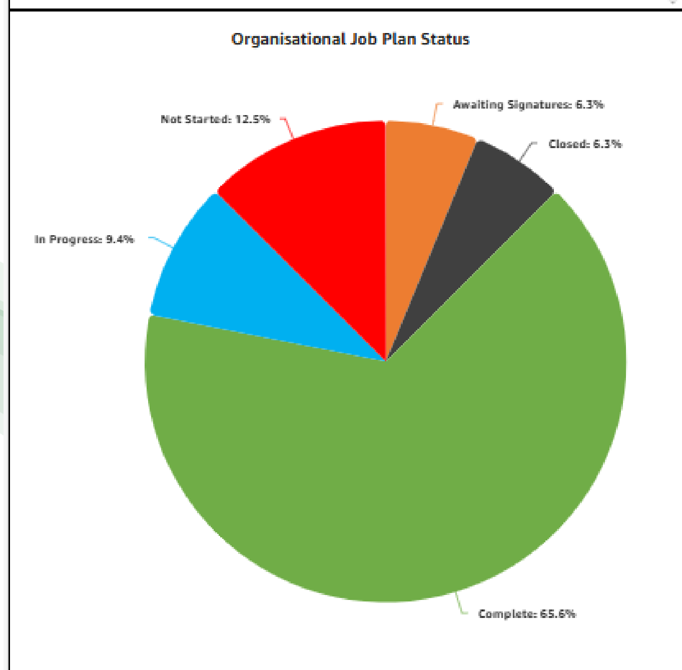
Consultant: Job Plan Compliance + Status by Division for **Surgery**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Dermatology	11	0	84.6%	1	0	1	0	0
ENT	7	0	63.6%	0	0	2	2	0
General Surgery	13	0	41.9%	2	3	8	4	1
Haematology	10	0	83.3%	0	0	1	1	0
Ophthalmology	6	1	53.8%	1	1	1	3	0
Oral & Maxillofacial ...	7	0	77.8%	0	1	0	1	0
Rheumatology	8	0	100.0%	0	0	0	0	0
Trauma & Orthopaedic	13	0	40.6%	14	0	5	0	0
Urology	4	0	36.4%	1	0	3	3	0
Total	79	1	57.1%	19	5	21	14	1

Consultant: Job Plan Compliance + Status by Division for Urgent Care

Total count	32
Total job plans completed *(In-date L2P and/or Uploaded)*	21
Total compliance	65.6%
Difference from previous month	-11.8%

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Emergency Medicine
Compliant Non-compliant



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	21	65.6%
	Uploaded	0	0.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	2	6.3%
	In progress	3	9.4%
	Not started	4	12.5%
	Non-compliant with reason	2	6.3%
	Grand total	32	100%

Consultant: Job Plan Compliance + Status by Division for **Urgent Care**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Emergency Medicine	21	0	65.6%	2	0	3	4	2
Total	21	0	65.6%	2	0	3	4	2

SAS: Health Board Job Plan Compliance + Status by Division

Total count	157
Total job plans completed *(In-date L2P and/or Uploaded)*	75
Total compliance	47.8%
Difference from previous Month	-5.7%

Clinical Support Services
Family and Therapies
Medicine
Mental Health
Primary Care and Communities
Surgery
Urgent Care
Compliant
Non-compliant

Organisational Job Plan Status

Uploaded: 1.9%
Awaiting Signatures: 8.9%
Referred Back: 1.3%
Not Started: 10.2%
Closed: 10.2%
In Progress: 21.7%
Complete: 45.9%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	72	45.9%
	Uploaded	3	1.9%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	2	1.3%
	Awaiting signature(s)	14	8.9%
	In progress	34	21.7%
	Not started	16	10.2%
	Non-compliant with reason	16	10.2%
	Grand total	157	100%

SAS: Job Plan Status + Compliance by Division for **Family & Therapies**

Total count	21
Total job plans completed *(In-date L2P and/or Uploaded)*	9
Total compliance	42.9%
Difference from previous month	0%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	9	42.9%
	Uploaded	0	0.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	2	9.5%
	In progress	5	23.8%
	Not started	5	23.8%
	Non-compliant with reason	0	0.0%
	Grand total	21	100%

SAS: Job Plan Status + Compliance by Division for **Family & Therapies**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Community Paediatrics	0	0	0.0%	0	0	1	0	0
Neonates	4	0	80.0%	0	0	0	1	0
Obs & Gynae	0	0	0.0%	2	0	2	4	0
Paediatrics	0	0	0.0%	0	0	2	0	0
Sexual Health	5	0	100.0%	0	0	0	0	0
Total	9	0	42.9%	2	0	5	5	0

SAS: Job Plan Status + Compliance by Division for **Mental Health**

Total count	16
Total job plans completed *(In-date L2P and/or Uploaded)*	6
Total compliance	37.5%
Difference from previous month	+6.2%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	6	37.5%
	Uploaded	0	0.0%

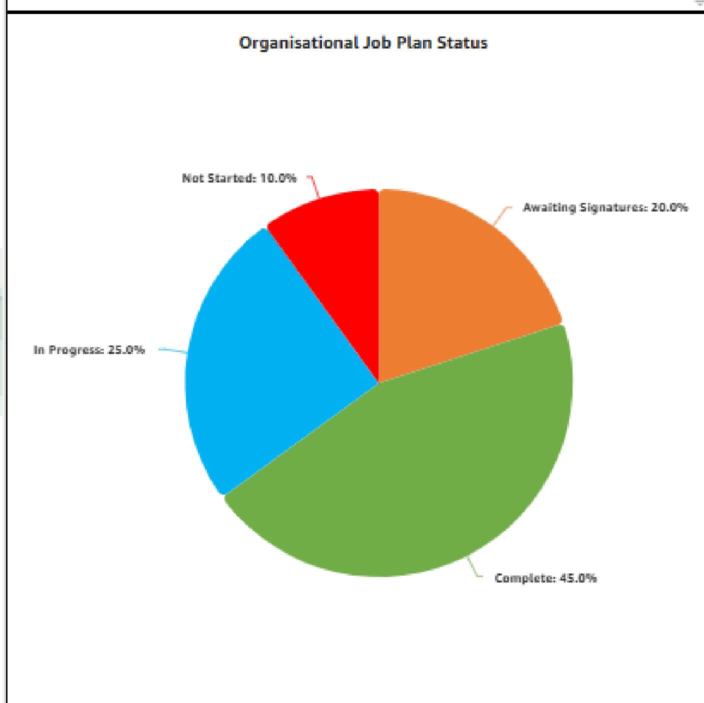
Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	1	6.3%
	Awaiting signature(s)	2	12.5%
	In progress	7	43.8%
	Not started	0	0.0%
	Non-compliant with reason	0	0.0%
	Grand total	16	100%

SAS: Job Plan Status + Compliance by Division for **Mental Health**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
General Adult Psychiatry	4	0	28.6%	2	1	7	0	0
Older Adult	2	0	100.0%	0	0	0	0	0
Total	6	0	37.5%	2	1	7	0	0

SAS: Job Plan Status + Compliance by Division for **Medicine**

Total count	20
Total job plans completed *(In-date L2P and/or Uploaded)*	9
Total compliance	45.0%
Difference from previous month	+10%



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	9	45.0%
	Uploaded	0	0.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	4	20.0%
	In progress	5	25.0%
	Not started	2	10.0%
	Non-compliant with reason	0	0.0%
	Grand total	20	100%

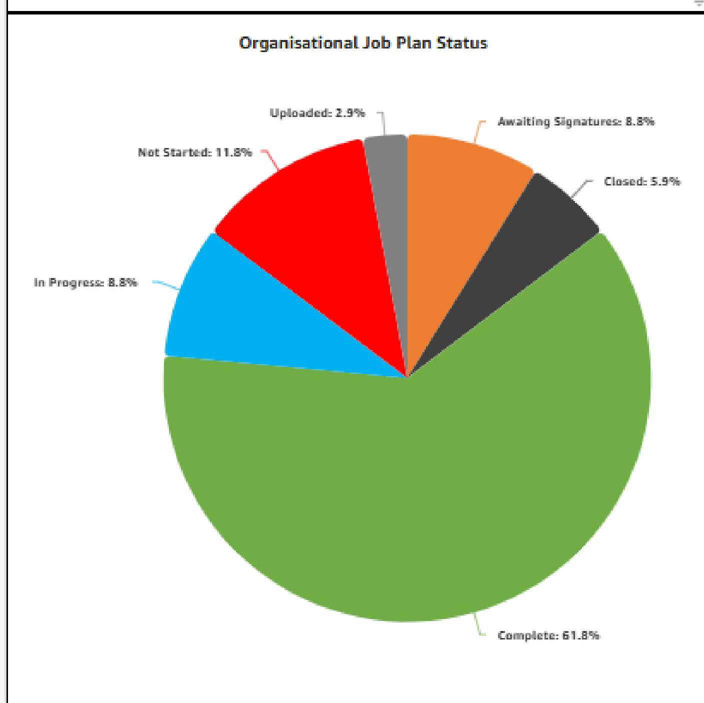
SAS: Job Plan Status + Compliance by Division for **Medicine**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Acute Medicine	0	0	0.0%	1	0	1	0	0
COTE	3	0	42.9%	2	0	2	0	0
COTE North	0	0	0.0%	0	0	1	0	0
COTE YYF	2	0	50.0%	1	0	0	1	0
Endocrinology Diabetes	3	0	100.0%	0	0	0	0	0
Stroke	1	0	33.3%	0	0	1	1	0
Total	9	0	45.0%	4	0	5	2	0

SAS: Job Plan Status + Compliance by Division for **Primary Care**

Total count	34
Total job plans completed *(In-date L2P and/or Uploaded)*	22
Total compliance	64.7%
Difference from previous month	-14.7%

Community COTE
Frailty
Palliative Care
Compliant
Non-compliant



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	21	61.8%
	Uploaded	1	2.9%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	3	8.8%
	In progress	3	8.8%
	Not started	4	11.8%
	Non-compliant with reason	2	5.9%
	Grand total	34	100%

SAS: Job Plan Status + Compliance by Division for **Primary Care**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Community COTE	10	0	62.5%	2	0	1	2	1
Frailty	8	0	80.0%	0	0	0	2	0
Palliative Care	3	1	50.0%	1	0	2	0	1
Total	21	1	64.7%	3	0	3	4	2

SAS: Job Plan Status + Compliance by Division for **Clinical Support Services**

Total count	20
Total job plans completed *(In-date L2P and/or Uploaded)*	7
Total compliance	35.0%
Difference from previous month	0%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	7	35.0%
	Uploaded	0	0.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	0	0.0%
	In progress	0	0.0%
	Not started	0	0.0%
	Non-compliant with reason	13	65.0%
	Grand total	20	100%

SAS: Job Plan Status + Compliance by Division for **Clinical Support Services**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
PACCT - Anaesthetics	3	0	18.8%	0	0	0	0	13
PACCT - Pain	1	0	100.0%	0	0	0	0	0
Pathology - Chemical	1	0	100.0%	0	0	0	0	0
Pathology - Micro	1	0	100.0%	0	0	0	0	0
Radiology	1	0	100.0%	0	0	0	0	0
Total	7	0	35.0%	0	0	0	0	13

SAS: Job Plan Status + Compliance by Division for Surgery

Total count	41
Total job plans completed *(In-date L2P and/or Uploaded)*	20
Total compliance	48.8%
Difference from previous month	-14.6%

Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	18	43.9%
	Uploaded	2	4.9%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	1	2.4%
	Awaiting signature(s)	3	7.3%
	In progress	12	29.3%
	Not started	4	9.8%
	Non-compliant with reason	1	2.4%
	Grand total	41	100%

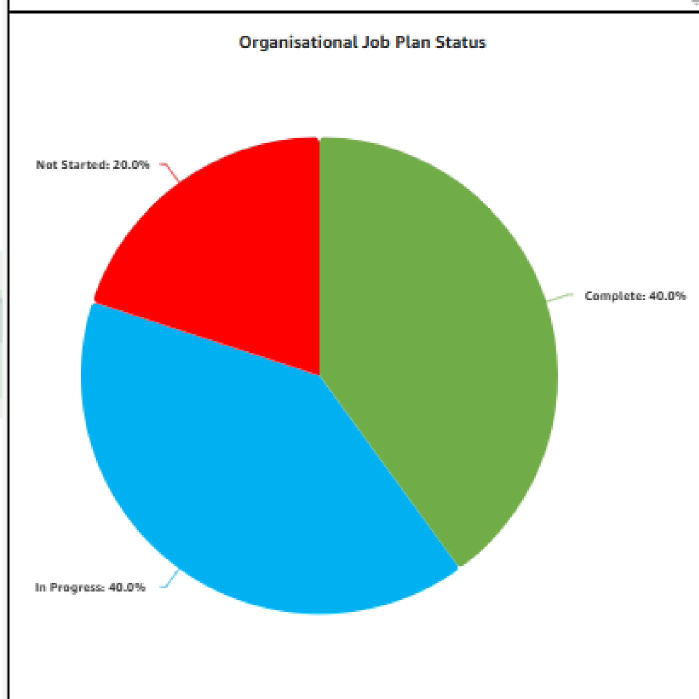
SAS: Job Plan Status + Compliance by Division for **Surgery**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Dermatology	3	0	33.3%	1	0	1	3	1
ENT	3	0	100.0%	0	0	0	0	0
General Surgery	5	0	71.4%	0	0	1	1	0
Haematology	1	0	50.0%	1	0	0	0	0
Ophthalmology	1	2	60.0%	0	1	1	0	0
Oral & Maxillofacial ...	5	0	83.3%	0	0	1	0	0
Trauma & Orthopaedic	0	0	0.0%	1	0	8	0	0
Total	18	2	48.8%	3	1	12	4	1

SAS: Job Plan Status + Compliance by Division for Urgent Care

Total count	5
Total job plans completed *(In-date L2P and/or Uploaded)*	2
Total compliance	40.0%
Difference from previous month	-20%

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Emergency Medicine
Compliant
Non-compliant



Category	JPs in category	Number of JPs in category	% of total
Compliant Job Plans	Complete	2	40.0%
	Uploaded	0	0.0%

Category	JPs in category	Number of JPs in category	% of total
Non-compliant Job Plans	Referred back	0	0.0%
	Awaiting signature(s)	0	0.0%
	In progress	2	40.0%
	Not started	1	20.0%
	Non-compliant with reason	0	0.0%
	Grand total	5	100%

SAS: Job Plan Status + Compliance by Division for **Urgent Care**

Division	Complete	Uploaded	Compliance	Awaiting Signature	Referred back	In progress	Not Started	Non-compliant with reason
Emergency Medicine	2	0	40.0%	0	0	2	1	0
Total	2	0	40.0%	0	0	2	1	0

Job Plan 'In Progress' by Division/Directorate Status Summary

Division/Directorate	02/12/2025	03/11/2025	02/10/2025	01/09/2025	05/08/2025	04/07/2025	05/06/2025	02/05/2025	05/04/2025	05/03/2025	05/02/2025	05/01/2025	05/12/2024	05/11/2024	05/10/2024	Job Plan Status as at 10/09/02024
Family & Therapies																
Obs and Gynae	Job plans for consultants are due to be completed by end of December. Consultant Locum Vacancy approved on this basis. SAS job plans will be completed after.	Action with directorate to complete job plans	Action with directorate to complete job plans	Action with directorate to complete job plans expiring in September. Directorate has advised this is unachievable.	If 2 job plans awaiting signatures are signed they would have achived 90% compliance, action with directorate to organise job plan meetings ready for 20 job plans expiring in September	2 Consultants remaining to sign thier job plans from 2024. Job plans are now expiring, action with directorate to complete.	2 Consultants remaining to sign thier job plans from 2024. Job plans continue to be completed as they expire.	Same as previous month	3 consultants remaining to sign their job plans from 2024.	5 job plans are remaining to be signed by clinicians since October 24. This has improved from last month since GM has chased sign off.	Job plans have been completed and ready to be signed by clinicians since October 24. 12 job plans are still waiting to be signed.	Job plans have been completed and ready to be signed by clinicians since October 24. 15 job plans are still waiting to be signed. 18 have been signed and completed since October.	6 further job plans have been signed and completed.	3 Job plans have been signed and completed. Directorate manager has chased clinicians to sign off job plans.	A few amendments have needed to be made within the job plans by the directorate, this may delay the signing of job plans by 1 week.	Admin staff in the directorate have been inputting the data of the job plans agreed into the L2P with help from the MWES team, which are now finalised. DM will be notifying the Dr's the job plans are ready to be agreeded and asking them to sign these in the system by 4th Oct 2024
Paediatrics	Same as previous month, however MWES team are starting to add the data into the job plans in readiness for agreement.	Admin tariff's have been agreed for 6 months. No job plans can be undertaking until this and the OOH rate is resolved.	Issues regarding admin time will be addressed this month in job planning consistency group. No job plans can be undertaking until this and the OOH rate is resolved.	Issues with regards to OOH rate and admin time raised in the deep dive meeting. Papers are being submitted for the agreement before job planning can commence. 90% compliance by end of Sept	Deep dive meeting to be held on 12/08/2025 where directorate will be raising issues for discussion and advise with regards to consistency.	A few issues with job calculations and historic agreements have been escalated to DD. Meeting arranged 04/07/2025 with CD to create a job plan template to ensure all calulations are	Some amendments were made to clinics and admin times in job plans, action with directorate to complete job plans.	2 job plans completed this month. There has been a new CD appointed and a meeting will be arranged to discuss job plan completion along with training.	MWES met with CD and DM and agreed on job plan content. MWES have been working on applying the content to all other consultant job plans. CD has agreed and signed their job	MWES team have a meeting with CD and DM on 12/03/2025 to discuss job plans entered and progress with job plan meetings	MWES team have entered the data of the majority of the activites into the job plan, they will be ready this month to pass to the directorate to finalise.	MWES team are working with rostering to input job plans as per rotas.	No change on previous month	MWES team are working with rostering to input job plans as per rotas.	Meeting set up with CD, DM, MWES & L2P on 4th October to query a few calculation differences that were highighted in the meeting held on 30/09/2024. Once these have been	Action with CD to approve master job plan template for Directorate. On approval job plan meetings can be scheduled in diaries and job plans completed. Meeting arranged with CD to answer some queries on 30/09/2024
Community Paediatrics	Same as previous month.	Admin tariff's have been agreed for 6 months. Action with directorate to complete job plans.	Issues regarding admin time will be addressed this months consistency group	Action with directorate to complete job plans.	Action with directorate to complete job plans.	2 job plans awaiting signatures, one from October 2024 and the other from May 2025. Action with directorate to complete job plans.	Same as previous month	Job plans are being undertaken.	3 job plans awaiting DM's signature. Spoke to DM on 12/03/2025 who advised there were some queries that she needed to deal with before signing the job plans.	Further communitcation sent to CD and DM with no response as yet. Also chased those awaiting signatories, still no reponse as yet.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Action with directorate to schedule job plan meetings and complete job plans within the eSystem.	No change on previous month	No change from previous month	No change from previous mor	Action with directorate to schedule job plan meetings in diaries and complete job plans.
Neonates	Same as previous month	100% Compliant for consultant. Action with direcotorate to complete SAS job plans.	100% Compliant for consultants	100% Compliant for consultants	100% Compliance for consultants has been achieved	90.9% Compliance with consultants has been achieved. Action with directorate to complete remaining Consultant and SAS Dr job plans.	Job plans are being undertaken.	7 Job plans have been completed. At least 3 more job plans should be completed this month.	7 Job plan meetings have being held and 5 job plans are awaiting signatures.	MWES team spoke with CD on 17/02/2025 who advised no meetings were booked in yet but would ensure job plans are completed by May 25.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. CD has responded and meeting date is being	Team Job planning meeting held with SAS Dr's 21/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	Team Job planning meeting held with SAS Dr's 21/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	Team Job planning meeting held with consultants 04/11/2024 - No issues/concerns to delay job planning. Action with CD & DM to complete job plans.	No change from previous mor	Team job planning sessions arranged for 04/11/2024 (consultants) 21/11/2024 (SAS) - Job plan meetings will be held after this date.
Sexual Health	100% Compliant for SAS job plans. 1 consultant job plan awaiting DM signature.	100% Compliant for consultant. Action with directorate to complete SAS job plans.	100% Compliant for consultants	100% Compliant for consultants	100% Compliant for consultants	100% Compliance has been achieved.	Only 1 job plan remaining to be signed by Leanne Watkins	1 of the 4 job plans have been completed.	No longer 100% compliant as job plans have expired. 4 job plan meetings need to be arranged.	100% compliant, 1 job plan coming out of complaince on 1st April that now need to be scheduled.	4 job plans remaining to be compelted, CD is working on getting these resolved ASAP.	3 Job plans remaining to complete to achieve 100% compliance.	No change on previous month	No change from previous month	No change from previous mor	CD competent on L2P system. Action is with directorate to schedule job plan meetings and complete job plans.
CAMHS	1 x Locum Consultant job plan to complete	100% Compliant for consultant. Action with directorate to complete 1 SAS job plan.	100% Compliant for consultants	3 Job Plans still awaiting signatures. Action with directorate to complete all job plans.	3 Job plans now awaiting signatures for consultants.	No change from previous month.	4 Job plans awaiting signatures to significantly improve compliance	4 Job plans awaiting signatures - 1 job plan meeting to be arranged.	Meeting to be held on 10/04/2025 with CD for more training on the system.	Meeting held on 06/02/2025 with CD and GM. Went through remaining job plans and actions were agreed for each one. Some actions have resulted in more completed job plans, some are actions	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 06/02/2025.	Job plans have been completed in the eSystem, some since spring 2024 and are still awaiting clinician and manager sign off. MWES team have chased on multiple occations.	There is a hold on one job plan while the Core and OOH's are amended. No success in progressing signatures for the other job plans.	MWES team have been assisting CD chase signatures on outstanding job plans. However job plan meetings still need to be arranged for some job plans.	No change from previous mor	Directorate competent on L2P system. Action is with CD to schedule job plan meetings in diaries and complete job plans.
Mental Health																
General Adult Psychiatry	Action with directorate to complete job plans	Action with directorate to complete job plans	Action with directorate to complete job plans	1 Consultant job plan to be completed to reach 90% compliant next month.	1 x consultant vacancy being held until consultant job plans are complete. Action with directorate to complete remaining job plans.	5 Job plans are awaiting signatures, action with directorate to complete remaining job plans.	Same as previous month	Although no contact has been made with directorate, 5 job plans are awaiting signatures	No change from previous months	MWES team have had unsuccessful attempts of communication with directorate.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	5 Job plans are completed in the eSystem. 6 job plans are awaiting sign off. Action with directorate to complete remaining job plans.	No change from previous month	No change from previous month	No change from previous mor	DM competent on L2P system. Action is with CD to arrange job plan meetings in diaries and complete job plans.
Learning Disabilities	100% Compliant	100% Compliant	100% Compliance for consultants	100% Compliance for consultants has been achieved	Action with directorate to complete 1 remaining job plan.	1 Job plan awaiting signatures, action with directorate to complete remaining 2 job plans.	3 job plans have now expired and need to be completed.	100% compliant in April although 3 Job plan meetings need to be arranged for May.	1 job plan still needs to be completed.	MWES team continue to chase 2 remaining job plans, one job plan has now changed to awaiting signatures.	2 Job plans to complete, 1 job plan meeting is booked for February.	1 Job plan to be completed to achieve 100% compliance.	No change from previous month	1 Job plan now outstanding.	No Action required from this Directorate, 100% compliant.	No Action required from this Directorate, 100% compliant.
Older Adult Psychiatry	Action with directorate to complete expired job plans.	100% Compliant for SAS Dr's. Action with directorate to complete 1 consultant job plan.	91.7% compliant with consultants	97.7% compliant with consultants	91.7% Consultant compliance achieved	1 Job plans meeting needs to be arranged, 2 job plans need to be agreed after meetings were held.	4 Job plan meetings need to be arranged.	2 Job plan meetings need to be arranged.	1 Job plan needs to be completed this month. 1 job plan due to expire in May.	Directorate has achieved 100% compliance. 1 job plan coming out of complaince on 1st April that now needs to be scheduled.	Directorate has achieved 92% compliance with consultant job planning.	3 Job plans to be completed to achieve 100% compliance.	Have made good progress, only 5 job plans left to complete.	CD has 3 job plan meetings booked in November.	4th Oct 24 New CD attended managers training. Meeting also held to discuss progress of job plans. Meeting dates have been provided to MWES team who will enter these on the system. 5 job plans have	Directorate competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Medicine																
Acute Med	6 x Job Plans awaiting CD's signature.	Action with directorate to complete job plans	Action with directorate to complete job plans, MWES will assist with chasing signatures.	Job plan content has been added to the job plan with the detail we need for the roster. Action with directorate to continue job plan completion in line with the agreed monthly	1x consultant vacancy being held until consultant job plans are complete. Medicine Deep Dive held 22/07/2025 - Action - Maintain regular bi weekly meetings with the Workforce and Organisational	No change from previous month.	Regular meetings have taken place with DM this month, Action with directorate to provide clinic detail to be added into the job plans.	2 Job plans awaiting signatures and 4 job plan meetings need to be arranged.	No improvements seen in March.	CD and DM have been in touch with MWES team and have made a small improvement this month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	MWES team have been assisting directorate with amending job plans ready for sign off. Action with directorate to complete and sign 7 remaining job plans.	MWES team have been assisting directorate with amending job plans ready for sign off.	MWES team have been in touch with CD and DM and progress is being made to complete job plans. Some job plan meetings have been held, but the job plans are waiting for signatures by all	2nd Oct 24 a meeting was scheduled with DM to discuss job plan progress, meeting cancelled due to service pressures. Directorate competent on L2P system. Action with directorate to	Directorate competent on L2P system. Action with directorate to schedule job plan meetings and complete job plans.
Cardiology	Same as previous month.	Action with directorate to complete job plans. Some job plans remain outstanding for several years.	Action with directorate to complete job plans.	Continue progressing with job plan completion in alignment with the monthly trajectory to ensure full compliance by the end of September.	Medicine Deep Dive held 22/07/2025 - Action - Continue progressing with job plan completion in alignment with the monthly trajectory to ensure full compliance by the end of	3 further job plans have been completed this month.	2 job plans completed this month	No progress on 6 job plans ready for sign off.	6 job plans are ready for sign off and should be completed in April	MWES team have given access to Business support manager in the area who will help with the job plan data in the system.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Directorate have had a team meeting to agree job plan template and can start individual job plans.	Directorate have had a team meeting to agree job plan template and can start individual job plans.	No change from previous month	No change from previous mor	CD and DM competent on L2P system. Action is with directorate to complete job plans.
COTE	Action with directorate to complete job plans. Some job plans are awaiting signature from CD for several months.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Maintain progress with job planning in accordance with the monthly trajectory to achieve full compliance by the end of September.	2 x consultant vacancies being held until consultant job plans are completed. Medicine Deep Dive held 22/07/2025 - Action - Rhys Monk to arrange for Natalie Brooks to attend meetings	5 job plans are awaiting signaatures, meeting held with the DM and CD to assist in completing job plans, action with directorate to complete job plans.	4 Job plans awaiting signatures, meeting arranged with DM to work through some issues but meeting was cancelled by DM. MWES had a meeting with CD to resolve some on-call queries for SAS	2 Job plans awaiting signatures and 4 job plans entered onto L2P by the MWES team for sign off.	CD did not attend scheduled meeting. No reponse with regards to re-scheduling meeting. DM advised no meeting was required however no progress being made.	Meeting set up with CD and ADM for 20/03/2025	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	4 Job plans have been signed by consultants and are still awaiting CD's sign off. Action is with directorate to complete job planning.	3 Job plans have been signed by consultants and are now awaiting CD's sign off.	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	4th Oct 24 DM has requested help from MWES team to add 11 job plans onto the system, this will be completed by MWES team by 11th Oct 24. Job plans will be expected to be signed after this date	DM competent on L2P system. Action is with directorate to schedule job plan meetings in diaries and complete job plans.
COTE YYF	Action with directorate to complete remaining job plans.	100% for SAS Dr's. Action with directorate to complete consultant job plans.	Action with directorate to complete job plans.	Continue with job plan completion in line with the monthly trajectory to ensure compliance by the end of September	Medicine Deep Dive held 22/07/2025 - Action - Continue with job plan completion in line with the monthly trajectory to ensure compliance by the end of September	Same as previous month	Action with directorate to complete job plans	MWES team have provided further training for DM who is working on completing job plans.	Same as previous months	Same as previous month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	2 Job plans have been signed by clincians and are still awaiting CD's sign off. Action is with directorate to complete job planning.	2 Job plans have been signed by clincians and are awaiting CD's sign off.	No change from previous month	No change from previous mor	DM competent on L2P system. Action is with directorate to schedule job plan meetings in diaries and complete job plans.
Endo Diabetes	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Sustain regular Monday meetings with the MWES team and ensure job plan completion remains on track with the monthly trajectory to meet the September compliance	Medicine Deep Dive held 22/07/2025 - Action - Sustain regular Monday meetings with the MWES team and ensure job plan completion remains on track with the monthly trajectory to meet	2 job plans awaiting signatures, MWES team are in regular contact with CD to assist with completing job plans.	1 Job plan completed this month. Regular weekly meeting being held with CD to help input job plans on the system ready for meetings to be held.	1 Job plan meeting was held in April. Meeting to be arranged with MWES, DM&CD to help add content into the system.	MWES team met with CD and ADM, MWES have offered assistance on entering job plans onto the system and will also join job plan meetings at the end to assist the CD with entering	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required changed to 02/04/2025.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 12/03/2025. Awaiting confirmation of this date	MWES team have worked with directorate to enter activites for one clinician. Action with MWES team to amend this job plan. Action with directorate to complete job planning for the rest of	MWES team have worked with directorate to enter activites for one clinician. Directorate are to set up a follow up meeting to discuss the final version before sign off.	No change from previous month	No change from previous mor	Action is currently with directorate to schedule job plan meetings in diaries and complete job plans. Further assistance may be required from MWES team.
Gastro	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Continue completing job plans in accordance with the monthly trajectory to ensure full compliance by the end of September.	Medicine Deep Dive held 22/07/2025 - Action - Continue completing job plans in accordance with the monthly trajectory to ensure full compliance by the end of September.	Meeting being held 04/07/2025 to make final adjustment to job plans	Follow up meeting to be held on 11/06/2025 with directorate to finalise job plans ready for meetings to be held.	On-call has now been confirmed, MWES team working with directorate to add this into job plans, meeting arranged for 09/05/2025 to finalise	No change from previous month.	CD needs to confirm on-call arrangements before job plan meetings can be held. Workforce colleagues are assiting the direcorate with on-call issues.	CD needs to confirm on-call arrangements before job plan meetings can be held. Meeting is being held by the directorate to discuss this on 11/02/2025.	Action with directorate to con	No update from previous mor	Meeting had with Assistant DM's and all job plans were added to the system with help from MWES team. CD needs to confirm on-call arrangements before job plan meetings can be held.	Meeting due to be held on 9th Oct 24 with CD & DM to receive an update on job planning progress.	Directorate competent on L2P system. Action with CD to review and agree job plan template for the directorate. Once agreed MWES team will support directorate to input job plans on L2P.
Neurology	Action with directorate to complete 2 remaining job plans.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline.	Medicine Deep Dive held 22/07/2025 - Action - Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline.	3 Job plans complete, action with directorate to complete remaining job plans.	2 Job plans awaiting signatures.	1 further job plan complete due to it being needed for NCIA application.	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	1 Job plan has been signed and completed. Action with directorate to complete job planning.	1 Job plan has been signed and completed.	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	No change from previous mor	DM competent on L2P system. On Call template shared with Consultants for agreement. Job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
Nephrology	Action with directorate to complete job plan.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Same as previous month	Same as previous month	Same as previous month	Same as previous month	No progress with the job plan this month. Job plan now 3 years out of compliance	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	Action with directorate to complete job planning.	No change from previous month	No change from previous month	DM confirmed the job plan is with service manager for approval w/c 7th October	DM competent on L2P system. Action with Directorate to schedule job plan meeting and complete job plan.
Respiratory	Same as previous month.	MWES team are working to build rota patterns for priority activities which will help complete job plans consistently.	MWES held meeting with CD and DM, follow up meetings have been arranged to discuss and agree how job plans will be entered in line with job plan procedure.	Meeting being held 05/09/2025 with MWES team and Directorate management to ensure job plans are recorded accurately on L2P. 90% compliance by the end of Sept will not be achieved.	Medicine Deep Dive held 22/07/2025 - Action - Keri Russell to arrange a meeting with the new Clinical Director and the MWES team to agree on a method for integrating job plans into the L2P system.	Meeting being arranged with management to discuss entering job plan onto L2P.	Same as previous month	Escalated concerns with DD with regards to job plans potentially being recorded incorrectly.	Same as previous month	Same as previous month.	Meeting required with MWES team, DD, CD and DM to discuss how job plans should be entered onto e-system.	1 job plan complete. Action with directorate to complete job planning.	No change from previous month	No change from previous month	No change from previous mor	DD confirmed L2P system can record directorates way of working correctly as the CD expressed concerns. Action with CD to contact MWES team to discuss correct input of data into the L2P system.
Stroke	Action with directorate to complete job plans.	100% compliant for SAS Dr's. Action with directorate to complete consultant job plans.	Action with directorate to complete job plans.	Continue working toward job plan completion in line with the monthly trajectory to meet the September compliance deadline.	Medicine Deep Dive held 22/07/2025 - Action - Phillip Campbell to support resolution of job plans exceeding 14 sessions to facilitate agreement and sign-off.	2 Job plans complete, action with directorate to complete remaining job plans.	Same as previous month	No progress made with job plans this month.	DM has returned, no progress with job plan this month.	Directorate has confirmed who will be supporting in DM's absense. No response on meeting requested as yet.	DM not in work, MWES are have contacted Division to enquire who is covering in their absence. No response as yet.	2 Job plans have been signed and completed. Action with directorate to complete job planning.	2 Job plans have been signed a	MWES Team have added some job plans on the system for the directorate. MWES team have also chased for consultants to sign the job plans.	No change from previous mor	DM competent on L2P system. Action with directorate to schedule job plan meetings in diaries and to complete job plans.
Primary Care and Community																
Community COTE	Action with directorate to complete remaining job plans.	Same as previous month	No consultants in this area, only 2 remaining job plans to complete.	No consultants in this area, only 2 remaining job plans to complete.	No consultants in this area, only 2 remaining job plans to complete.	Only 3 job plans remaining to be completed.	Same as previous month	Same as previous month	Job plan meetings have been and are being held over the next few months. Improvements should be seen in April.	1 further job plan was completed. There are 3 job plans expiring next month that need to be scheduled.	Action with directorate to complete remaining 5 job plans. 4 Job plan meetings due to be held in February.	Action with directorate to complete remaining 6 job plans.	No update from previous mor	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	DM competent on L2P system. Action with directorate to complete remaining job plans.
Dental	Action with directorate to complete 1 expired job plan.	100% Compliant	100% Compliant for consultants	100% Compliance for consultants has been achieved	100% Compliance has been achieved	1 job plan awaiting signatures	Same as previous month	1 Job plan remaining to complete.	Same as previous month.	Same as previous month.	Action with directorate to complete 2 remaining job plans.	Action with directorate to con	No update from previous mor	Training session held with CD, DM and consultants. Directorate will commence job planning	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	CD & DM need to complete L2P training.
Frailty	Action with directorate to complete 1 expired job plan.	100% Compliant	100% Compliant for consultants	100% Compliance for consultants has been achieved	Action with directorate to complete remaining job plans	3 job plans to be completed, meetings have been arranged for July.	2 out of the 3 job plans were completed from previous month.	3 Job Plan meeting due to take place in May	4 job plans completed. Some due to come out of compliance shortly.	4 job plans awaiting signatures. MWES team have chased these.	Action with directorate to complete 6 remaining job plans.	Action with directorate to complete 8 remaining job plans.	5 Job plans remaining to comp	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	DM competent on L2P system. Action with directorate and to complete remaining job plans.
Palliative Care	Action with directorate to complete expired job plans. 2 x JP's awaiting CD's signature for several weeks.	100% Compliant for consultants. Action to complete 1 outstanding SAS job plan.	100% Compliant for consultants	100% Compliance for consultants has been achieved	Action with directorate to complete remaining job plans	2 job plans awaiting signatures and 2 job plans awaiting agreement following meetings in June.	Same as previous month	Action with directorate to complete remaining job plans	MWES team have met with CD to resolve some queries with job plans. 2 job plans signed by CD and are awaiting others sign off.	Job plan's are ready for sign off. Directorate are aware and chasing.	Action with directorate to complete 2 remaining job plans.	Action with directorate to complete 4 remaining job plans.	5 Job plans remaining to comp	Meeting was cancelled and is to be re-arranged.	Meeting to be held with DD, CD's, DM's and Workforce to disuss job plan completion 16th Oct 24	All clinicians 100% complete on L2P training. Directorate competent on L2P system. Action with directorate to complete remaining job plans.
Clinical Support Services																
PACCT - Anesthetics	Same as previous month.	Same as previous month	Some job plans are being progressed, however due to ongoing disputes, most job plans continue to be delayed.	6 Job plans awaiting signature that are able to be completed. 90% consultant compliance will not be achieved due to ongoing issues in directorate.	3 job plans have been entered by MWES team and are awaiting sign off	3 job plans have been entered by MWES team and are awaiting sign off	Same as previous month	Same as previous month	Some job plans are being progressed, however due to ongoing disputes, most job plans will be delayed.	A further 7 job plans were sent to MWES to input into the system and are ready for sign off.	12 paper job plans sent to MWES team from the directorate for the data to be input onto the L2P system. CD has signed these within the e-system and some are awaiting clinician signature.	A range of job planning queries were submitted to the MWES team. Stephen Edwards responded to these queries and directorate advised they would be commencing job planning in	Email addressing queries sent by Stephen Edwards. Job planning is to be commenced in the new year.	No change from previous month	No change from previous mor	Group training being progressed with MWES team, 46% of clinicians have completed L2P training. A number of queries were raised from the directorate and the MWES team e.g. Agreed local sessional rates for activities, concerns with L2P not recording job plans
PACCT - Critical Care	100% compliant SAS Dr's. Action with directorate to complete expired consultant job plans.	100% compliant SAS Dr's. Action with directorate to complete 3 job plans.	Same as previous month	Action for directorate to complete remaining job plans	1 Consultant vacancy being held until consultant job plans are completed. Action for directorate to complete remaining job plans.	Job plans are being undertaken.	Job plans are being undertaken.	Job plans are being undertaken.	MWES team met with the new CD to offer training and assistance, they are comptent on the system and will start job planning those outstanding.	Same as previous month.	MWES team have requested a meeting with the directorate to gain an update on 'in progress' job plans and offer support where required. No response as yet.	Action with directorate to complete remaining 8 job plans.	No change from previous month	No change from previous month	No change from previous mor	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
PACCT - Pain	Same as previous month.	Action with directorate to complete 1 job plan.	Same as previous month	1 Job Plan remaining to be completed to achieve compliance.	Same as previous month	Same as previous month	Same as previous month	ADD will pick up the outstanding job plan whilst CD is on leave.	CD is on A/L. MWES team will pick up on their return.	CD is on A/L. MWES team will pick up on their return.	CD is on A/L. MWES team will pick up on their return.	Action with directorate to complete 2 job plans.	No change from previous month	No change from previous month	No change from previous mor	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Pathology	Action with directorate to complete expired job plans.	Action with directorate to complete 2 SAS and 1 consultant job plans.	90.48% compliant for consultant job plans	2 consultant job plans remaining to be completed to achieve compliance by end of Sept.	Action with directorate to complete remaining job plans	Same as previous month	Same as previous month	Progress continued to be made in this directorate and they are engaged with the process. Some disputes still ongoing.	MWES team met with CD and AGM who are attempting to resolve a dispute with a job plan, MWES also assisted with changing deal on job plans were responsibilites have changes. Progress	CD and DM have been in touch with MWES team and job plans are ready to be signed.	Cell path specialty are 100% compliant. Job plan meetings are being held during February for the remaining specilities.	Cell path specialty are 100% compliant. Action with directorate to complete Micro and Chemical speciality.	1 Job plan has been signed and completed in Micro.	Pathology - Cellpath is 100% completed - the CD and DM are working on Micro next.	CD has been in touch with MWES for assistance with queries. CD advised all job plans are to be completed in October 24	CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Radiology	Action with directorate to complete expired job plans.	100% compliant for SAS Dr's, action with directorate to complete consultant job plans.	Action with directorate to complete job plans.	3 Job plans awaiting signatures. Action with directorate to complete remaining consultant job plans to achieve compliance by end of Sept.	Action with directorate to complete remaining job plans	6 job plans are awaiting sign off.	Same as previous month	3 Job plans are awaiting signature	1 out of the 7 job plans has been completed.	Action with directorate to complete remaining 7 job plans.	Action with directorate to complete remaining 6 job plans.	Action with directorate to complete remaining 11 job plans.	MWES team worked with directorate to tidy up multiple job plans within the system. 4 job plans awaiting final signature from the DM.	No change from previous month	No change from previous month	Directorate competent on L2P system. Action with directorate to complete the remaining job plans.
Surgery																
Dermatology	Action with directorate to complete expired job plans.	Action with directorate to complete 1 job plan.	92.3% compliant for consultant job plans	92.3% compliant for consultant job plans	92.3% compliant for consultant job plans	92.3% Compliance has been achieved for consultants. 1 remaining job plan to be completed.	Only 2 remaining job plans to be complete	4 Job plans to be progressed in May.	Same as previous month.	Action with directorate to complete remaining 5 job plans. 1 job plan due to expire on 1st April and needs to be scheduled.	Action with directorate to complete the remaining 7 job plans. MWES team had a meeting with DM who is working their way through the job plans and contacts us regulary if help is required.	Action with directorate to complete the remaining 12 job plans.	No change from previous month	No change from previous month	No change from previous mor	Directorate competent on L2P system. Action with directorate to complete the remaining job plans.
ENT	Action with directorate to complete expired job plans.	100% compliant for SAS Dr's. Action with directorate to complete 5 consultant job plans.	Action with directorate to complete job plans.	2 remaining consultant job plans to complete to achieve compliance by end of Sept.	Action with directorate to complete remaining job plans.	Action with directorate to complete remaining job plans.	4 Job plans awaiting signature	Good progress being made. 3 job plans complete and 5 job plans awaiting signatures	Same as previous month.	6 job plan meetings have been held this year, but none have been signed/completed. MWES are in contact with directorate to chase completion.	5 job plan meetings being held in February.	Action with directorate to commence job planning.	MWES team have been assisting directorate amend job plan content. Action with directorate to commence job planning.	No change from previous month	No change from previous mor	Directorate competent on L2P system. On Call template shared with Consultants for agreement. Once agreed job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
General Surgery	Action with directorate to complete job plans, some have been expired for over 12 months.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	MWES team attended 2 drop in sessions where 4 job plans were completed.	6 job plans awaiting signature, MWES drop in session arranged with this dorectorate	7 Job plans awaiting CD or DM signature	All templates have been alloacted in job plans. MWES team attending directorate meeting to do further training on L2P system with clinicians.	MWES team worked on allocating all on-call templates in job plans and have been answering regular queries from the directorate. Progress should be seen in April.	MWES team met with CD 27/02/2025 and has offered help with allocating on-call into the job from the rota. This should hopfully speed up the process of completion of job plans.	MWES team have a meeting arranged with the directorate to gain an update on 'in progress' job plans and offer support where required on 07/02/2025.	Action with directorate to complete the remaining job plans.	Action with directorate to complete the remaining job plans.	Action with directorate to complete the remaining job plans.	MWES team attending directorate meeting on 9th Oct 24 to deliver a group training session	Action is with new CD to attend training with MWES team and to complete remaining job plans.
Haematology	Action with directorate to complete expired job plans. 1 x job plan not agreed since meeting 3 months ago.	100% compliant for SAS Dr's. Action with directorate to complete 2 consultant job plans.	Action with directorate to complete job plans.	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	90.9% Compliance achieved with consultants	Only 3 job plans remaining to be completed	Same as previous month	Some job plans are currently trying to be resolved in the directorate and has been escalated to the DD for assitance in resolving.	Action with directorate to complete 4 remaining job plans.	5 Job plans left to complete.	Action with directorate to complete the remaining job plans.	No change from previous month	No change from previous month	No change from previous mor	DM & CD competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
Opthalmology	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	4 Job plans awaiting signatures, action with directorate to complete remaining job plans.	Action with directorate to complete job plans	Action with directorate to complete remaining 6 job plans	Action with directorate to complete remaining 6 job plans as one job plan had to be reffered back for amendments.	Action with directorate to complete 5 remaining job plans	5 job plans are complete. 4 job plans awaiting signatures.	3 Job plans have been signed and completed. Action with directorate to complete remaining job plans.	2 Job plans have been signed and completed.	No change from previous month	4th Oct 24 Meeting with DM arranged who advised they are undertaking a job plan meeting per week until compliance is reached.	Job planning principles team session undertaken 10/09/24. Directorate will progress job plans after session and further assistance may be required from MWES team.
Oral Surgery	Action with directorate to complete job plans. CD's job plan has not been agreed since 2019.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Action with directorate to complete remaining job plans.	Action with directorate to complete remaining job plans.	7 Job plans still awaiting signature from previous month	4 Job plans have been completed and 7 job plans awaiting signatures.	3 job plans awaiting signatures, 5 job plan meetings held in March.	No change from previous month	2 Job plans are awaiting signatures, 4 job plan meeting are to be held in February.	Action with directorate to commence job planning.	Action with L2P to change Core and OHH's as per directorates request.	No change from previous month	No change from previous mor	Job plan template added to L2P for Directorate. Action with directorate to schedule job plan meetings in diaries and complete job plans
Rheumatology	100% Compliant job plans	100% Compliant job plans	100% Compliant job plans	100% Compliant job plans	100% Compliance has been achieved	Only 2 job plans remaining to be completed	Only 3 job plans remaining to be completed	Same as previous month	Action with directorate to book meetings for job plans due to expire over the next month.	2 job plans remaining to be compelted. 2 job plan expiring in April that need to be scheduled.	3 Job plans remaining to be completed. Directorate advised they are having difficulty with agreeing these job plan with the clinicians, they will escalate if needed.	Action with directorate to complete the remaining 3 job plans.	3 Job plans left to complete.	No change from previous month	No change from previous mor	DM & CD is competent on L2P system. Action with directorate to schedule job plan meetings in diaries and complete job plans.
T&O	Issues continue to be worked through before job plans can be completed.	Issues continue to be worked through before job plans can be completed.	Issues raised following meeting last month, these are to be worked through before job plans can be completed.	Meeting to be held to discuss job plan content.	2 x consultant vacancies being held. Some job plans awaiting Stephen Edwards signature, Stephen has requested call with CD to discuss before approving.	Issues were escalated that may take time to resolve, however some job plans are being completed.	1 Job plan completed this month. Issues have been escalated and meeting to be held with DD 11/06/2025.	4 job plans are awaiting signatures	DM has signed 4 job plans and they are awaiting others signatures.	AGM advised 21 job plans are ready for signing and all SAS Dr's have a date in the diary for March for completion.	MWES team have inputted all job plan data into the system. Action with directorate to finalise job plans.	MWES team are assisting directorate to input the data of the job plans and rota into the system. Action is with directorate to book job plan meetings and check the details of the e-job plans to	Mutiple meetings with DM had this month. MWES team are entering the content of the job plan and on-call rota patterns in the system. This needs to be completed and agreed before job plans can	Meeting to be set up with DM to assist with inputting job plans to L2P. - Awaiting suitable times from directorate	No change from previous mor	Action is with directorate to schedule meeting with MWES team to discuss on call allocation of job plan template.
Urology	MWES team met with CD and DM to present job plan insight data. Directorate will be working on JP's in Dec/Jan with suggested improvements/queries to job plans.	Job plans that have expired need to be completed.	Job plans that have expired need to be completed.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	100% Compliant.	Action with directorate to complete remaining 2 job plans.	2 Job plans left to complete.	Job plan meeting are being held by the directorate and 2 job plans completed so far.	DM raised concerns that clincians in the area have concerns with the job plan process. DM requested we meet with the clinicians with the DD to answer any concerns they have. Action	CD & DM competent on L2P system. On Call template shared with Consultants for agreement. Once agreed job plan meetings can be scheduled in diaries and job plans completed. Action with Directorate.
Urgent Care																
Emergency Medicine	Action with directorate to complete job plans. 1 JP has not been agreed since 2019.	Action with directorate to complete job plans.	Action with directorate to complete job plans.	Action with directorate to ensure consultant job plans are compliant by the end of Sept.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate continue to complete job plans.	Directorate have made significant improvement in compliance and are continuing to complete job plans.	Action with directorate to complete remaining job plans.	4 Job plans awaiting CD sign off. 3 Job plans signed and completed.	08/10/2024 meeting held with MWES team, CD & DM and an agreed way to record job plans was agreed and 9 job plans were added to be submitted from the system. DM has chased clinicians to sign these job	3rd Oct 24 MWES team received 8 paper job plans from DM. MWES team have added 2 of those job plans onto the system in an annualised format. Action with diretorate to arrange	Action with directorate to arrange follow up meeting with MWES team to input job plan template on L2P. Protected time in diary is required by Directorate, once date confirmed.

Division	Total to be trained on System	Percentage Trained or Signed Job Plan	Percentage Trained	Percentage sign job plan without training
General Surgery	32	69	47	22
Dermatology	14	100	64	36
ENT	11	73	27	45
Haematology	12	92	33	58
Opthalmology	14	79	29	50
Oral & Max	9	78	0	78
Rheumatology	8	100	50	50
T&O	32	84	44	41
Urology	12	92	58	33
DD & GM	2	100	100	0
Surgery	146	**83**	**42**	**40**
CAMHS	12	92	67	25
Neonates	12	100	42	58
Obs & Gynae	25	100	44	56
Paediatrics	31	81	71	10
Sexual Health	7	100	86	14
DD & GM	2	100	50	50
Family & Therapies	89	**92**	**61**	**31**
Acute Medicine	14	64	29	36
Cardiology	15	60	13	47
COTE	29	72	7	66
Diabetes	10	70	40	30
Gastro	18	100	78	22
Nephrology	1	0	0	0
Neurology	11	82	27	55
Stroke	5	100	40	60
Respiratory	16	31	31	0
DD & GM	2	50	0	50
Medicine	121	**69**	**31**	**39**
PACCT	92	68	46	23
Pathology	23	74	22	52
Radiology	35	89	29	60
DD & GM	2	100	100	0
Clinical Support Services	152	**74**	**39**	**36**
General Adult Psychiatry	19	89	21	68
Learning Disability	7	100	71	29
Older Adult MH	13	100	69	31
DD & GM	2	0	0	0
Mental Health & LD	41	**90**	**44**	**46**
Emergency Department (ED)	32	88	28	59
DD & GM	2	0	0	0
Urgent Care	34	**82**	**26**	**56**
Palliative Care	6	100	100	0
Frailty	5	100	40	60
Dental	4	100	100	0
Community COTE	2	100	100	0
DD & GM	2	50	50	0
Primary & Community Care	19	90	75	15
Total	**602**	**80**	**42**	**38**

Division	Percentage Trained
General Surgery	9
Dermatology	14
ENT	10
Haematology	36
Opthalmology	8
Oral & Maxfax	22
Rheumatology	38
T&O	12
Urology	27
Surgery	**16**
CAMHS	33
Neonates	42
Obs & Gynae	17
Paediatrics	55
Sexual Health	75
Family & Therapies	**40**
Acute Medicine	0
Cardiology	15
COTE	7
Diabetes	0
Gastro	22
Nephrology	0
Neurology	50
Stroke	17
Respiratory	25
Medicine	**15**
Pathology	5
PACCT	27
Radiology	34
Clinical Support Services	**25**
General Adult Psychiatry	11
Learning Disability	86
Older Adult	57
Mental Health & LD	**39**
Emergency Department (ED)	25
Urgent Care	**23**
Palliative Care	67
Frailty	0
Dental	50
Community COTE	0
Primary & Community Care	**29**
Total	**24**

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 January 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Discharge Planning Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Nursing
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 purpose of this report is to provide the Audit, Risk and Assurance Committee with clear and comprehensive assurance that the Health Board has delivered demonstrable and sustained improvements in discharge planning, and that the work underway will continue to strengthen and embed these improvements going forward.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Discharge planning has been a longstanding area of focus for the Health Board due to its direct impact on patient flow, safety, and patient experience. It has therefore been subject to regular scrutiny through internal and external audit reviews.

Whilst operational oversight of discharge planning sits with the Patient Quality, Safety and Outcomes Committee the Audit, Risk and Assurance Committee has a clear responsibility to seek assurance that audit recommendations are being effectively implemented and that identified risks are being addressed.

Across several audit cycles, discharge planning has received limited assurance ratings with a number of high-priority recommendations remaining partially complete for an extended period. When monitored solely through the routine audit recommendation tracker, the Committee found it difficult to form a clear and comprehensive understanding of progress. Updates provided in that format appeared fragmented, making it challenging to assess whether the Health Board

had sufficient grip on the broader discharge improvement agenda or to judge the system-wide impact of the actions underway.

As a result, the Committee requested a single, cohesive assurance report to provide an overarching view of performance improvement, delivery against audit recommendations, and the wider programme of work to strengthen discharge planning.

The purpose of this report is therefore to present a full picture of the current position, demonstrating the progress that has already been achieved and the targeted actions that remain in progress.

Cefndir / Background

The Clinical Futures Strategy introduced a modern, consultant-led acute care model for the Health Board, centred around the opening of the Specialist and Critical Care Centre at the Grange University Hospital (GUH). Under this model, the Royal Gwent Hospital and Nevill Hall Hospital were repurposed, alongside the Health Board's other hospital sites, into Enhanced Local General Hospitals (eLGHs). This reconfiguration was designed to optimise clinical pathways and ensure that patients receive the right level of care, in the right setting, first time.

A key feature of the Clinical Futures model is its reliance on timely discharge and effective partnership working, ensuring that acute bed capacity remains responsive to emergency and unscheduled care demand. Historically, prolonged length of stay and delays in discharge have resulted in patients remaining in acute hospital beds despite being medically optimised, increasing risks such as deconditioning and delayed recovery.

In response, the Health Board has established a comprehensive improvement programme, delivered closely with Local Authority partners, to support safe, efficient, and person-centred discharge. This programme is aligned with Welsh Government's Six Goals for Urgent and Emergency Care, particularly Goals 5 and 6, which emphasise a "home first" approach and strong collaboration across health and social care to enable timely transition from hospital to home or community settings.

The programme has also been informed by internal and external audit recommendations, which emphasised improvements in documentation, consistency of discharge processes, communication across clinical teams, and access to community pathway information. Improvements such as Clinical Workstation 2 (CWS2), renewed discharge guidance, digital dashboards and the Ask Annie platform, enhanced Discharge Lounge utilisation, and Hospital to Home support have been designed to strengthen discharge planning and reduce preventable delays in a sustainable way.

Asesiad / Assessment

While the operational and policy environment continues to evolve, which can give the impression that initiatives are shifting or not yet fully embedded, the evidence shows that the Health Board has strong control and oversight of discharge

planning. Tangible improvements are being delivered, and further work is actively underway to enhance and sustain safe and timely discharge going forward.

There is strong evidence of sustained performance improvement as a result of the actions taken. Discharge performance metrics show that length of stay following emergency admission has reduced to 11.9 days, reflecting continued improvement throughout 2025. The proportion of patients discharged within seven days has continued on an upward trajectory since 2023, reaching over 83% in October 2025, helping reduce deconditioning risk and improve patient experience. There has also been a significant year-on-year fall in the number of patients experiencing prolonged hospital stays, with occupied beds over 21 days reducing to around 520, consistently below previous year levels. Weekend discharge levels remain steady at 17% of total discharges, demonstrating a good foundation to build seven-day services from.

In addition, data from Pathways of Care Delays shows that both the number of delayed patients and days delayed have reduced markedly compared with the same period in 2024, almost a third fewer patients delayed, and days delayed almost halved, with a joint record low achieved in July 2025.

Hospital to Home continues to expand its reach, supporting 294 patients back into the community over the last 12 months and proving critical during performance escalation earlier this year. **Appendix A** contains data providing a detailed overview of improvements.

Alongside this measurable impact, internal and external audit recommendations have progressed significantly. Actions relating to digital communication of discharge tools, improved documentation, and discharge policy alignment with national guidance have been fully completed. Where recommendations remain partially complete, including the workforce shift required for seven-day discharge, the final roll out of standardised discharge notifications, and consistent access to community assessment information, evidence confirms that work is well advanced and embedded activity is already demonstrating benefit.

Most importantly, there is no suggestion that actions have stalled or regressed. In many cases, the Health Board’s responses have gone beyond the narrow scope of original audit findings, for example, digitalisation of discharge processes not only supports timeliness and documentation but also ensures that General Practitioners receive the necessary information on the same day, a step that exceeds the original audit intent.

The improvement programme has also attracted national recognition. The introduction of a weekly multidisciplinary scrutiny panel in April 2025 has been highlighted as best practice by NHS Wales Performance and Improvement, with a demonstrable reduction in the length of stay for the longest-waiting patients, falling from 207 to between 150-168 days for this cohort, confirming the value of targeted, collaborative case management.

Investment in the Optimal Hospital Flow Framework and the GUH Transfer Lounge have further supported system-wide flow, with lounge throughput increasing to more than 140 patients per week, peaking at 178 admissions per week in October 2025.

Audit reviews stated that the pace of change and breadth of initiatives can make it appear that existing work is incomplete. However, this reflects the reality of a continuously maturing discharge model rather than a failure to implement improvements. Transformation at this scale requires both initial delivery and ongoing cultural and operational reinforcement.

Taken together, the available evidence demonstrates that the Health Board is making strong progress, with discharge arrangements showing material improvement compared to the position identified in earlier audits. A detailed analysis of the live recommendations on the Tracker is provided in **Appendix B**, and these updates have been incorporated into the Audit Tracker report for approval.

At the December meeting of the Audit, Risk and Assurance Committee, three recommendations required an extension to their implementation dates. These are set out in **Appendix C**. While the Committee did not formally approve the extensions at that meeting, it requested that they be included in this report for further discussion and consideration.

Looking ahead, the Health Board will continue to strengthen organisational learning from discharge processes and ensure that lessons identified translate into operational improvement. This includes the introduction of a consistent method for capturing patient and carer feedback specifically related to discharge, enabling responsive changes based on lived experience.

Remaining audit actions will be fully embedded through defined implementation milestones: final standardisation of discharge notification processes will be completed and audited within the coming quarter; improved staff access to community pathway information will be delivered through continued enhancement of digital tools; and a structured workforce review with Local Authorities will determine the actions required to realise sustainable seven-day discharge. These combined efforts ensure that improvement remains continuous and data-driven, embedded within quality governance, and aligned with national strategic expectations.

The Audit Committee can therefore be assured that discharge planning is not only improving but is governed within a culture committed to ongoing learning, accountability, and delivery, evidenced by, performance indicators confirming earlier discharge, reduced long length of stay, fewer patients delayed, and an increasingly effective partnership approach all of which are directly linked to the discharge planning improvements and actions arising from audit recommendations.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to:

- Take assurance that the Health Board has delivered demonstrable and sustained improvements in discharge planning and to
- Approve the revised implementation dates for three audit recommendations.

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):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

Discharge Performance Data October 2025

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GIG CYMRU NHS WALES

Dyfodol Clinigol Clinical Futures

Discharge Summary

Provider Length of Stay (Emergency Admissions):

- Average provider length of stay from emergency admissions of 11.9 days
- This measure has seen a marked reduction since the start of the year

<7d LoS Discharge Performance:

- Continuous upward trend in emergency admission discharges with length of stay less than 7 days since April 2023
- October 25 value of 83.2%

Weekend Discharge Performance:

- Weekend discharge performance has remained consistent since April 2023, accounting for an average of 17% of total discharges per week.

Occupied Beds >21days LoS:

- The number of occupied beds with a length of stay more than 21 days has seen a slight increase in recent months, an expected seasonal trend, with values consistently around 500-520.
- The values from October 2025 also show a year-on-year reduction compared to 2024.

POCDs (September Census):

- Number of patients delayed down by almost a third on September last year
    - Consistent reduction in patients delayed since December 2024
    - Record low of 154 achieved in July 2025
- Number of days delayed down by almost half on September last year
    - Consistent reduction in days delayed since December 2024
    - Record low of 4694 achieved in July 2025

Hospital to Home Discharges:

- Steady increase month-on-month for patient discharges enabled through the Hospital to Home scheme, which is now starting to stabilise at ~20 patients per month
- 294 patients helped by the scheme in the past 12 months
- The scheme was integral in supporting the Health Board in the de-escalating of the declared critical incident on the 13th of January 2025 – demonstrated by the exceptionally high discharge rate of 45 patients that month.

Discharge Summary

Longest Staying Patients / Scrutiny Panel
Lowest mean average LoS of 150 days achieved in early August, still well below starting position in April
100s of Bed Days saved by achieving more timely discharge of patients, in addition to closely monitoring patient outcomes against Balancing Rights and Responsibilities
Will continue to be monitored through Winter

Optimal Hospital Flow Framework (OHFF)
RGH Community

- Weekly Patient discharges home target of 16 has been met nearly universally since OHFF introduced (and still 15 when missed). Three weeks of 20+ discharges home
- POCDs on ward have reduced May 2025 (28) to only 17 in August. Days delayed at the same time have reduced from 755 days to 469 days.

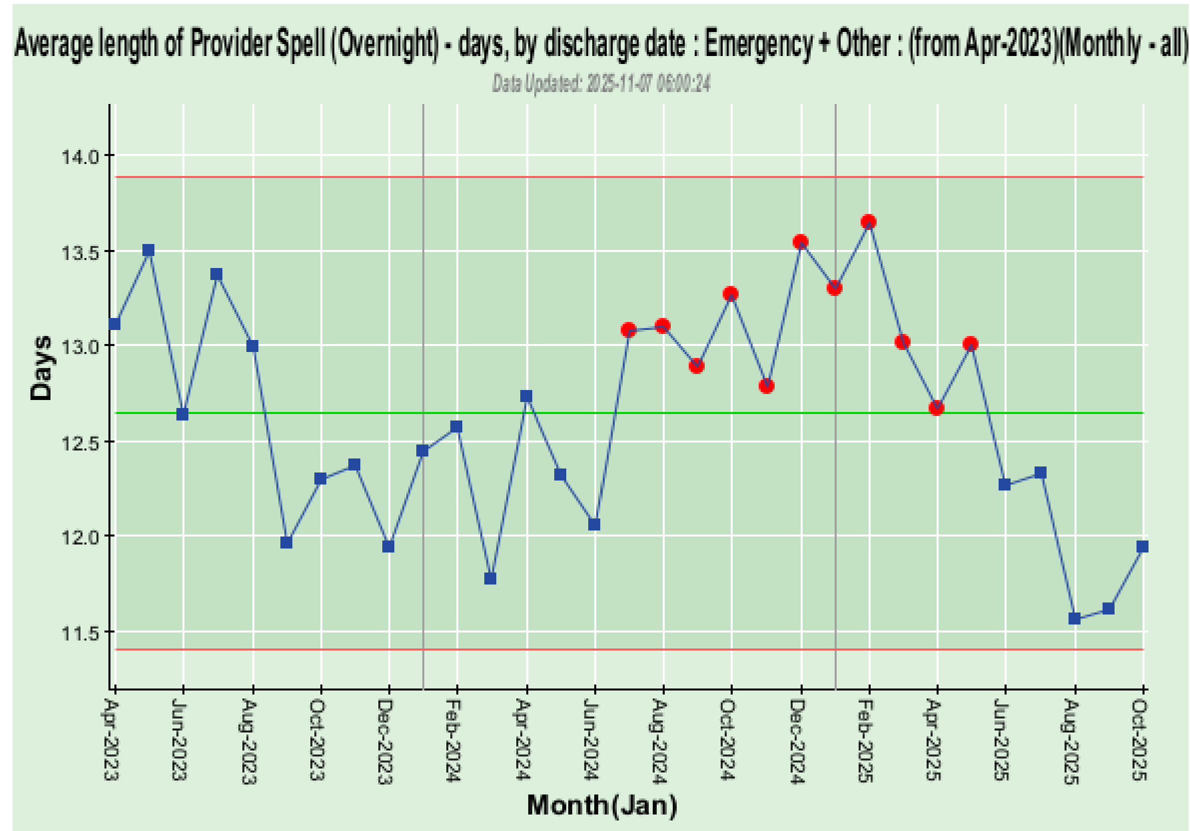
RGH D5W

- Mon-Fri Patient discharges home target of 13 has been met twice since OHFF introduced (and still at least 10 when missed). Was more like 6-10 weekly previously.
- POCDs on ward have maintained around 5. However, days delayed have reduced from 172 days to 34 days. Average delay reduced to a week from 6 weeks.

Transfer Lounge

- Consistent flow of patients through the Transfer Lounge weekly
- Recent all time record of 170 patients in one week supported
- Based on Average Length of Stay in the lounge, this has freed up 447 hours of time for other clinical areas of GUH to see other patients.

Provider Spell Length of Stay (LoS)

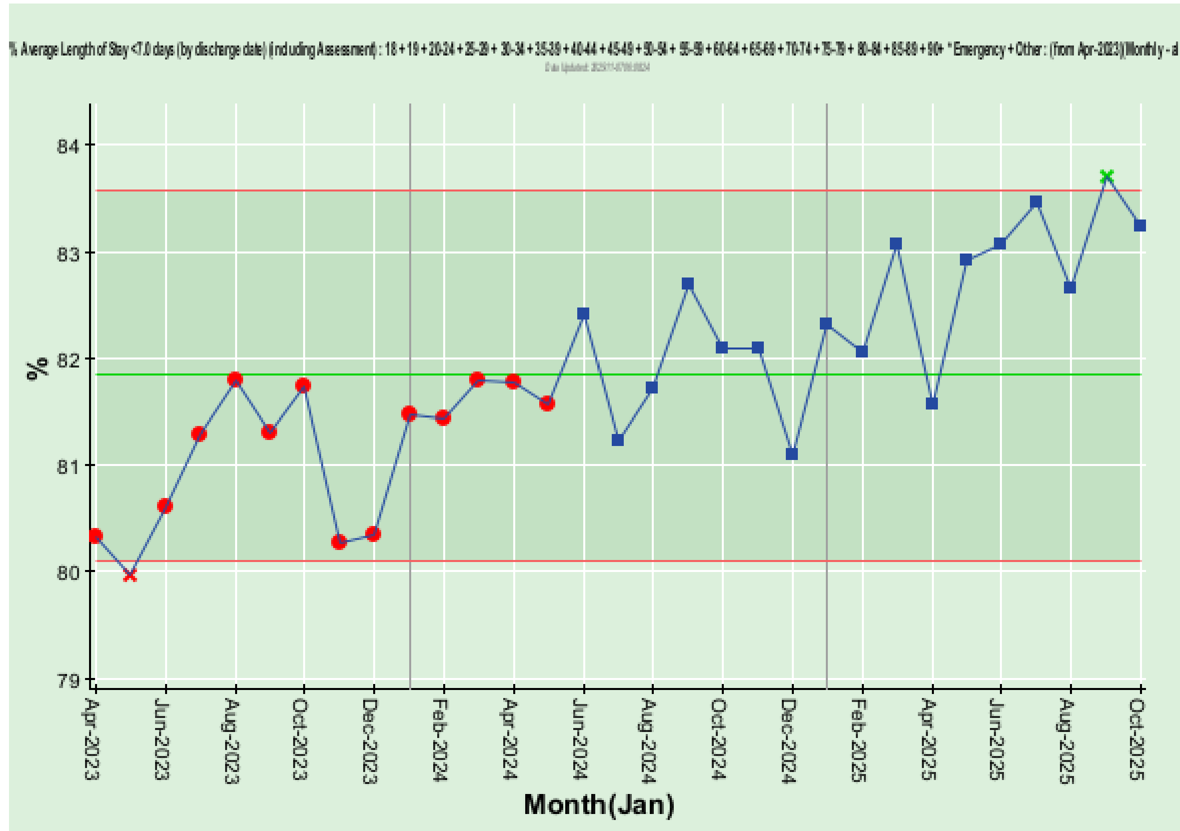


- Average provider length of stay from emergency admissions of 11.9 days
- This measure has seen a marked reduction since the start of the year

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Dyfodol Clinigol Clinical Futures

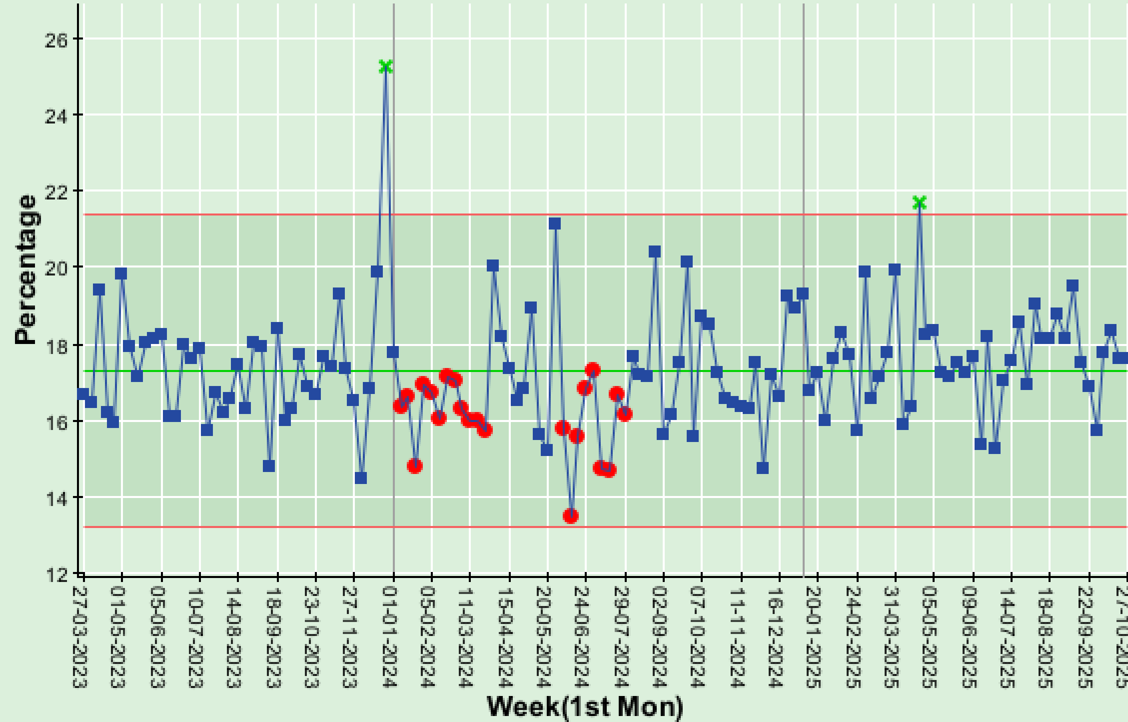
<7d LoS Discharge Performance



- Continuous upward trend in emergency admission discharges with length of stay less than 7 days since April 2023
- October 25 value of 83.2%

- <7d discharge performance for emergency admissions (adults)

Weekend Discharge Performance

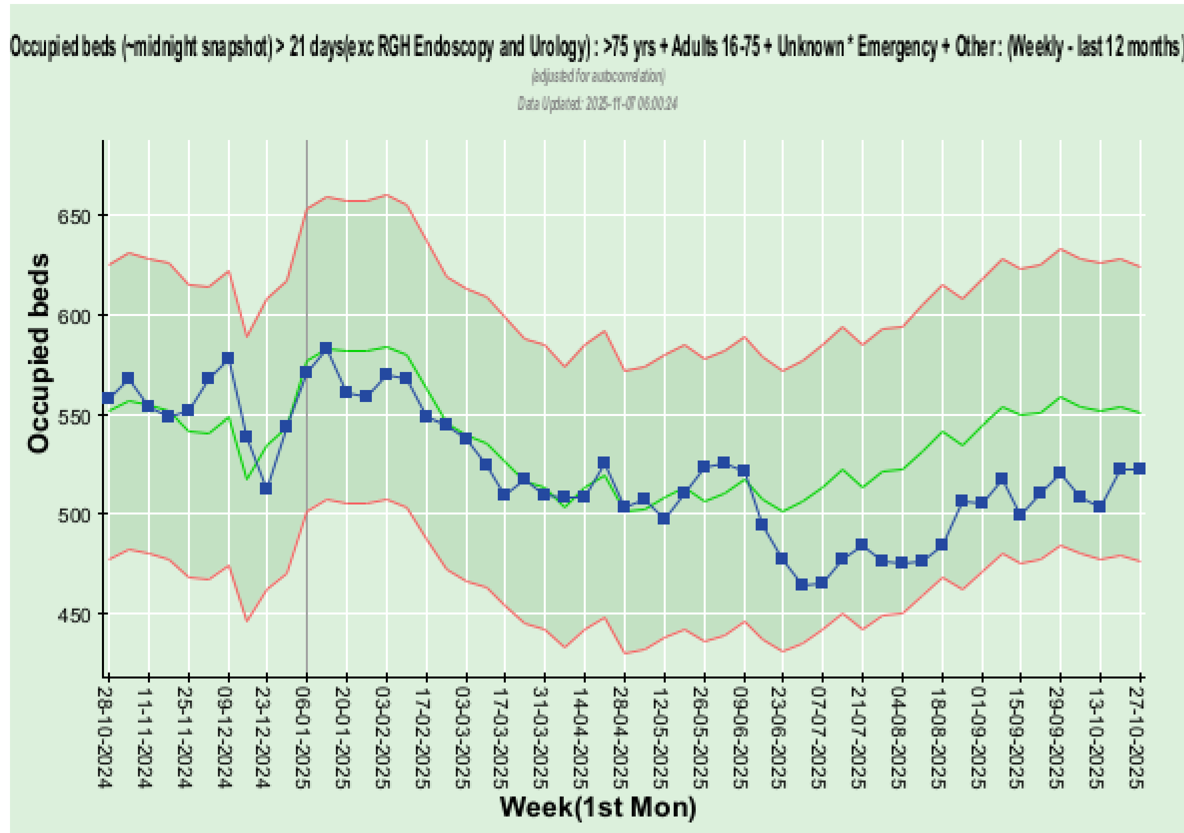


- Weekend discharge performance has remained consistent since April 2023, accounting for an average of 17% of total discharges per week.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Dyfodol Clinigol Clinical Futures

Occupied Beds >21days LoS



- The number of occupied beds with a length of stay more than 21 days has seen a slight increase in recent months, an expected seasonal trend, with values consistently around 500-520.
- The values from October 2025 also show a year-on-year reduction compared to 2024.

POCD Summary (October Census)

	Reported Delays		Days Delayed		Health Delays		Social Delays		Joint Delays	
Current	167		5,188		41		43		83	
	Last Month	Last Year	Last Month	Last Year	Last Month	Last Year	Last Month	Last Year	Last Month	Last Year
	Sep 2025	Oct 2024	Sep 2025	Oct 2024	Sep 2025	Oct 2024	Sep 2025	Oct 2024	Sep 2025	Oct 2024
	184	232	5381	10016	51	50	43	59	90	123
	↓	↓	↓	↓	↓	↓	↔	↓	↓	↓
	-9.2%	-28.0%	-3.6%	-48.2%	-19.6%	-18.0%	0.0%	-27.1%	-7.8%	-32.5%

- Number of patients delayed down by almost a third on October last year
- Number of days delayed down by almost half on October last year

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

Dyfodol Clinigol Clinical Futures

Total Pathway of Care Delays

Reported Pathway of Care Delays (POCDs)

Month	POCDs
Apr 2023	250
May 2023	227
Jun 2023	241
Jul 2023	255
Aug 2023	251
Sep 2023	260
Oct 2023	268
Nov 2023	264
Dec 2023	226
Jan 2024	266
Feb 2024	240
Mar 2024	232
Apr 2024	240
May 2024	237
Jun 2024	244
Jul 2024	235
Aug 2024	261
Sep 2024	262
Oct 2024	232
Nov 2024	234
Dec 2024	201
Jan 2025	175
Feb 2025	210
Mar 2025	171
Apr 2025	176
May 2025	208
Jun 2025	181
Jul 2025	154
Aug 2025	160
Sep 2025	184
Oct 2025	167

UCL · Average · LCL

- Consistent reduction in patients delayed since December 2024
- Record low of 154 achieved in July 2025

Total Pathway of Care Days Delayed

Reported Days Delayed

Month	Days delayed
Apr 2023	7696
May 2023	7196
Jun 2023	7375
Jul 2023	7826
Aug 2023	8477
Sep 2023	8607
Oct 2023	10224
Nov 2023	10297
Dec 2023	8399
Jan 2024	9708
Feb 2024	9204
Mar 2024	8937
Apr 2024	9465
May 2024	8718
Jun 2024	9501
Jul 2024	9427
Aug 2024	10445
Sep 2024	10531
Oct 2024	10016
Nov 2024	10147
Dec 2024	9720
Jan 2025	6904
Feb 2025	6912
Mar 2025	6195
Apr 2025	5904
May 2025	5480
Jun 2025	5091
Jul 2025	4694
Aug 2025	4850
Sep 2025	5381
Oct 2025	5188

Y-axis: 0, 2000, 4000, 6000, 8000, 10000, 12000, 14000 — UCL, Average, LCL

- Consistent reduction in days delayed since December 2024
- Record low of 4694 achieved in July 2025

POCDs by Delay Owner (October Census)

POCDs by Delay Owner

Delay Owner: Social, Joint, Health

120
100
80
60
40
20
0

Apr 2023, May 2023, Jun 2023, Jul 2023, Aug 2023, Sep 2023, Oct 2023, Nov 2023, Dec 2023, Jan 2024, Feb 2024, Mar 2024, Apr 2024, May 2024, Jun 2024, Jul 2024, Aug 2024, Sep 2024, Oct 2024, Nov 2024, Dec 2024, Jan 2025, Feb 2025, Mar 2025, Apr 2025, May 2025, Jun 2025, Jul 2025, Aug 2025, Sep 2025, Oct 2025

Joint

Social

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

Dyfodol Clinigol
Clinical Futures

POCD Days Delayed by Delay Owner (October Census)

Reported Days Delayed by Delay Owner

POCDs by Site (October Census)

POCDs by Site

Site ● Community ● GUH ● MHLD ● NHH ● RGH/STW ● YYF

80
60
40
20
0

Apr 2023 May 2023 Jun 2023 Jul 2023 Aug 2023 Sep 2023 Oct 2023 Nov 2023 Dec 2023 Jan 2024 Feb 2024 Mar 2024 Apr 2024 May 2024 Jun 2024 Jul 2024 Aug 2024 Sep 2024 Oct 2024 Nov 2024 Dec 2024 Jan 2025 Feb 2025 Mar 2025 Apr 2025 May 2025 Jun 2025 Jul 2025 Aug 2025 Sep 2025 Oct 2025

Community
RGH/STW
NHH
YYF
MHLD
GUH

POCDs by Locality (October Census)

POCDs by Locality

Locality ● Blaenau Gwent ● Caerphilly ● Monmouthshire ● Newport ● Out of Area ● Torfaen

80
60
40
20
0

Caerphilly
Monmouthshire
Newport
Blaenau Gwent
Out of Area

Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 | Apr 2024 | May 2024 | Jun 2024 | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025

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

Dyfodol Clinigol
Clinical Futures

Hospital to Home Discharge Activity

Hospital to Home Discharges

0 10 20 30 40

1 5 2 7 6 3 8 3 16 13 15 14 20 15 18 31 21 23 13 21

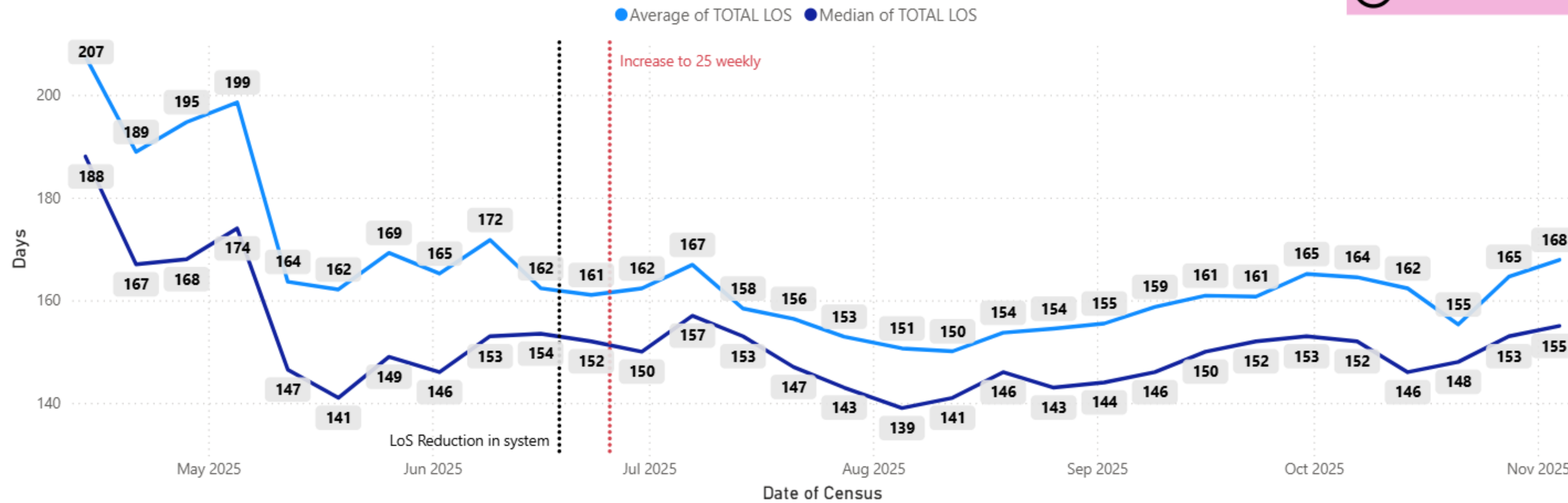
Jul 2023 Jan 2024 Jul 2024 Jan 2025 Jul 2025

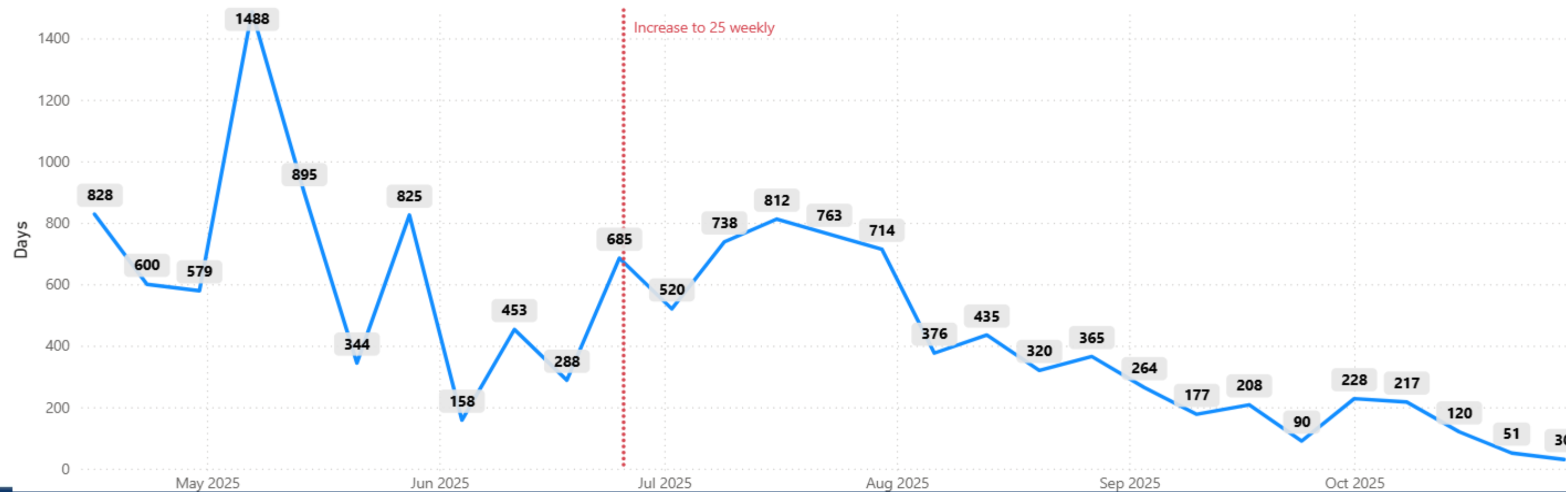
Year

- Steady increase month-on-month for patient discharges enabled through the Hospital to Home scheme, which is now starting to stabilise at ~20 patients per month
- 294 patients helped by the scheme in the past 12 months
- The scheme was integral in supporting the Health Board in the de-escalating of the declared critical incident on the 13th of January 2025 – demonstrated by the exceptionally high discharge rate of 45 patients that month.

Scrutiny Panel / Longest Staying Patients

Return to Filters





- Weekly tracking of 25 patients with longest length of stay (across all sites within one patients' stay)
- Lowest mean average LoS of 150 days achieved in early August, still well below starting position in April
- Will continue to be monitored through Winter

- 100s of Bed Days saved by achieving more timely discharge of patients, in addition to closely monitoring patient outcomes against BRR

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

Dyfodol Clinigol
Clinical Futures

Optimal Hospital Flow Framework (OHFF)

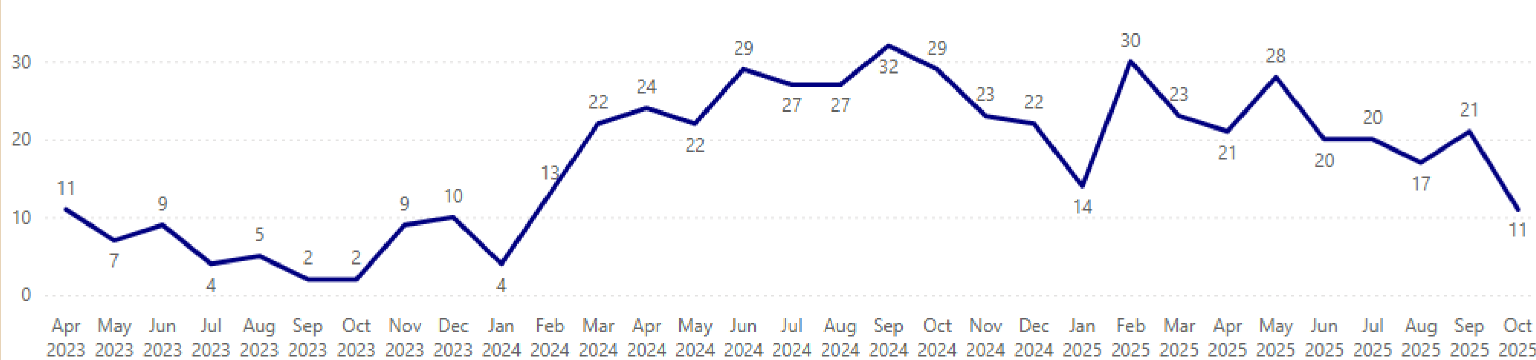
Weekly Patient Discharges Home from RGH Community (C5E, C5W, D6E)

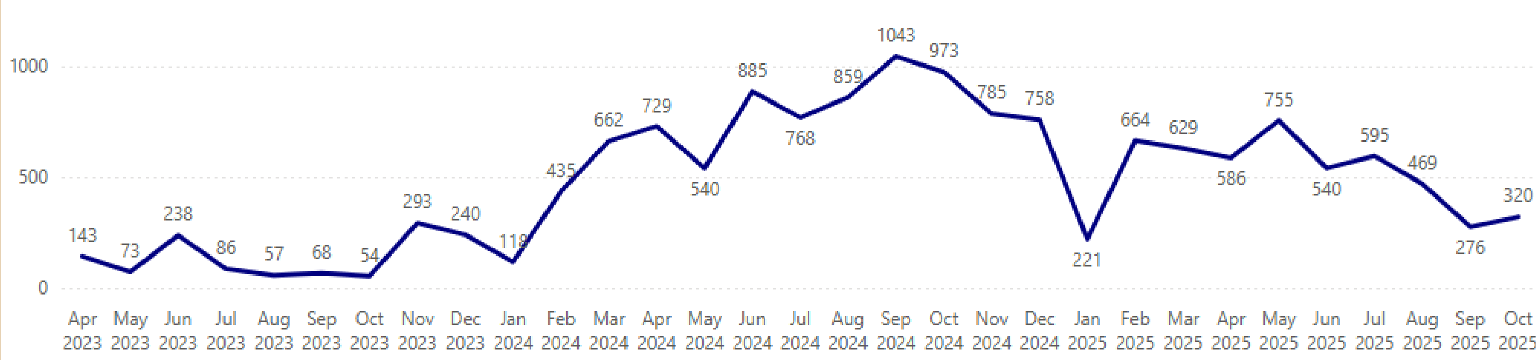
OHFF Start | 2025 week | 2024 week | 2025 Diff from Target | Target | Meeting Target

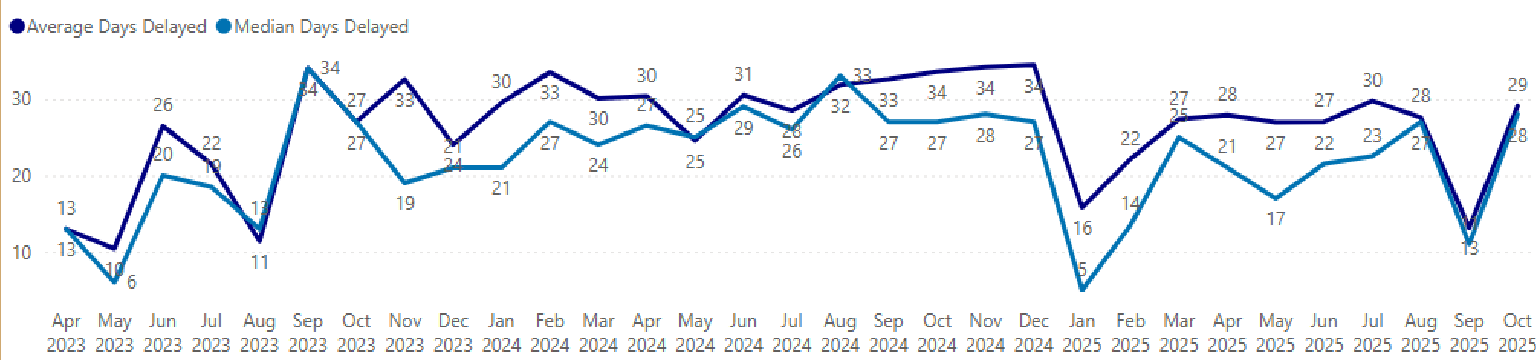
RGH Community

- Weekly Patient discharges home target of 16
- Has been met in 7 of 10 weeks since OHFF introduced (and still 14+ when missed).
- Five weeks of 20+ discharges home

- With exception of week commencing 29th Sep, consistently higher discharges vs a year ago (light blue)







- POCDs on ward have reduced May 2025 (28) to only 11 in October.
- Days delayed at the same time have reduced from 755 days to 320 days.
- Average Delay length remains around 30 days.

Optimal Hospital Flow Framework (OHFF)

Weekly Patient Discharges Home from D5 West

Week	2025 week	2025 Diff from Target
31/03/25	4	-9
07/04/25	9	-4
14/04/25	9	-4
21/04/25	2	-11
28/04/25	6	-7
05/05/25	9	-4
12/05/25	6	-7
19/05/25	8	-5
26/05/25	5	-8
02/06/25	7	-6
09/06/25	9	-4
16/06/25	10	-3
23/06/25	6	-7
30/06/25	6	-7
07/07/25	11	-2
14/07/25	6	-7
21/07/25	9	-4
28/07/25	6	-7
04/08/25	12	-1
11/08/25	10	-3
18/08/25	14	1
25/08/25	10	-3
01/09/25	14	1
08/09/25	11	-2

OHFF Start | 2025 week | 2024 week | 2025 Diff from Target | Target | Meeting Target

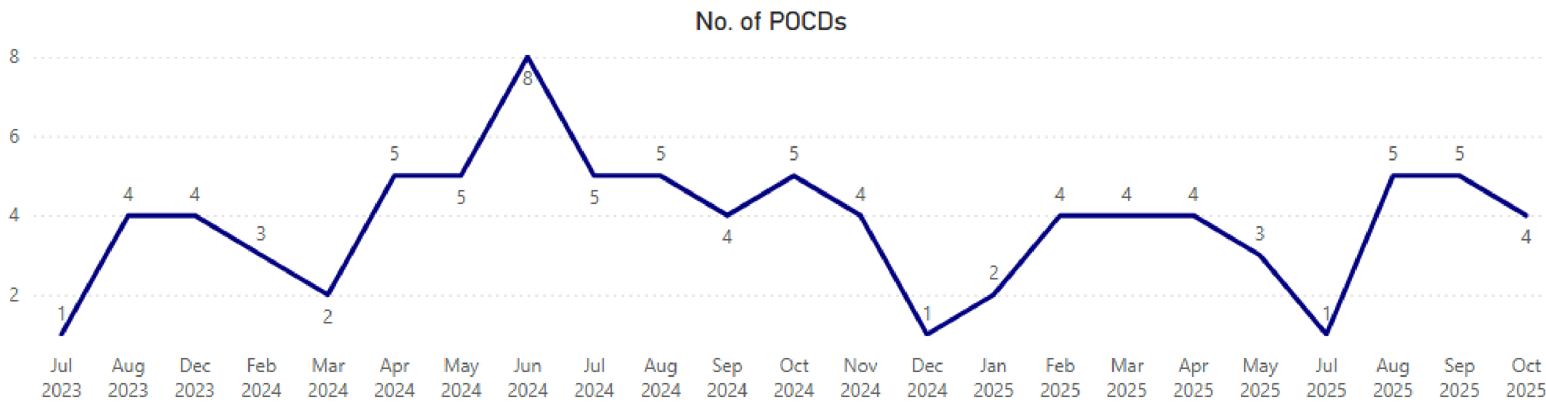
RGH D5W

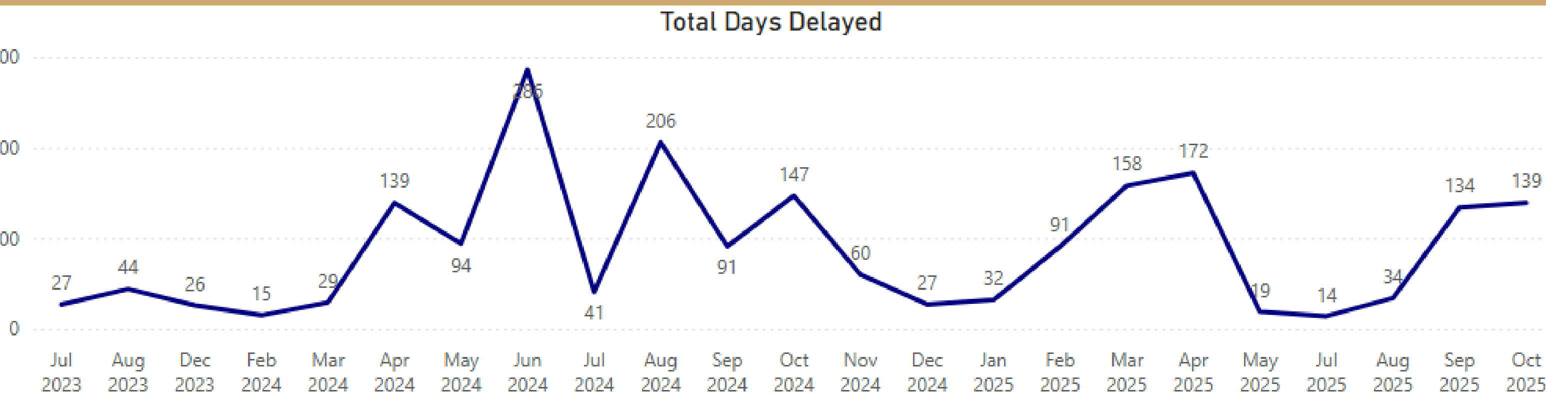
Mon-Fri Patient discharges home target of 13 has been met twice since OHFF introduced (and still at least 10 when missed). Was more like 6-10 weekly previously.

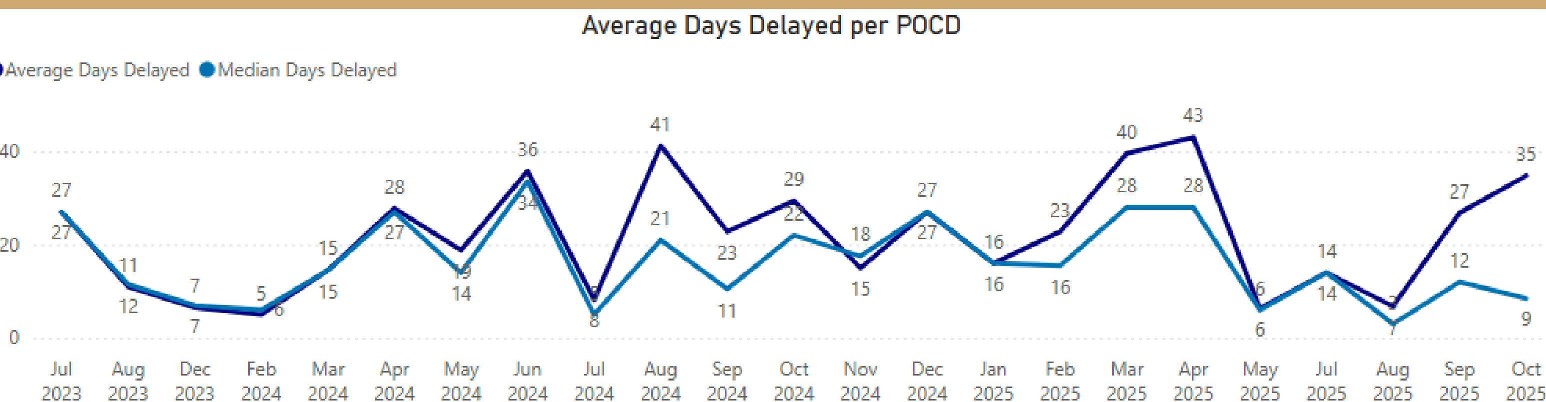
This time a year ago usually saw only around 5 discharges home a week and more consistent with pre-OHFF discharges.

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

Dyfodol Clinigol Clinical Futures

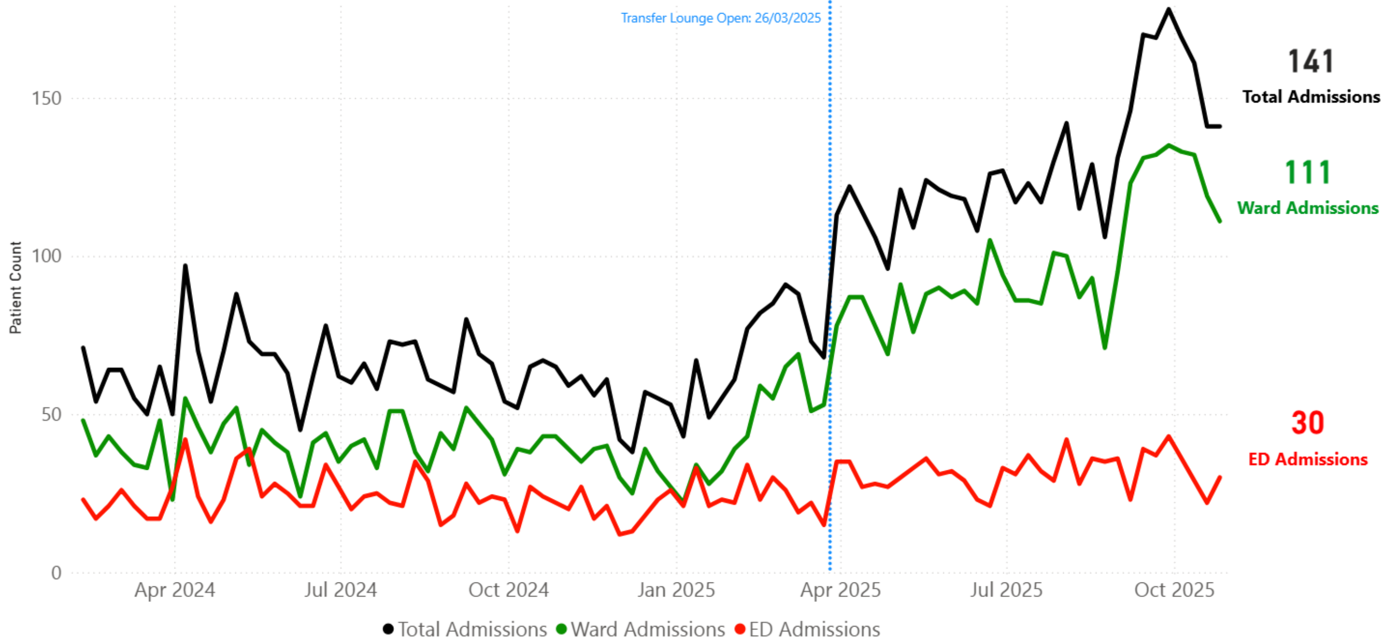


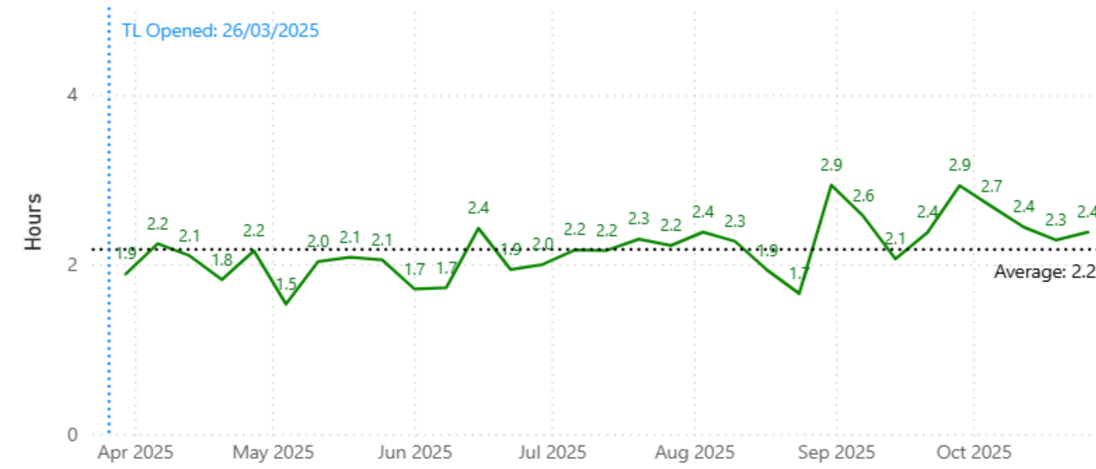


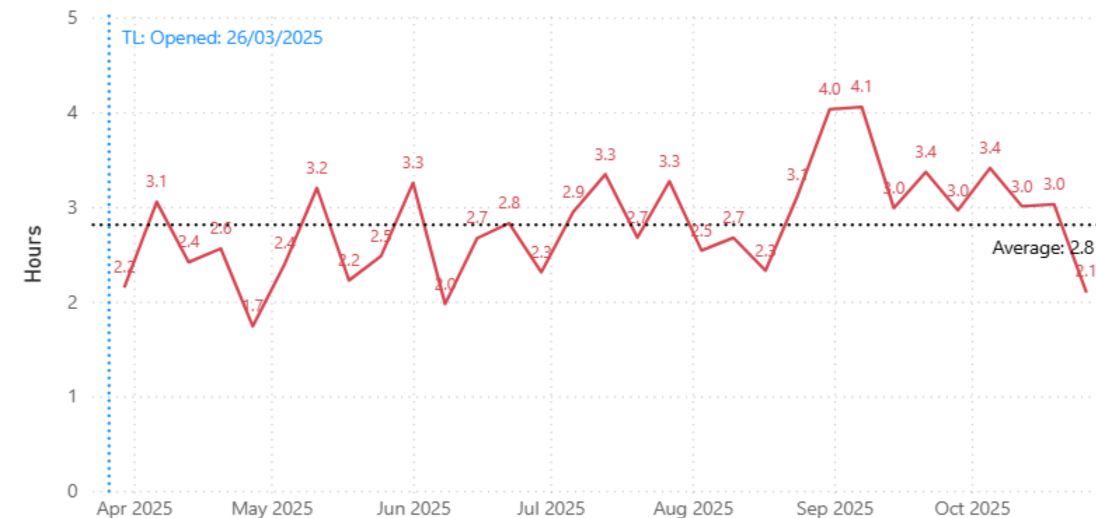


- POCDs on ward have maintained around 5 with a recent jump in August, down to 4 for October
- However, days delayed have reduced from 172 days in April 2025 to 139 days in Oct 2025.
- Average delay reduced to a 5 weekd from 6 weeks.

GUH Transfer Lounge







- Consistent flow of patients through the Transfer Lounge weekly
- Recent all time record of 178 patients in one week supported
- Based on Average Length of Stay in the lounge, this has freed up 524 hours of time for other clinical areas of GUH to see patients

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

Dyfodol Clinigol Clinical Futures

2023 Internal Audit Discharge Planning - Analysis of Live Audit Recommendations				
Recommendation	**Management Response**	**Analysis of response vs intent**	**Status**	**If not Complete.** **What needs to be implemented to complete the recommendation.**
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.	**Exceeds scope** The response remains relevant but introduces a broader digital process enhancement beyond what was requested. By including the aim of sending the discharge summary electronically to the GP on the same day, this is a broader operational improvement than merely issuing notifications timely and effectively controlled.	**Partially Complete** 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. However, while digital transmission to GPs has been piloted, the core intent, ensuring all discharges are evidenced by a timely, complete notification is only partially embedded.	Finalise and roll out the standardised discharge notification process across all specialties. Conduct a compliance audit to confirm timeliness and completeness of discharge documentation.
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.	**Within scope** Directly addresses consistency issue; additional details are contextual, not beyond scope. The explanation about SBAR for inter-site transfers is relevant but goes a bit further it justifies the current practice rather than committing to consistency review or alignment across both areas. Still, this does not expand beyond scope it simply describes the current process in more detail.	**Partially Complete** Work under the Task & Finish Group has started addressing inconsistencies in discharge methods across specialities. SBARs are already used for inter-site transfers, which partially meets the intent for consistency. However, variation remains in day care discharge communication methods, and a unified procedure is still to be finalised.	Finalise a standardised discharge notification process for day cases and integrate it with existing inter-site transfer documentation. Include the unified process in the revised discharge policy and ensure communication and training across teams.

We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further.	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of specialty, consultant, diagnosis etc. This makes any analysis difficult to interpret or perhaps meaningless. The planning department is currently working with clinical teams to develop a number of meaningful measures to determine and understand readmission trends, and to identify where improvement is required. A number of data viewers have been developed and can provide 'bespoke' data by request. Moving forward, these measures will be included within the outcome measures and QPS insights. The Health Board has dedicated services to address frequent or 'high impact' service users that are working across Divisional Boundaries to provide alternative pathways. There is also a workstream focusing on patients at high risk of readmission supported by Lightfoot data and linked to goals 1 and 2 of the 6 Goals for Urgent & Emergency Care programme.	**Exceeds scope** The response goes beyond "continuing analysis and investigating themes" into broader operational reform and system-level improvement efforts.	**Complete** Regular trend analysis is now in place through CHKS benchmarking, QPS Insights, and weekly scrutiny panels. The Planning Department continues to refine readmission measures with clinical teams. Although additional improvement initiatives (e.g., Lightfoot data, 6 Goals programme) exceed the original scope, the analytical intent of the recommendation is met.	Maintain regular review cycles and ensure outcomes continue to feed into service improvement reporting. *(No further action required to meet original scope — broader system reforms are outside this recommendation's intent.)*

2024 External Audit Follow-Up Discharge Planning - Analysis of Live Audit Recommendations				
Recommendation	**Management Response**	**Analysis of response vs intent**	**Status and Update to be used**	**If not Complete. What needs to be implemented to complete the recommendation.**
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.	Plans to review and update the Discharge Policy in line with the new National Policy (with SOPs and a communication plan). Development of multiple digital and operational tools: CWS2 integration with Qlik, Complex List, and 'Ask Annie' app. Workshops to create an integrated discharge pathway. Perfect Ward project, audit and evaluation, and training initiatives. Development of a patient discharge leaflet and embedding of the Optimal Hospital Flow Framework.	**Exceeds scope significantly** The response includes several broader improvement initiatives unrelated to the specific action of developing, communicating, and displaying discharge tools. Introduces broad policy, training, and operational reform beyond communication and display of tools.	**Complete** 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. The core intent of partner development, communication, and ward visibility has been achieved.	N/A
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.	**Falls short of scope** The recommendation concerns staff having access to transport policies and information, plus monitoring their use. The response makes no reference to monitoring mechanisms.	**Partially Complete** Some transport guidance has been made available, but not all staff can readily access the current policies, and there is no consistent monitoring mechanism confirming whether the policies are operating effectively.	Publish and signpost all transport policies clearly on the intranet and ward areas. Introduce a simple monitoring process (e.g., quarterly review of transport policy use and compliance).
Implement a formal mechanism to monitor waiting times for patient transport to highlight themes and address challenges.	Discuss potential for live reporting system with National NEPTS Delivery Action Group and Joint Commissioning Committee. Utilise WAST reports to provide monthly updates on waiting times and themes. Add standing agenda item at Tier 3 Transport Group meeting.	**Slightly Exceeds** The recommendation seeks a formal monitoring mechanism for transport waiting times. The response meets and slightly exceeds scope — not only establishing monitoring via WAST data and reporting mechanisms but also adding structural improvements (standing agenda item, discharge lounges).	**Complete** Formal monitoring is now in place via WAST reports, with regular data presented through the Tier 3 Transport Group and linked operational meetings. Additional operational initiatives such as Discharge Lounges exceed the scope but complement delivery.	N/A

	Discharge Lounges to be operational across all sites to ensure timely patient transport.	The Discharge Lounge element extends beyond "monitoring" into operational efficiency, but it remains relevant.		
Work with local authority partners to give staff up-to-date information on waiting times for community-based assessments and service lead-in times.	Improved information flow to be addressed through the 'Perfect Ward' project. Integrated Discharge Board to be formalised as a tactical RPB sub-group, with increased transparency and a dashboard showing waiting times and service availability. Continued development of the 'Ask Annie' app for access to discharge pathway information. Weekly review of pathway delays and long-stay patients with local authority partners.	**Exceeds scope** The recommendation seeks better, up-to-date information sharing for staff on community service waiting times. The response directly meets this (through dashboards and app development) but also includes broader organisational and strategic elements, such as governance changes, new project structures, and multi-programme linkages (Perfect Ward, RPB sub-group). These additional initiatives are valuable but extend beyond the narrow remit of improving staff access to information.	**Partially Complete** Joint reviews with the Regional Partnership Board are in place, and digital developments (e.g., dashboard, 'Ask Annie' app) are progressing to share waiting-time data. However, real-time access for frontline staff is still developing, and information is not yet consistently available across all sites.	Finalise and roll out the shared dashboard with local authorities to provide live updates. Ensure all relevant staff can access this information easily. *(Wider governance or transformation projects linked to the RPB exceed the recommendation's intent and are not needed for completion.)*

2024 External Audit Flow Out of Hospital - Analysis of Live Audit Recommendations				
Recommendation	**Management Response**	**Analysis of response vs intent**	**Status and Update to be used**	**If not Complete. What needs to be implemented to complete the recommendation.**
The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.	Current hospital discharge models are being reviewed and will be communicated to all hospital and community staff once finalised. Significant regional investment in Balancing Rights and Responsibilities (BRR) training, involving all five local authorities and the Health Board. Training focuses on risk-based decision-making and proportionate care. All discharge staff will have access to relevant policies and procedures during induction and ongoing CPD.	**Slightly exceeds scope** The response aligns with the recommendation's focus on joint communication and shared training, including induction and refresher elements. However, it goes further by referencing system simplification and cultural change through BRR training, which extend beyond communication of discharge guidance.	**Partially Complete** Joint work with all five local authorities and inclusion of Balancing Rights and Responsibilities (BRR) training demonstrate progress in communicating discharge guidance and promoting shared understanding. However, a structured and documented communication and training programme (covering induction and refresher delivery for permanent and temporary staff) is not yet fully in place.	Develop and record a formal training and communication framework. Ensure refresher sessions are built into staff development cycles. *(The BRR and system redesign elements exceed the original recommendation's intent and are not required for closure.)*
The Health Board should update its discharge policy to ensure that it reflects the national guidance issued by the Welsh Government in December 2023.	Update discharge policies including complex and reluctant discharges and choice policy to reflect the national guidance	**Within scope** Fully aligned; clear and proportionate response	**Complete** The revised discharge policy aligns with national guidance and has been developed in partnership with local authorities. Related updates to complex and reluctant discharge and choice policies are consistent with the intent of the recommendation	Confirm ratification date and circulate the approved policy across all teams.
The Health Board and local authorities should review capacity to embed and deliver 7-day discharge.	Discharge Community Hospitals out to advert, focus on embedding the delivery of 7-day discharge	**Within scope** The response directly responds to the intent, focusing on increasing capacity to deliver 7-day discharge.	**Partially Complete** Weekend discharge levels remain consistent (17%) and several workstreams (e.g., Criteria-Led Discharge, 7-Day Home First) are underway. However, a full capacity review across Health Board and partner services has not been completed to identify the resources and staffing model needed for sustainable 7-day discharge.	Undertake a formal capacity and resource review with local authorities. Develop an implementation plan to address identified gaps.
The Health Board should review its cultural appetite and approach to risk in relation to patient discharge.	Updated discharge policies will be shared as part of the education and communication framework, prioritising discharge across the MDT.	**Slightly exceeds scope** The response aligns with the recommendation's focus on risk culture	**Partially Complete** Risk discussions now take place at divisional and corporate levels, and risk-	Conduct a formal review of discharge-related risk appetite.

	Risk related to non-compliance discussed at divisional and corporate levels, feeding into discharge workstreams.	and organisational awareness, but it expands the scope from assessing cultural appetite to creating a formalised governance framework.	based training (e.g., BRR) has been introduced. These are positive steps, but a formal review of the organisation's risk appetite and a shared partner framework are still required to meet the full intent of the recommendation.	Agree and embed a shared risk approach across all partners.
The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners.	Review of best practice and POCD datasets. Three recommendation areas presented to the Integrated Discharge Board. Embedding Balancing Rights and Responsibilities training for front-door teams. DST model moved to community to reduce joint-assessment delays. Collaboration with care homes to implement Trusted Assessor model.	**Exceeds scope** The response fully addresses the recommendation and clearly demonstrates embedding and partner engagement. However, it goes beyond scope by incorporating multiple operational reforms (DST relocation, care home models, new training cohorts) that are not strictly about embedding or communication.	**Not Complete** No formal evidence of an embedded Trusted Assessor model. While related actions (DST model changes, care home collaboration, and training) support discharge efficiency, they do not demonstrate that a consistent Trusted Assessor model has been agreed, implemented, and communicated	Confirm whether a Trusted Assessor model currently operates. If so, document governance, communication, and implementation arrangements. If not, develop a short implementation plan with clear partner roles.
The Health Board should monitor compliance with its discharge policy to assess effectiveness and consistency and ensure annual learning reports are submitted.	Data from POCD and CWS2 to inform guidance and education. Formal dashboard in development, reported to Integrated Discharge Board. Learning and feedback to be shared at local forums and the Patient Quality Outcomes Committee.	**Within scope** Directly meets the recommendation's intent, compliance monitoring, evaluation, and reporting. The dashboard and data-driven learning aspects strengthen implementation but do not exceed scope.	**Partially Complete** Monitoring occurs through the weekly Scrutiny Panel and quarterly POCD reviews, and development of a formal dashboard is underway. However, annual reporting of learning to PQSOC has not been evidenced	Finalise the discharge dashboard. Produce and present an annual learning report to PQSOC to close the loop.
The Health Board should improve record keeping by ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information.	Details extensive audits, training programmes, Ward Accreditation, WNCR system, and audit results with percentages. Describes Medical Records Review and inclusion in the internal audit plan.	**Within scope** The response strongly aligns with the recommendation's intent to improve documentation quality and awareness.	**Complete** Implementation of Clinical Workstation 2 and Red-to-Green monitoring has improved documentation and record-keeping standards. Continued embedding of these tools is underway.	N/A
The Health Board should ensure it has mechanisms in place to understand the experiences of patients and carers in the discharge process and apply learning	Describes use of CIVICA Experience Platform to capture feedback across wards and areas.	**Partially meets / Slightly short of scope** The response partially fulfils the	**Partially Complete** Feedback is being collected through the CIVICA platform and person-centred	Introduce structured discharge feedback (e.g., short surveys or interviews).

	Notes lack of a specific “discharge” question but outlines analysis through themes and sub-themes (Patient Pathway → Discharge).	recommendation’s requirement for mechanisms but does not fully show how learning will be applied.	initiatives (‘What Matters’, Hospital to Home). However, there is no consistent mechanism for gathering discharge-specific feedback or demonstrating how learning is applied to improve processes	Link findings to service improvement reporting.

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
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			

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 January 2026
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 December 2025 and January 2026, there have been no amendments made to the committees forward work programme.

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.

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

ANNUAL PROGRAMME OF BUSINESS 2025/26

AUDIT, RISK & ASSURANCE COMMITTEE

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2024 and the Structured Assessment 2024 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

Area of Focus as per Standing Orders:
The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

The Committee has been established to enable the scrutiny and review of matters related to audit, financial accounting, assurance, and risk management, to a level of depth and detail not possible in Board meetings.

The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing, and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and
- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22nd April 2025	20th May *Draft Accounts*	24th June *Final Accounts*	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					√		√

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
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		√					

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

√ **D**	Deferred Scheduled agenda item Received
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee