

# Audit, Risk and Assurance Committee - Main Meeting

Thu 12 February 2026, 09:30 - 11:30

## Agenda

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### 1. PRELIMINARY MATTERS

 1.0 ARAC 20260212 Agenda - Main Meeting.pdf (2 pages)

#### 1.1. Welcome and Introductions

*Oral*            *Chair*

#### 1.2. Apologies for Absence

*Oral*            *Chair*

#### 1.3. Declarations of Interest

*Oral*            *Chair*

#### 1.4. Draft Minutes of the last Meeting held on 12th January 2026

*Attached*            *Chair*

 ARAC 20260212 1.4 20260122 Minutes Template - Final.pdf (7 pages)

#### 1.5. Committee Action Log and Matters Arising

*Attached*            *Chair*

 ARAC 20260212 1.5 20260122 Action Log - Final.pdf (4 pages)

##### 1.5.1. Update on Records Management Audit following review of management responses

*Attached*            *Director of Digital*

 ARAC 20260212 1.5.1 SBAR - Records Management Audit Responses Update.pdf (11 pages)

### 2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

#### 2.1. To Approve the Committee Annual Programme of Business 2026/27

*Attached*            *Director of Corporate Governance*

 ARAC 20250212 2.1 Development of the ARA Committee Forward Work Programme 2026-27.pdf (3 pages)

 ARAC 20260212 2.1a Appendix A ARA Committee Work Programme 2026-27 DRAFT.pdf (6 pages)

#### 2.2. To Approve the Audit Recommendations Tracking Report

*Attached*            *Director of Corporate Governance*

 ARAC 20260212 2.2 Internal\_External Audit Recommendations Cover Report.pdf (8 pages)

 ARAC 20260212 2.2a Appendix A.pdf (6 pages)

 ARAC 20260212 2.2b Appendix B .pdf (7 pages)

 ARAC 20260212 2.2c Appendix C .pdf (4 pages)

#### 2.3. To Approve Reviewed and Updated Financial Control Procedures.

*Attached*                      *Director of Finance and Procurement*

- Purchasing Cards
- Engaging Off Payroll Workers
- Patients Property
- Procurement Policy
- Grant Funding

- 📄 ARAC 20260212 2.3 Finance Governance Report - 12.02.26.pdf (13 pages)
- 📄 ARAC 20260212 2.3a Appendix 1 ABUHB\_Finance\_0963 FCP Purchasing Cards\_Final.pdf (20 pages)
- 📄 ARAC 20260212 2.3b Appendix 2 ABUHB\_Finance\_0787 FCP Engaging Off Payroll Workers\_Final.pdf (17 pages)
- 📄 ARAC 20260212 2.3c Appendix 3 ABUHB\_Finance\_0279 Patients' Property\_Final.pdf (43 pages)
- 📄 ARAC 20260212 2.3d Appendix 4 ABUHB\_Finance\_0993 Procurement Policy\_Final.pdf (15 pages)
- 📄 ARAC 20260212 2.3e Appendix 5 ABUHB\_Finance\_0997 Grant Funding\_Final.pdf (26 pages)

### **3. ITEMS FOR DISCUSSION**

#### **3.1. To consider the approach and timelines for the Annual Report and Accounts**

*Attached*                      *Director of Corporate Governance*

- 📄 ARAC 20260212 3.1 Development of Annual Report 25.26 ARAC.pdf (5 pages)

#### **3.2. To Receive Internal Audit Progress Report**

*Attached*                      *Internal Audit*

- 📄 ARAC 20260212 3.2 ABUHB Jan 2026 Audit Committee Progress Report FINAL.pdf (8 pages)

#### **3.3. Receive External Audit Progress Report 2025-26**

*Attached*                      *Audit Wales*

- 📄 ARAC 20260212 3.3 ABUHB Audit Committee Update Feb 2026.pdf (10 pages)

### **4. ITEMS FOR INFORMATION**

#### **4.1. To Receive Internal Audit briefs of audits underway**

*Attached*                      *Internal Audit*

- Falls Management
- Divisional Budgetary Control
- Discharge Planning

- 📄 ARAC 20260212 4.1a ABUHB 2526-08 Falls Management Final Internal Audit Brief.pdf (3 pages)
- 📄 ARAC 20260212 4.1b ABUHB-2526-01 Divisional Budgetary Control Final Audit Brief client issue.pdf (4 pages)
- 📄 ARAC 20260212 4.1c Final Internal Audit Brief ABU-2526-15 Discharge Planning.pdf (3 pages)

#### **4.2. Committee Programme of Business 2025/26**

*Attached*                      *Director of Corporate Governance*

- 📄 ARAC 20260212 4.2 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- 📄 ARAC 20260212 4.2a Appendix A ARA Committee Work Programme 2025-26 Final.pdf (7 pages)

#### **4.3. Structured Assessment 2025 – Final**

*Attached*                      *Audit Wales*

- 📄 20250212 4.3 5186A2025\_2025\_structured\_assessment\_abuwb.pdf (46 pages)

## **5. OTHER MATTERS**

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

*Oral*      *Chair*

### **5.2. Any Other Urgent Business**

*Oral*      *Chair*

### **5.3. Date of the Next Meeting: Tuesday 28th April 2026 09:30**

*Oral*      *Chair*



<b>4 ITEMS FOR INFORMATION</b>			
4.1	To Receive Internal Audit briefs of audits underway <ul style="list-style-type: none"> <li>- Falls Management</li> <li>- Divisional Budgetary Control</li> <li>- Discharge Planning</li> </ul>	Attached	Internal Audit
4.2	Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
4.3	Structured Assessment 2025 – Final	Attached	Audit Wales
<b>5 OTHER MATTERS</b>			
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: Tuesday 28 <sup>th</sup> April 2026 09:30		

### **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*

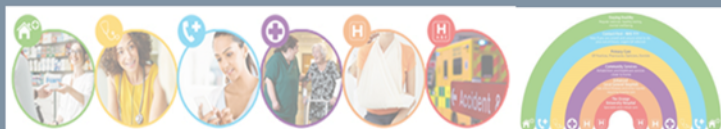




**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN  
BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
MEETING MINUTES OF THE AUDIT RISK & ASSURANCE  
COMMITTEE**

<b>DATE OF MEETING</b>	Thursday 22 <sup>nd</sup> January 2026 11:30-12:30
<b>VENUE</b>	Microsoft Teams

<b>PRESENT</b>	Iwan Jones - Committee Chair – Independent Member
	Dafydd Vaughan - Independent Member
	Paul Deneen – Independent Member
	Neil Patrick - Independent Member ( <i>Joined 12:00</i> )
	Helen Sweetland – Independent Member
<b>IN ATTENDANCE</b>	Rani Dash - Director of Corporate Governance
	Lucy Windsor – Head of Corporate Risk and Assurance
	Stephen Chaney - Head of Internal Audit
	Efion Jones – Deputy Head of Internal Audit
	Sara Utley - Performance Audit Lead, Audit Wales
	Seema Srivastava - Medical Director
	Jennifer Winslade - Director of Nursing
	Stephen Edwards – Deputy Medical Director
	Leanne Watkins – Chief Operating Officer
	Leeanne Lewis - Assistant Director for quality and Patient Safety
	Nicola Prygodzicz – Chief Executive Officer
	Ann Lloyd – Chair



	Danielle Jackson - Secretariat
<b>OBSERVING</b>	None to note
<b>APOLOGIES</b>	None to note

Minute Reference	Preliminary Matters
<b>ARAC 0122/01</b>	<b>Welcome and Introductions</b> The Chair welcomed everyone to the meeting.
<b>ARAC 0122/02</b>	<b>Apologies for Absence</b> Apologies were noted.
<b>ARAC 0122/03</b>	<b>Declarations of Interest</b> There were no declarations of interest raised to record.
<b>ARAC 0122/04</b>	<b>Minutes of the previous meeting</b> The minutes of the meeting held on the 16th of December 2026 were agreed as a true and accurate record.  Iwan Jones (IJ), Committee Chair highlighted that a reference within the minutes stated that an item was due to return to “the next meeting,” but this should have referred to the February meeting. <b>ACTION: Secretariat</b>
<b>ARAC 0122/05</b>	<b>Committee Action Log</b> The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due.  The Committee <b>AGREED</b> that completed actions could be removed from the Action Log.
	<b>ITEMS FOR APPROVAL / RATIFICATION / DECISION</b>
<b>ARAC 0122/06</b>	<b>To Approve the Local Corporate Clinical Audit Plan</b> Seema Srivastava (SS), Medical Director, presented the proposal for the development of the Corporate Local Clinical Audit Plan for 2026–2027. SS advised that the revised approach aimed to establish a structured, visible and risk-based method of selecting and delivering corporate local clinical audits, ensuring stronger alignment with the Health Board’s Quality Strategy and supporting governance structures. The plan was intended to bring together previously separate audit activity into a single, prioritised programme.



Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, provided detailed information regarding the planned approach. LL confirmed that although corporate audits had historically been undertaken, this was the first formal plan to be presented to the Committee. Approximately ten corporate audits were proposed for 2026–2027, based on available resource within the corporate team. It was highlighted that audit topics would be selected using a risk-based prioritisation matrix informed by the corporate risk register, serious incident data, and external regulatory requirements. LL also confirmed that audits would have identified clinical leads, clear objectives, and action plans tracked via AMaT.

The Committee discussed the plan in depth. Iwan Jones (IJ), Committee Chair, expressed concern and queried how the Committee could be assured that the selected audits represented adequate coverage of the Health Board’s full clinical risk landscape. IJ emphasised the need to understand the wider “audit universe” to ensure that risks were not being excluded due to capacity constraints. LL acknowledged this and confirmed that Divisions were still contributing to the risk identification process. SS assured the Committee that any significant gaps would be escalated for consideration of additional support or re-prioritisation.

The Committee welcomed the strengthened approach and recognised the work undertaken to introduce consistency and transparency. The Committee **NOTED** the progress and supported continued development of the Corporate Local Clinical Audit Plan.

## ITEMS FOR DISCUSSION



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

Seema Srivastava (SS), Medical Director, introduced the mid-year report on participation in the National Clinical Audit and Outcomes Review Programme. SS advised that the paper summarised compliance with mandated audits, governance processes, and progress against audit recommendations.

Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, presented the detailed mid-year position. It was reported that overall participation remained strong and that reporting arrangements had improved through standardisation and the consistent use of AMaT to track actions. LL provided examples of national audit findings leading to demonstrable service improvements, including strengthened MDT documentation, improving psychosis waiting time performance and changes to lung cancer pathways.

Two areas of concern were highlighted:

1. **National Respiratory Audit Programme (NRAP):** It was advised that the Health Board's multi-site model resulted in duplicate patient entries within NRAP's data structure, creating challenges for compliance. Work was underway with Planning colleagues and national audit representatives to resolve this.
2. **National Institute for Health and Care Excellence (NICE) End-of-Life Care Audit:** LL reported ongoing challenges in data collection and resource availability. A recovery plan had been initiated.

The Committee requested clearer presentation of overdue audit recommendations in future reports. Iwan Jones (IJ), Committee Chair, emphasised the importance of providing assurance that actions were being completed and reflected accurately in AMaT.



**To Receive an Update on Job Planning Performance**

Seema Srivastava (SS), Medical Director, introduced the update on Consultant and SAS doctor job-planning compliance. SS expressed disappointment that compliance had fallen due to the expiry of a significant number of plans, combined with staff sickness, maternity leave, and ongoing formal disputes. SS emphasised that job planning was critical to service and workforce planning, as well as to demonstrating financial control.

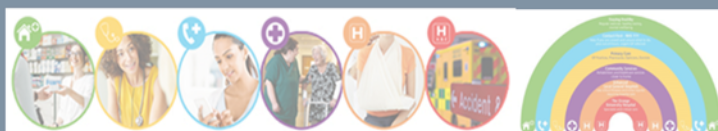
Stephen Edwards (SE), Deputy Medical Director, reported that many expired plans were awaiting signatures for completion and these were being prioritised. It was explained that complex cases were progressing through appropriate formal processes and were being handled in line with the principles of fairness, equity, and consistency. SE confirmed that improved training had been provided to Clinical Directors and Directorate Managers to strengthen the use of the electronic job-planning system.

Committee members expressed significant concern about the persistent nature of job-planning challenges. Dafydd Vaughn (DV), Independent Member, noted that improvements had historically occurred only during periods of heightened scrutiny, raising concerns about sustained engagement within Divisions. Leanne Watkins (LW), Chief Operating Officer, provided assurance that Divisions were actively engaged, confirming that all consultants had job plans, although not all were digitally updated.

SS confirmed that new consultant posts would not be approved unless divisional job-planning compliance had been demonstrated. Members supported the need for this stronger approach.

It was agreed that detailed scrutiny of Job Planning activity should continue through the People and Culture Committee, with escalation to the Board when necessary.

The Committee **NOTED** the update and endorsed the strengthened management approach to improve compliance.



## To Receive an Assurance Report on Systems and Processes to Improve Discharge Performance, linked to Audit Recommendations

Jennifer Winslade (JW), Director of Nursing, presented the discharge-planning update and associated audit action position. JW emphasised that discharge should be viewed within the full urgent and emergency care (UEC) pathway and that deconditioning prevention and timely transfer of care remained key priorities.

Multiple sustained improvements were highlighted, including:

- Maintaining monthly delayed-discharge days below 5,000 since June.
- Reducing very long delays, with approximately 75% of pathway delays resolved within a month.
- Enhancing digital dashboards to improve staff visibility of real-time discharge data.
- Improving documentation and language surrounding discharge processes to support confidence among clinical teams.

It was reported that although December saw a rise in the number of delayed discharges, the total days lost remained stable. JW identified continued challenges linked to social work assessment delays, predominantly in Monmouthshire, Newport and Caerphilly. JW also advised that some audit actions relating to discharge notifications remained partially complete due to necessary digital system developments.

The Committee acknowledged the progress made and supported the intention to develop a single integrated discharge pathway across health and social care. JW confirmed that the first workshop was scheduled and would include a review of RPB-funded support services.

Iwan Jones (IJ), Committee Chair, Highlighted discrepancies between divisional and Committee-level audit action status and



	<p>requested a review of all audit actions be completed to ensure the audit tracker was entirely accurate.</p> <p><b>ACTION: Director of Nursing and Head of Corporate Risk and Assurance.</b></p> <p>The Committee <b>NOTED</b> the progress and acknowledged remaining system-wide challenges.</p>
	<b>ITEMS FOR INFORMATION</b>
<b>ARAC 0122/10</b>	<p><b>Committee Programme of Business 2025/26</b></p> <p>The Committee <b>NOTED</b> the report.</p>
	<b>Other Matters</b>
<b>ARAC 0122/11</b>	<p><b>Items to be Brought to the Attention of the Board and Other Committees</b></p> <ul style="list-style-type: none"> <li>• No items raised</li> </ul>
<b>ARAC 0122/12</b>	<p><b>Any Other Urgent Business</b></p> <ul style="list-style-type: none"> <li>• Nothing reported.</li> </ul>
<b>ARAC 0122/13</b>	<p><b>Date of the next meeting</b></p> <ul style="list-style-type: none"> <li>• Thursday 12<sup>th</sup> February 2026</li> </ul>

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<b>Outstanding</b>	<b>In Progress</b>	<b>Not Due</b>	<b>Completed</b>	<b>Transferred to another Committee</b>
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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
<b>May 2025</b>	<b>ARAC 2005/05</b> 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 scope of the recommendations.	Director of Corporate Governance/Director of Digital and Head of Internal Audit	21 September 2025	<b>Completed</b>  Item scheduled to be presented to the Committee in February 2026
<b>September 2025</b>	<b>1809/06</b> Checklist for future projects	Provide a follow up report to assess the impact of the checklist.	Director of strategy, planning and partnerships	April 2026	<b>Not Due</b>



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
<b>October 2025</b>	<b>ARAC 2110/05</b> 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	<b>Completed</b> Discussed alongside presentation of the Job Planning at the January 2026 meeting. It was agreed that detailed scrutiny of Job Planning activity should continue through the People and Culture Committee
<b>October 2025</b>	<b>ARAC 2110/05</b> Committee Action Log – Job Planning	Review Terms of Reference alignment to ensure outputs from reports are routed through the appropriate Committees	Director of Corporate Governance	May 2026 Included as part of the annual review of ToRs	<b>Not Due</b>
<b>October 2025</b>	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	<b>Not Due</b>



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
<b>December 2025</b>	<b>ARAC 1216/08</b> To Receive the Audit Recommendation Tracking report and Approve closing position.	Conduct a deep dive into all live digital related audit recommendations to ensure timelines are realistic.	Head of Corporate Risk and Assurance	April 2026	<b>Not Due</b>
<b>January 2026</b>	<b>ARAC 0122/04</b> Minutes from the previous meeting.	Amend reference "to the next committee meeting" to "Februarys meeting" due to an extraordinary meeting being added in between.	Secretariat	January 2026	<b>Completed</b>
<b>January 2026</b>	<b>ARAC 0122/09</b> To Receive an Assurance Report on Systems and Processes to Improve Discharge	Conduct a review of all Discharge Planning audit actions be to ensure the audit tracker is entirely accurate.	Head of Corporate Risk and Assurance and Director of Nursing	April 2026	<b>Not Due</b>



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
	Performance, linked to Audit Recommendations				

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

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



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

<b>DYDDIAD Y CYFARFOD:</b> <b>DATE OF MEETING:</b>	12 February 2026
<b>CYFARFOD O:</b> <b>MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD:</b> <b>TITLE OF REPORT:</b>	Update to 2024/2025 Records Management Audit
<b>CYFARWYDDWR</b> <b>ARWEINIOL:</b> <b>LEAD DIRECTOR:</b>	Paul Solloway, Director of Digital
<b>SWYDDOG ADRODD:</b> <b>REPORTING OFFICER:</b>	Anne McDonnell, Head of Digitised Health Records Services

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA**  
**SBAR REPORT**

**Sefyllfa / Situation**

The 2024/2025 Records Management Audit undertaken in December 2004 and presented in February 20025 concluded Limited Assurance, identifying urgent risks including:

- Non-adherence to records management
- Unretrievable patient records (paper and digital)
- Two examples of unauthorised access to patient records
- Inappropriate storage conditions
- Limited strategies to secure or optimise library/storage space

**Cefndir / Background**

The Records Management audit reviewed four objectives and review identified risks in record quality, storage and security of records and transport/tracking processes. The objectives were:

- Appropriate policies, procedures and guidelines are in place for the management of records that encompasses the full records lifecycle. (Reasonable Assurance)

- Record quality is ensured. Documentation and records are kept to an appropriate standard. (Limited Assurance)
- Records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards. (Limited Assurance)
- Physical records are transported appropriately, tracked and records are available when and where needed by operational staff. (Limited Assurance)

The findings from the audit fieldwork identified 8 findings and this report outlines actions taken in 2025 to address these issues, providing detailed responses for Objectives 2, 3, and 4, where limited assurance was reported along with evidence of progress and positive operational changes.

### **Asesiad / Assessment**

The audit provided a Limited Assurance rating for Objective 2: *Record quality is ensured. Documentation and records are kept to an appropriate standard.*

The Audit findings highlighted issues across 18 different wards on 7 hospital sites with an update on actions completed and future plans:

<b>Audit Finding</b>	<b>Action Taken in 2025</b>	<b>Evidence</b>	<b>Forward Plan</b>
2.1: Evidence of poor records management. Poor filing standards, loose papers, missing patient identification.	<b>Ward Engagement</b> 63 ward visits completed between April – November 2025.	Microsoft list tracking, feedback from ward clerks via survey and provided on-site support.	Continue engagement with ward clerks, sharing best practice in records management and Standard Operating Procedures via The Health Records Support Network.
	<b>Embedding Training</b> Increasing attendance at Health Records Supplementary Training	Submitted proposal on Health Records Awareness Training to Core Learning Committee to be considered for mandatory status.	Present proposal to Core Learning Committee (meeting scheduled 09/12/2025 cancelled, to be rescheduled in 2026)
		Agreement with Deputy Head of Nursing Education to include records management training in Ward Accreditation compliance criteria and Journey of Excellence	Continue to embed records management and best practice in induction programmes and ward accreditation, sharing health records awareness sessions via the ward accreditation

	<p><b>Governance and Support</b>  Launched Health Records Support Network on Microsoft Teams. Updated Employee Handbook with new guidance and resources to support new staff.</p> <p>Developed Health Record Keeping Survey, launched in November 2025.</p>	<p>Corporate Induction for Nurses.</p> <p>Secured slots in corporate induction for newly qualified nurses and doctors plus international nurse preparation programmes.</p> <p>MS Teams Network expanded to nearly 100 members. Best practice guides, informational videos and Standard Operating Procedures are shared. Queries answered in real time.</p> <p>Survey responses (due to close end of March 2026) will identify gaps in records management standards and inform improvement plans.</p>	<p>AB Pulse intranet page.</p> <p>Present best practice guidance in records management at Corporate Induction programmes. Core Induction for newly registered nurses scheduled on 16/02/2026, 19/05/2026 &amp; 19/10/2026</p> <p>Network growth and continue to share best practice guidance.</p> <p>Introduce monthly "Spotlight on....." posts to increase engagement and share standard operating procedures.</p> <p>Develop the Health Records Standards plan.</p>
3.1: System Alerts. Missing alerts on patient records	<p>Welsh Patient Administration System (WPAS) lesson plans and guides are currently awaiting final sign off. User guides which include instructions on updating the keynote are going</p>	<p>Updated lesson plans, user guides and Standard Operating Procedures.</p> <p>Meetings with services to review best practice and booking processes.</p>	<p>New WPAS team in place to manage version control and publish guides ahead of January 2026 go-live.</p> <p>Continue to finalise Patient Policy to align with the</p>

	through version control ahead of publication. Standard Operating procedures including the patient policy are being reviewed to align with the Planned Care Academy.	Best practice and demonstrations on how to add key notes presented as part of health records awareness sessions and Corporate Induction.	Planned Care Academy.  WPAS system manager to submit a request in WPAS functionality to prompt users to check keynotes for alerts.  Continue to embed best practice in Health Records Awareness sessions and Corporate Induction.
4.1: Spot Checks. Spot checks on patient records are not conducted at ward level	The Business case to establish an audit team is part of the Digital, Data & Technology Integrated Medium Term Plan (IMTP) response.	To Be Confirmed.	To Be Confirmed.

The audit provided a limited assurance rating for Objective 3: *Records storage facilities ensure that records are protected from unauthorised access, destruction or theft and from accidental damage from environmental hazards.*

Key issues included inadequate security of records at St Cadocs Hospital storeroom, the White Valley Centre at St Cadocs and Block 3 at Nevill Hall, poor storage conditions in St Cadocs storeroom due to leaks from the roof/high humidity and uncertainty regarding future accommodation for Online House.

<b>Audit Finding</b>	<b>Action Taken in 2025</b>	<b>Evidence</b>	<b>Forward Plan</b>
5.1: Security of patient records in Nevill Hall Block 3 storage block & St Cadocs Hospital.	<b>Security Improvements</b> Secure keypad lock installed at White Valley Centre.	Confirmation email from Child Health Manager (August 2025) that a keypad lock has been installed.	Monitor and report security issues as they arise.
	The lift to the filing library in Nevill Hall is operational.	Lift in working order.	Monitor and report issues with the lift as they arise.
	The gates to Block 3 are locked out of	Gates locked out of hours.	

<p>6.1: Storage conditions in St Cadocs record storeroom.</p>	<p>hours and records are stored in terminal digit order to reduce the risk of unauthorised persons accessing another person's record easily.</p> <p>Remaining live patient records stored in Block 3 will move to Online house in January 2026.</p> <p><b>Reduction of Records</b> Block 3 at Nevill Hall Hospital is now at 30% capacity through controlled destruction, digitisation and transfer of live patient records to Online House.</p> <p><b>Closure of St Cadocs Stores.</b> Following pest control treatment, all records stored in St Cadocs Mental Health archive storeroom emptied.</p> <p><b>Operational Improvements.</b> Digital Health Record (DHR) Phase 3 commenced June 2025; recruited 3 whole time equivalent band 3 staff.</p>	<p>No "current" or live patient records stored in Block 3. This space is now a non-active deceased patient record archive.</p> <p>All remaining live acute patient records stored in Online House.</p> <p>Online House will be the primary storage hub for live patient acute health records.</p> <p>Pest risks mitigated and St Cadocs stores records transferred To Online House. Key returned to facilities.</p> <p>Microsoft list tracking progress of scanning "other" service records for Family &amp; Therapies, Community &amp; Primary Care, Scheduled Care,</p>	<p>Deceased records from 2017 and 2018 are stored in Block 3, due for destruction 2026 &amp; 2027. (Hold on this due to the embargo re: Infected Blood Compensation scheme).</p> <p>Complete scanning of remaining acute health records. Due to the embargo, staff involved in destruction support the digitisation process.</p> <p>Begin digitisation of mental health records. Provide a forecasted completion date when more key performance indicator (KPI) data is available.</p> <p>Monitor progress and provide forecasts of completion for each service as part of the agreed work package.</p>
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		<p>Unscheduled Care and Mental Health &amp; Learning Disabilities.</p> <p>NHS Wales Shared Services Partnership (NWSSP) instructed to explore lease extension options.</p>	<p>Secure lease extension renewal terms agreed.</p>
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The audit provided a limited assurance rating for Objective 4: *Physical records are transported appropriately, tracked and records are available when needed by operational staff.*

Key issues included lack of formal tracking, an inconsistent use of The Welsh Patient Administration System and ward clerk shortages impacting record management on the wards.

Audit Finding	Action Taken in 2025	Evidence	Forward Plan
<p>7.1 Access to Paper records. Patients transferred without their paper records, no records raised for admission by the ward, patients not formally discharged from clinical workstation after they have left hospital.</p>	<p>Similar actions to address these issues as taken to address issues for finding 2.1.</p> <p><b>Embedding Training</b> Increasing attendance at Health Records Supplementary Training</p>	<p>Submitted proposal Health Records Awareness Training to Core Learning Committee for mandatory status.</p> <p>Agreement with Deputy Head of Nursing Education to include records management training in Ward Accreditation compliance criteria and Journey of Excellence Corporate Induction for Nurses.</p> <p>Secured slots in corporate induction for newly qualified</p>	<p>Present proposal to Core Learning Committee (meeting scheduled 09/12/2025 cancelled, to be rescheduled in 2026)</p> <p>Continue to embed records management and best practice in induction programmes and ward accreditation.</p>

	<p><b>Contingency Planning</b> Liaising with Senior Divisional Nurses to develop plans for ward clerk absences</p> <p><b>Governance and Support</b> Launched Health Records Support Network on Microsoft Teams. Updated Employee Handbook.</p>	<p>nurses and doctors plus international nurse preparation programmes.</p> <p>Draft contingency procedure shared with Divisional Nurses.</p> <p>MS Teams Network expanded to nearly 100 members. Best practice guides, informational videos and Standard Operating Procedures are shared. Queries answered in real time.</p>	<p>Contingency plan in place if procedure agreed By Divisional Nurses.</p> <p>Network growth and continue to share best practice guidance.</p>
8.1 Access to Systems. Ward clerks with "write" access to Welsh Nursing Care Records (WNCR).	To ensure WNCR training sessions are available to ward clerks.	All ward clerks have been trained and have access to WNCR. Log of training received available.	Training actioned by Clinical Nurse Specialist for adult WNCR.

The work plan below provides evidence of digitisation activity across additional record types, including work that has been completed, activity currently underway and planned digitisation initiatives scheduled for 2026. As the programme progresses, additional record types will be added to the work plan.

Division	Record Type	Start Date	End Date	Number of Records Digitised	Number of Records to Digitise	Status
Corporate	Acute Care Health Records (Live Patients)	Mar-12	Ongoing	660,000	180,000	Monitoring & Controlling
Family & Therapies	Podiatry & Orthotics	27/07/2024	Ongoing	24,229	38,015	Monitoring & Controlling
Family & Therapies	Lymphoedema	16/08/2023	Ongoing	5,163	10,000	Monitoring & Controlling
Corporate	Finance	25/01/2025	17/05/2025	467		Completed
Family & Therapies	Paediatric Diabetes	18/06/2025	23/06/2025	221		Completed
Unscheduled Care	Cardiac Rehabilitation & Heart Failure	08/07/2025	10/10/2025	10,324		Completed
Family & Therapies	Childrens Epilepsy Service	16/10/2025	30/11/2025	467		Completed
Primary Care & Community	District Nursing	12/01/2026	TBC		78,988	Planning
Mental Health & LD	St Cadocs Mental Health Archive	07/01/2026	TBC		75162	Planning
Family & Therapies	Dietetics (St Cadocs Goldcliffe)	02/02/2026	TBC		149,413	Planning
Family & Therapies	Speech & Language Therapy (St Cadocs Langstone Hut)	02/02/2026	TBC		30,728	Planning
Family & Therapies	Adult Weight Management (St Cadocs Goldcliffe)	02/02/2026	TBC		3,900	Planning
	<b>Total</b>			700,871	566,206	

## **Service Manager Feedback on Digitisation Initiatives**

Feedback received from five Service Managers following recent digitisation initiatives demonstrates that these initiatives have delivered improvements in record accessibility, operational efficiency and information governance.

<b>Theme</b>	<b>What service managers reported</b>	<b>Governance / assurance relevance</b>
Access to patient records	Digitisation has enabled immediate access to patient records, reducing delays and reliance on physical files. Historical records that were previously inaccessible are now held with the main patient record.	Supports continuity of care, timely clinical decision-making-, and operational resilience.
Reduction in clinical and administrative risk	Prior to digitisation, prolonged storage of paper records created risks relating to governance and difficulty responding to Access to Health requests. Digitisation has strengthened the security of patient information.	Strengthens compliance with information governance, records management, and statutory requirements.
Operational efficiency and productivity	Services reported a reduction in administrative burden, including elimination of manual pulling, filing, transporting, and retrieving notes. Clinicians and staff can now focus on core clinical activities.	Demonstrates efficiency gains and better use of clinical and administrative capacity.
Improved security and auditability	Digitised records have enhanced confidentiality, reducing the risk of lost or misplaced files.	Provides assurance on data security.
Patient experience and service flexibility	Improved record availability has increased flexibility in appointment	Supports quality of care and patient

	delivery, including short notice visits and -community-based care.	centred- service delivery.
Physical estate and space utilisation	Removal of paper records has freed up valuable space and reduced the need for physical storage.	Contributes to better use of estate and reduced dependency on physical record storage.
Cross service- collaboration	Digitisation allows multiple services to access relevant patient information, improving shared understanding of patient conditions and supporting integrated care.	Supports integrated working and multidisciplinary care.

### **Argymhelliad / Recommendation**

The Digitised Health Records Service has taken action to address critical risks identified in the 2024/2025 audit including issues with storage, security, operational inefficiencies and gaps in ward level record management training. Through capacity planning, operational improvements and embedding Health Records best practice principles into induction programmes, the actions taken are designed to deliver sustainable and long-term improvements in records management.

The Audit, Risk and Assurance Committee are asked to consider the contents of this report and:

1. Support the submission of Health Records Management Training to the Core Learning Committee for approval as a mandatory requirement for all ward clerks and relevant staff.
2. Recognise the inclusion of records management training in corporate induction for nursing staff and clinical record keeping for junior doctors as a key governance improvement. Embedding these principles into staff education and induction will strengthen compliance and best practice.
3. Encourage divisional leadership to endorse the Health Records Support Network and promote its use during local induction of ward clerks, ensuring consistent access to standard operating procedures and best practice guidance.
4. Support the lease extension for Online House to secure long term storage and scanning capability, enabling continuity of digitisation.

### **Amcanion: (rhaid cwblhau)**

### **Objectives: (must be completed)**

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3. Effective Care 3.5 Record Keeping 7. Staff and Resources

Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	DHR – Digital Health Record IMTP – Integrated Medium-Term Plan KPI – Key Performance Indicators NWSSP – NHS Wales Shared Services Partnership WNCR – Welsh Nursing Care Record WPAS – Welsh Patient Administration System
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	
• <b>Workforce</b>	Not Applicable
• <b>Service Activity &amp; Performance</b>	Not Applicable
• <b>Financial</b>	Not Applicable
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>

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

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

Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives  
Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	12 February 2025
<b>CYFARFOD O: MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Audit, Risk and Assurance Committee Work Plan 2025/26
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Director of Corporate Governance
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Director of Corporate Governance

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

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA  
SBAR REPORT**

Sefyllfa / Situation

The Audit, Risk and Assurance Committee is asked to consider the draft Committee work plan appended to this report for approval. The work plan has been developed aligned to Guidance set out in the NHS Wales' Audit Committee Handbook (June 2012) to enable the Audit, Risk and Assurance Committee to:

- Fulfil its Terms of Reference (Agreed by the Board May 2025)
- Seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of key elements of the Health Boards internal and external audit, counter fraud and PPV arrangements (Second and third lines of defence);
- Seek assurance that governance, risk and assurance arrangements are in place and working well;
- Seek assurance in relation to the preparation and audit of the Annual Accounts; and
- Ensure compliance with key statutory, national and best practice audit and assurance requirements and reporting arrangements.

Cefndir / Background

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of

assurances on governance, risk management, the control environment and the integrity of financial statements of the annual report.

In line with good governance practice, a committee work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting function.

### Asesiad / Assessment

The Committee is requested to approve the Committee work plan as outlined in Appendix A noting that the work plan will be presented at each committee meeting for oversight and noting.

The Committee is asked to approve the proposal to combine the following two reports into a single, comprehensive update:

- Counter Fraud Annual Report; and
- Counter Fraud Functional Return.

The work plan will be used to inform Committee business alongside the Board and Assurance Framework which will seek to highlight areas of limited or reduced gaps in assurance.

### Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each Committee meeting for oversight;
- **AGREE** to reference and utilise the Committee work plan to inform committee meeting agendas and items for discussion in conjunction with the Risk Management Framework.

### **Amcanion: (rhaid cwblhau)**

#### **Objectives: (must be completed)**

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Choose an item. Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives <a href="#">Strategic Equality Objectives 2020-24</a>	Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
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

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	
• <b>Workforce</b>	Not Applicable
• <b>Service Activity &amp; Performance</b>	Not Applicable
• <b>Financial</b>	Not Applicable
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	Not Applicable Choose an item.

## **ANNUAL PROGRAMME OF BUSINESS 2026/27**

### **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 2025 and the Structured Assessment 2025 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
			28th April 2026	19th May 2026 Draft Accounts	23rd June 2026 Final Accounts	15th Sept 2026	24th November 2026	11th Feb 2027
<b>Preliminary Matters</b>								
Attendance and Apologies	SI	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
<b>Committee Requirements as set out in Standing Orders</b>								
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	√					
<b>Corporate Governance, Risk &amp; Assurance</b>								
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 and Welsh Health Circulars (WHC)	BI	DofCG		√			√	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	An	DofCG						√
Audit Recommendations Tracking Report <i>(April-June, July-September, October-December, January-March.)</i>	Qu	DofCG	√Q4			√Q1	√Q2	√Q3
Annual Review of Risk Management Framework	An	DofCG			√			
Report on the Implementation of the Risk Management Framework	An	DofCG			√			
Committee Risk & Assurance Report	SI	DofCG	√		√	√	√	
<b>Financial Governance and Control</b>								
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	19th May 2026 Draft Accounts	23rd June 2026 Final Accounts	15th Sept 2026	24th November 2026	11th Feb 2027
Report of Losses and Special Payments <i>(May report will be included in the Accounts)</i>	BI	DofF&P	√	√			√	
To Approve Reviewed and Updated Financial Control Procedures	Ad hoc	DofF&P	√		√	√	√	
<b>Annual Report and Accounts</b>								
To consider the approach and timelines for the Annual Report and Accounts	An	DofCG						√
Review the Health Board's Annual Report (Overview & Performance Section) <b>(Part 1)</b>	An	DofCG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement <b>(Part 2)</b>	An	DofCG		√	√			
Review Draft/Final Annual Accounts and Financial Statements <b>(Part 3)</b>	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			√			
<b>Counter-Fraud</b>								
Review of the Counter Fraud, Bribery and Corruption Policy <b>(Feb 2028)</b>	3-Yearly	DofF&P	-	-	-	-	-	-
Receive the Counter Fraud Annual Report and Agree the Counter Fraud Functional Standard Return Declaration	An	HofCF		√				
Agree the Counter Fraud Annual Workplan	An	HofCF	√					√
Receive a Progress Report on Counter Fraud Activity	Quarterly	HofCF			√	√		√
<b>Post Payment Verification</b>								
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	An	PPV Manager			√			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	19th May 2026 Draft Accounts	23rd June 2026 Final Accounts	15th Sept 2026	24th November 2026	11th Feb 2027
Receive a Mid-Year update in respect of Post-Payment Verification Activity	An	PPV Manager					√	
Clinical Audit								
Receive the Clinical Audit Activity Annual Report 2025 - 2026	An	Medical Director			√			
Agree the Clinical Audit Plan 2026 - 2027	An	Medical Director			√			
Mid-year Report on the delivery of the Clinical Audit Plan	An	Medical Director					√	
<b>Internal Audit (Including Specialised Audit) – NWSSP Audit &amp; Assurance Services</b>								
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	√					
<b>External Audit – Audit Wales</b>								
Receive the External Audit Annual Audit Report	An	AW		√	√			
Agree the External Audit Annual Plan	An	AW	√					
Receive the 2026 Structured Assessment	An	AW					√	
Receive External Audit Progress Report 2025-26	SI	AW	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	Ad hoc	AW						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad hoc	AW						
<b>Total Items Scheduled</b> (excluding preliminary items) -to be updated prior to each meeting			<b>15</b>	<b>12</b>	<b>19</b>	<b>9</b>	<b>16</b>	<b>9</b>

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	19th May 2026 <i>Draft Accounts</i>	23rd June 2026 <i>Final Accounts</i>	15th Sept 2026	24th November 2026	11th Feb 2027

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	
<b>DofCG</b>	Director of Corporate Governance
<b>DofF&amp;P</b>	Director of Finance and Procurement
<b>HofCF</b>	Head of Counter Fraud
<b>PPV</b>	Post Payment Verification
<b>HofIA</b>	Head of Internal Audit
<b>AW</b>	Audit Wales
<b>Chair</b>	Chair

Frequency of Inclusion Key	
<b>SI</b>	Standing Item
<b>AN</b>	Annually
<b>BI</b>	Biannually
<b>Quarterly</b>	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√R	Received at the Scheduled meeting
<b>D</b>	Deferred from this agenda
√ <b>D</b>	Deferred Scheduled agenda item Received
<b>W</b>	Withdrawn from FWP
<b>T</b>	Transferred to another Committee
<b>IC</b>	Matter discussed In Committee

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	12 February 2026
<b>CYFARFOD O: MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Internal and External Audit Recommendation Tracker Q3 Position
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Director of Corporate Governance
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Head of Corporate Risk and Assurance

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

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This report provides the Audit, Risk and Assurance Committee with an overview of the status of all internal and external audit recommendations as at the end of Quarter 3 2025/26 (31 December 2025).

It outlines progress since the previous reporting period, recommendations completed, revised implementation deadlines requested, and those exceeding agreed extension thresholds.

**Cefndir / Background**

The previous report to the Committee (December 2025) covered the position to the end of Quarter 2 2025/26. At that meeting:

- **74** recommendations were confirmed as completed
- Of **19** revised deadlines requested, **12** were agreed and **7** (relating to Discharge Planning and Job Planning) were not agreed

**Asesiad / Assessment**



## Internal and External Audit Recommendation Tracking

Since the previous report to the Committee, which recorded **99** live recommendations on the Tracker, an additional **34** recommendations have been added. As of the end of Quarter 3 (01 October 2025 – 31 December 2025), the Tracker contained a total of **133** live recommendations. Updates were requested for **62** recommendations that had reached their implementation date by 31 December 2025

Table 1 below reflects the position following updates against the **62** recommendations. Based on this information, the Committee is asked to:

- **Approve** the completion of **31** recommendations and;
- **Approve 31** revised implementation deadlines

Table 1

Lead Director	Completed	Revised Deadline	Total Updates
Chief Operating Officer	15	7	<b>22</b>
Director of Digital	4	8	<b>12</b>
Director of Finance & Procurement	-	3	<b>3</b>
Director of Nursing	5	5	<b>10</b>
Medical Director	-	1	<b>1</b>
Director of Workforce	1	2	<b>3</b>
Director of Allied Health Professions & Health Science	2	5	<b>7</b>
Director of Public Health	4	-	<b>4</b>
<b>Total updates this period</b>	<b>31</b>	<b>31</b>	<b>62</b>

**Table 3:** Provides a summary of the **31** recommendations confirmed as completed. (Refer to Appendix A for full details.)

Table 3

Completed Recommendations		
Audit Title	Assurance Rating	Number by Priority Rating
2021 IT Systems Controls (WRIS)	Reasonable	<b>1</b>
2021 Facilities Care After Death	Reasonable	<b>1</b>



2021 Primary Care	Not Rated	<b>1</b>			
2022 Records Management	Limited	<b>1</b>			
2022 Discharge Planning	Limited	<b>1</b>			
2023 Providing Care to Asylum Seekers and Refugees	Reasonable	<b>1</b>			
2024 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	<b>1</b>			
2025 Discharge Planning Progress Update	Not Rated	<b>2</b>			
2025 Eye Care Review	Not Rated	<b>1</b>			
2025 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	<b>2</b>			
2025 Embedding of Policies – Speaking up Safely	Limited	<b>1</b>			
2025 Divisional Governance Arrangements	Reasonable	<b>1</b>			
2025 Mental Health and Learning Disabilities	Reasonable	<b>2</b>			
2025 Health and Safety	Limited	<b>2</b>			
2025 Medical Equipment and Devices	Reasonable	<b>1</b>			
2025 Records Management	Limited	<b>1</b>			
2025 Intelligence Led Organisation	Reasonable	<b>1</b>		<b>1</b>	
2025 Health Board Managed Practices - Advisory	Not Rated	<b>5</b>			
2025 Newport East Health and Wellbeing Centre	Reasonable	<b>4</b>			
<b>TOTAL</b>		<b>1</b>	<b>16</b>	<b>2</b>	<b>12</b>
		<b>31</b>			

Table 4: Sets out the **31** recommendations with revised deadlines. (Refer to Appendix B for full details).

Table 4

<b>Recommendations with Revised Deadlines</b>		
<b>Audit Year and Title</b>	<b>Assurance Rating</b>	<b>Number by Priority Rating</b>
2020 Control and Risk Assessment - Advisory	Not Rated	<b>1</b>
2021 It System Controls (WRIS)	Reasonable	<b>5</b>
2021 Audit of Accounts Addendum	Not Rated	<b>1</b>
2022 Records Management	Limited	<b>2</b>
2022 Discharge Planning	Limited	<b>2</b>



2023 Waiting List Management	Reasonable	1			
2024 Structured Assessment	Not Rated	2			
2024 Review of Cost Savings Arrangements	Not Rated	1			
2024 End of Life	Reasonable	1			
2024 Health and Safety	Limited	2	3		
2025 Quality Governance Follow up	Not Rated	1			
2025 Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	1			
2025 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	1			
2025 Records Management	Limited	1	2		
2025 Job Planning	Limited	1			
2025 Intelligence Leg Organisation	Reasonable	1			
2025 Technical Continuity	Reasonable	1			
2025 Safeguarding	Reasonable	1			
<b>TOTAL</b>		<b>11</b>	<b>13</b>	<b>-</b>	<b>7</b>
		<b>31</b>			

Following the agreed removal of the **31** completed actions and the approval of **31** extension requests, **102** recommendations will remain live on the tracker.

Of the **102** recommendations, **86** remain within the accepted extension threshold of two deadline revisions. The remaining **16** exceed this threshold, warranting closer scrutiny and, where appropriate, escalation. It is important to note that in some cases, implementation is contingent on external factors or the completion of related recommendations. Additional information on these recommendations can be found in Tables 5 and 6 below.

Table 5

Implementation Status	Total number of Recommendations
Within Original Deadline	55
1 <sup>st</sup> Extension	23
2 <sup>nd</sup> Extension	8
<b>Total Number within the Threshold</b>	<b>86</b>
3 <sup>rd</sup> Extension	6



4 <sup>th</sup> Extension	3
5 <sup>th</sup> Extension	5
6 <sup>th</sup> Extension	1
7 <sup>th</sup> Extension	1
<b>Total Number Outside the Threshold</b>	<b>16</b>
<b>Overall Total</b>	<b>102</b>

The **16** recommendations that fall outside the extension threshold are taken from the following reports, refer to Appendix C for full details.

Table 6

Recommendations Outside of Agreed Deadline Extension Threshold			
Audit Year and Title	Assurance Rating	Number by Priority Rating	Number of Extensions Requested
Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	1	3 <sup>rd</sup> Extension
Discharge Planning 2022	Limited	2	2 X 3 <sup>rd</sup> Extension
Estates Condition 2024	Limited	1	3 <sup>rd</sup> Extension
IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	3	2 x 4 <sup>th</sup> Extension 1 x 6 <sup>th</sup> Extension
IT Infrastructure 2023	Reasonable	1	4 <sup>th</sup> Extension
IT Systems Controls (WRIS) 2021	Reasonable	5	5 x 5 <sup>th</sup> Extension
Pathology 2021	Reasonable	1	3 <sup>rd</sup> Extension
Records Management 2022	Limited	2	3 <sup>rd</sup> Extension 1 x 7 <sup>th</sup> Extension
<b>Total</b>		<b>16</b>	

### Argymhelliad / Recommendation

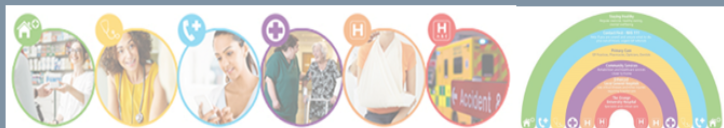
The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the completion of **31** recommendations;
- **APPROVE 31** revised implementation deadlines

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

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:  
Datix Risk Register Reference and Score:

Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.



Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Choose an item.  Integral to the delivery of the IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	Choose an item. Choose an item. Choose an item. Choose an item.

**Gwybodaeth Ychwanegol:  
Further Information:**

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

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

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



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

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

Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs  
Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies





ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	RS.1	"RS.1 The Board should introduce a completeness check to ensure that all requests received have been entered into WRIS."	Staff have SOP's and checks when putting forms on however human errors do occur without fully electronic requesting.		30/11/2025			Completed	Completed		SOP's are still active and staff work to them. The number of errors that occur are a small percentage compared to the amount of data inputted by the team.		SOP's are still active and staff work to them. The number of errors that occur are a small percentage compared to the amount of data inputted by the team. Risks will be reduce with the implementation of RISP.	31/12/2025
2021.3	Internal	Facilities - Care After Death	Reasonable	Chief Operating Officer	Medium	R3	"R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. If not, then alternative software / system should be procured, to include some / all of the following features: <ul style="list-style-type: none"> <li>remotely accessible across all sites, at all times;</li> <li>update immediately following any change inputted;</li> <li>link to key software within the Health Board, to minimise manual data entry;</li> <li>produce management information / a dashboard and other relevant information (e.g. patient location);</li> <li>raise warnings where breaches to the SOPs are imminent, e.g. capacity, temperature (if recommendation three is adopted) warnings;</li> <li>a full audit trail including access information and data changes;</li> <li>support profile levels to facilitate access control; and</li> </ul> be fully compliant with the Health Board and DHCW shared service software requirements"	It is acknowledged that the current system does present the Health Board with a risk due to the issues as identified within the audit. The issue of the current & inherited database being unfit for purpose is acknowledged; the Estates & Facilities Division will now engage with suppliers to identify a suitable replacement software system. A three-month window to identify supplier, design a system and implement is believed to be a significant challenge. It is expected that this work may take up to a six-month period.		31/12/2025			Completed	Completed		R3 The Care after Death Team should determine if the software delivers sufficient benefits in excess of the potential risks. System updates in real time when changes are made System is interfaced to PAS to minimise patient data entry System provides business information which will allow calculation of length of stay once sufficient data has been accumulated. System also displays info relating to patient location and status System will flag if a release was attempted whilst tissue samples were still outstanding. System will also flag a patient as red as and when body condition checking is required. Full audit information is available including access and changes Yes - access can be controlled through user profile levels System is fully compliant with HB and DHCW software requirements.	System has not been interfaced to LIMS due to 1) delays in delivery of LIMS2.0 2) interfacing costs Interfacing to LIMS would deliver a minor benefit and the cost v benefit of interfacing will be assessed once the LIMS2.0 deployment project is completed (potentially Q2 26/27)	Eden system has been configured, delivered and is in use live across the HB.	31/12/2025
2022.1	Internal	Records Management	Limited	Director of Digital	Low	R9	R9 Loose patient records should be properly filed	The CNIO will reinforce this requirement with the ward staff. The process for creating DHR supplementary folders on wards will be shared with all Divisional nurses.		31/12/2025			Completed	Completed		January 2026 Update - Records management training is now included in the Ward Accreditation Process.			31/12/2025
2022.2	Internal	Discharge Planning	Limited	Director of Nursing	Medium	R7	We recommend that the Health Board continue to analyse the reasons behind re-admissions within a suitable period of time. Where themes and trends are identified that these are investigated further	The analysis of readmission rates is acknowledged as being problematic, as without clinical input at the time of readmission, our current systems are unable to differentiate between a readmission for a reason connected to a prior episode of care, or one that relates to a completely different clinical scenario. CHKS, which is the national benchmarking solution choice for Wales looks at the number of patients who have been readmitted regardless of speciality, 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 walk		18/09/2025			Completed	Completed				"Analysis of readmission rates is recognised as challenging. Without clinical input at the point of readmission, current systems are unable to distinguish whether a readmission is related to the preceding episode of care or whether it reflects a completely separate clinical need. CHKS, the national benchmarking solution used across Wales, reports readmissions based solely on the number of patients who return within a defined period, regardless of speciality, consultant, diagnosis, or presenting complaint. This significantly limits interpretation and can render comparisons or conclusions unreliable.  To address this, the Planning team is working closely with clinical services to develop a suite of more meaningful measures to better understand readmission trends and target areas for improvement. Several data viewers are already in place, enabling bespoke analysis on request, and these enhanced measures will be incorporated into outcome dashboards and QPS Insights going forward.  Health Board also has dedicated services that support frequent or "high impact" users, working across divisional boundaries to provide alternative pathways and reduce avoidable readmissions. In parallel	31/12/2025
2023.4	Internal	Providing Care to Asylum Seekers and Refugees	Reasonable	Chief Operating Officer	Medium	1.1	The Health Board should undertake a service review based on the requirements of vulnerable groups within the Health Inclusion Service to determine if the workforce / resource position required remains appropriate. As part of the review, future demand and the level of patient support required should be considered alongside the requirement to build a resilient workforce and deliver the service in accordance with the Policy.	The Health Board will undertake a review to scope the demand and capacity requirements of Asylum Seekers and Refugees from initial arrival to settlement in Gwent to establish the workforce / resource requirements to sustain the service. The review will scope demand and capacity since service was developed in 2019 to current position, taking into account population needs assessment and changing legislation i.e. S98, supporting those fleeing conflict.		31/12/2025			Completed	Completed		A service review has been completed across the Health Inclusion service [delayed due to bereavement leave]. This review has scoped demand and capacity since the service was implemented to current position, taking into account all eligible service users i.e. Asylum seekers, refugees, sex workers, homeless and Gypsy and Romani travellers. The proposed review was approved by SLT in September 2025. An implementation plan has been created to support the service to embed the Tier 3 model pan Gwent to support our most vulnerable populations to access health services through outreach provision and a range of drop in clinics in collaboration with both internal and external partners.		A new service model has been implemented to support our most vulnerable populations to access health services via a range of outreach in collaboration with third sector providers and through collaborative drop in provision pan gwent. This outreach work is relational to support individuals into drop in clinics with a view to being supported into Tier 2 supplementary service provision and then onto accessing Universal services.	31/12/2025

2021EA A	External Audit	Primary Care	Not Rated	Chief Operating Officer	N/A	R4c	Subject to positive evaluation, begin to fund these new models from mainstream funding, rather than from the Primary Care Development Fund.	"Work has already begun and services such as Wet AMD for ophthalmology and extended skin are now funded as a core service which was initially established through pace setters"			20/12/2025			Completed	Completed		Wet AMD service, previously delivered through Primary Care Ophthalmic Diagnostic Treatment Centres (ODTC) transferred into WGOS 4 pathways from 31 March 2025. New Minor Surgery Directed Supplementary Service (DSS) commissioned in AB from 1 November 25. Three tiers to the service incorporating requirements of the previous Extended Skin Local Supplementary Service (LSS). The required 3 months notice has been served on the LSS and current transitional arrangements are in place.	ODTC has ceased.	31/12/2025
4001EA 2024	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	2.1	To support the ongoing delivery of Six Goals related initiatives, the Health Board needs to clarify and confirm the funding arrangements for schemes beyond March 2025. Plans for future years should also identify any funding needs beyond their current annual allocation.	To ensure the continued delivery and sustainability of Six Goals-related initiatives, the Health Board is taking the following steps: <ul style="list-style-type: none"><li>national programme funding has been secured and allocated to support the ABUHB Six Goals Programme through to March 2026.</li><li>a structured evaluation process will be undertaken for all projects funded up to March 2026. This will assess impact, outcomes, and alignment with strategic priorities to inform future funding decisions.</li><li>internal planning is underway to identify ongoing funding requirements for services expected to continue beyond 2025-26. This will include engaging with operational leads, finance colleagues, and strategic planning teams to ensure sustainability and alignment with health board priorities.</li><li>funding needs for continuing schemes will be incorporated into the Health Board's medium term financial plan and business planning processes, ensuring early visibility of any investment</li></ul>	Executive Director of Nursing	31/12/2025			Completed	Completed	0	Welsh Government have issued the Planning Framework and Financial allocation for 2026/27 which ring-fences £17M pan-Wales to support Health Boards in the delivery of Transformation programmes within Urgent & Emergency care.  The Health Board has an active Six Goals UEC Transformation programme that includes the following workstreams:  Care Homes Acute Frailty Community Beds Community Falls Single Point of Access Populations at Risk Discharge / Optimal Hospital Flow Framework  Internal planning is ongoing to identify ongoing funding requirements for services expected to continue into 26/27 and how the Welsh Government allocation will be utilised. This will include engaging with operational leads, finance colleagues, and strategic	our 'Integrated Discharge Board' meeting for the duration of Winter 2025/26. This is to ensure increased touch points with partners and maintains productivity through the period of higher demand.  However, the Integrated Discharge Board terms of reference include a wide range of stakeholder inclusion including Local Authority partners, Welsh Ambulance Services Trust, Llais, Urgent Care, Medicine and Primary & Community Care Divisions.  Continuous patient feedback comes from multiple sources including our putting it right service as well as CIVICA feedback. The CIVICA system continues to be the primary source of proactive patient feedback capturing real-time patient experience. Insights gathered are reviewed by divisions to ensure patient voice for divisional assurance and decision making.	31/12/2025	
4005EA 2025	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			Completed	Completed	0	Ambulance Care Dashboard has now been implemented with limited access to staff. Awaiting confirmation from Head of Operations of users needing access prior to full roll out.	Ambulance Care Dashboard has now been implemented with limited access to staff. Awaiting confirmation from Head of Operations of users needing access prior to full roll out.	31/12/2025	
4005EA 2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.4	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	Weekly review of Pathway of Care Delays, patients over 100 days, working local authority partners.	Executive Director of Nursing	31/12/2025			Completed	Completed	0	"A weekly review is undertaken of the top 20 longest-staying patients across all sites, in partnership with Local Authority colleagues. Emerging themes and learning are shared through the Integrated Discharge Board to support system improvement.  Weekly 'fishbowl' and length of stay meetings are held across acute and community sites, with attendance from Local Authority partners. These meetings focus on discharge delays and the required lead in times for services, ensuring timely escalation and action."	31/12/2025		
4007EA 2025	External Audit	Eye Care Review	Not Rated	Chief Operating Officer	N/A	6.1	The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed.	The Health Board acknowledges the recommendation and is committed to ensuring that risks related to eye care services are appropriately captured and managed within its established governance framework. Ophthalmology risks are managed through the Health Board's Risk Management Framework to support safe, sustainable, and high-quality service delivery. At the operational level, divisional risks - including those related to long waits, workforce shortages, and service pressures are actively monitored and reviewed through directorate and divisional governance structures to ensure timely mitigation and oversight where required. At the strategic level, there are currently no discrete ophthalmology risks recorded on the corporate or strategic risk registers. Relevant issues are reflected within broader strategic risks, such as recruitment and retention across specialties, the adequacy of strategic planning, and the delivery of planned care waiting list targets, which collectively encompass ophthalmology. Specialty-specific risks are	Associate Director of Planned Care	31/12/2025			Completed	Completed	0	Ophthalmology risk register has been reviewed and updated where appropriate. Existing risks that are no longer an issue have been closed, and emerging risks have been added to ensure the risk register is an accurate representation of current directorate circumstances. This satisfies the recommendation identified by WAO.	Ophthalmology risk register has been reviewed and updated where appropriate. Existing risks that are no longer an issue have been closed, and emerging risks have been added to ensure the risk register is an accurate representation of current directorate circumstances. This satisfies the recommendation identified by WAO.	31/12/2025	
4007EA 2025	External Audit	Eye Care Review	Not Rated	Chief Operating Officer	N/A	1.1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	Chair of Regional Ophthalmology Programme Board	31/12/2025			Completed	Completed	0	First Regional Joint Committee was held in November 2025 and the meeting frequency is quarterly. The committee is chaired by Jonathan Morgan (Chair of Cwm Taf Morgannwg Health Board) and has board level and Executive membership from all three Health Boards. All regional business cases will be agreed through this route from now on to increase the pace of delivery and streamline regional decision making.	First Regional Joint Committee was held in November 2025 and the meeting frequency is quarterly. The committee is chaired by Jonathan Morgan (Chair of Cwm Taf Morgannwg Health Board) and has board level and Executive membership from all three Health Boards. All regional business cases will be agreed through this route from now on to increase the pace of delivery and streamline regional decision making.	31/12/2025	

4916A2 025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	7.1	Use of patient feedback To ensure the Health Board is building on feedback from patients, plans for urgent and emergency care should demonstrate how they have considered patient feedback (Exhibit 9)	To ensure patient feedback actively informs the planning and improvement of urgent and emergency care, the Health Board is strengthening its approach in the following ways: patient stories are regularly incorporated into Six Goals Programme Board discussions. We recognise the value these narratives provide and are committed to expanding their use to inform strategic planning and service redesign.  we have recently implemented CIVICA, the national patient-reported experience measure tool, across our services. This will provide robust, real-time data on patient experience in urgent and emergency care. Insights generated will be regularly reviewed and presented to the Programme Board to guide evidence-based decision-making.  we have secured ongoing representation from our regional Llais partner on the Six Goals Programme Board. This ensures that the patient voice is present and the board membership includes broad representation from partners such as WAST, Llais, NHS Executive, and Local Authorities. Primary and Community Care (PCC) Division is represented by two Senior Responsible Officers who are part of the PCC divisional leadership team. In addition, primary care clinicians aligned to transformation initiatives are invited to participate. However, we acknowledge that regular clinical commitments can limit attendance and input from practising primary care clinicians. To address this, we will: <ul style="list-style-type: none"> <li>extend a standing invitation to all Neighbourhood Care Network (NCN) Leads, ensuring broader clinical representation across the geography;</li> <li>review scheduling and format of board meetings to improve accessibility for primary care participants;</li> <li>explore alternative models of engagement. These changes will be implemented by the end of Q2 2025, and the effectiveness of this enhanced representation will be reviewed at the end of the year.</li> </ul>	Director of Nursing	31/12/2025			Completed	Completed	0	The Six goals programme board has been temporarily integrated with our 'Integrated Discharge Board' meeting for the duration of Winter 2025/26. This is to ensure increased touch points with partners and maintains productivity through the period of higher demand.  However, the Integrated Discharge Board terms of reference include a wide range of stakeholder inclusion including Local Authority partners, Welsh Ambulance Services Trust, Llais, Urgent Care, Medicine and Primary & Community Care Divisions.  Continuous patient feedback comes from multiple sources including our putting it right service as well as CIVICA feedback. the CIVICA system continues to be the primary source of proactive patient feedback capturing real-time patient experience. Insights gathered are reviewed by divisions to ensure patient voice for divisional assurance and decision making.	The Six goals programme board has been temporarily integrated with our 'Integrated Discharge Board' meeting for the duration of Winter 2025/26. This is to ensure increased touch points with partners and maintains productivity through the period of higher demand.  However, the Integrated Discharge Board terms of reference include a wide range of stakeholder inclusion including Local Authority partners, Welsh Ambulance Services Trust, Llais, Urgent Care, Medicine and Primary & Community Care Divisions.  The Programme for UEC Improvement will ensure the above referenced stakeholder groups will remain to be included in the programme board going forward.	31/12/2025	
4916A2 025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	9.1	Primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board: To ensure the Health Board has a broad understanding of demand pressures and the interaction of urgent and emergency care services, it should ensure there is primary care representation at the Six Goals for Urgent and Emergency Care Improvement Programme Board (Exhibit 10).	Agreed Management Action: A review of demand for Speaking up Safely will be undertaken and the outcome of this review will inform an organisational discussion on resourcing implications. Expected Evidence of Implementation: Evidence of a demand and capacity review of the first 6 months with recommendations on the most suitable route forward. Outcome of review will be available September 2025	Director of Nursing	30/09/2025			Completed	Completed	0	The Six goals programme board has been temporarily integrated with our 'Integrated Discharge Board' meeting for the duration of Winter 2025/26. This is to ensure increased touch points with partners and maintains productivity through the period of higher demand.  However, the Integrated Discharge Board terms of reference include a wide range of stakeholder inclusion including Local Authority partners, Welsh Ambulance Services Trust, Llais, Urgent Care, Medicine and Primary & Community Care Divisions.  The Programme for UEC Improvement will ensure the above referenced stakeholder groups will remain to be included in the programme board going forward.	The Six goals programme board has been temporarily integrated with our 'Integrated Discharge Board' meeting for the duration of Winter 2025/26. This is to ensure increased touch points with partners and maintains productivity through the period of higher demand.  However, the Integrated Discharge Board terms of reference include a wide range of stakeholder inclusion including Local Authority partners, Welsh Ambulance Services Trust, Llais, Urgent Care, Medicine and Primary & Community Care Divisions.  The Programme for UEC Improvement will ensure the above referenced stakeholder groups will remain to be included in the programme board going forward.	31/12/2025	
ABUHB 2425-06	Internal Audit	Embedding of Policies - Speaking Up Safely	Limited	Director of Workforce & OD	High	1.1	Resourcing The current resourcing for the speaking up safely framework is insufficient, with no dedicated staff or budget allocation, except for the external reporting platform Vivup, which is funded for 12 months through charitable and income generation sources. Depending upon the volume of cases that are raised this may change in the future. Currently, the Assistant Director of Workforce & OD and the Consultant Clinical Psychologist serve as speaking up safely guardians but manage this role in addition to their existing responsibilities.	Agreed Management Action: A review of demand for Speaking up Safely will be undertaken and the outcome of this review will inform an organisational discussion on resourcing implications. Expected Evidence of Implementation: Evidence of a demand and capacity review of the first 6 months with recommendations on the most suitable route forward. Outcome of review will be available September 2025	Assistant Director of Workforce and OD	30/09/2026	#####			Completed	Completed	1	August 2025: The review of current resourcing levels has begun with a planned reporting date of September 2025 as per the final Audit report.	Charitable funds approved post to support the speaking up safely work. Job description being created and proposed starting date of April 1st 2026	31/12/2025
ABUHB 2425-08	Internal Audit	Divisional Governance Arrangements	Reasonable	Chief Operating Officer	Medium	1.1	Guidance on Key Risks There was no specific guidance provided on the nature of key risks and matters that should be considered for escalation, and the judgement required, including how this links into the risk management escalation process, set out within the Risk Management and Assurance Framework. Staff would benefit from specific guidance/ clarity on the threshold for issues to be escalated.	Agreed Action: We accept this recommendation and recognise that the absence of clear guidance on what constitutes a "key risk" and when escalation is appropriate may result in inconsistent or delayed escalation of important issues. To strengthen our risk management culture and improve consistency, the following actions will be taken: <ul style="list-style-type: none"> <li>Add a Risk management page introduced on Divisional Intranet.</li> <li>Adhere to the Risk Management and Assurance Framework reference escalation routes, risk grading, and ownership responsibilities.</li> <li>Communication and Awareness of the Risk Management Framework. <ul style="list-style-type: none"> <li>Risk management training.</li> </ul> </li> </ul> Expected Evidence of Implementation: Monitoring Uptake and Impact Use of the guidance and consistency of escalations will be reviewed through quarterly governance audits and feedback loops at SLT and divisional Programme meetings, as delegated by SLT.	Assistant Head of Business & Performance	27/06/2025			Completed	Completed	0	Work is ongoing to review the current risk registers to ensure they are accurate and up to date, and through this the DMT are reminded of the framework.  In addition a divisional risk management intranet page has been developed and published, including both localised Divisional processes and links to Corporate information, and will be reviewed regularly.  A review of the embedding and understanding of the divisional risk management processes will be undertaken in Spring 2026, and further work undertaken where required.	Processes are in place and will be reviewed regularly.	31/12/2025	
ABUHB 2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	3.1	Implementation The 90-day action plan was originally scheduled for completion by December 2023. However, as of January 2025, we confirmed three out of the four actions have been fully completed with one action partially complete. Whilst we confirmed that progress has been made against each of the actions, with considerable work completed / underway, the Plan has still not been fully delivered. Overall, we found that the Plan lacked specific delivery milestones and we found multiple live records in use to record status updates. Upon implementation of the Plan, there is value in reviewing the process adopted for the delivery and monitoring of actions to inform future plans. In particular, how accountability for the delivery of actions is maintained.	Agreed Action: <ul style="list-style-type: none"> <li>From September 2024, MH&amp;LD transitioned into Phase 2 of the Improvement Plan, focusing on sustaining actions and developing long-term initiatives.</li> <li>The Triumvirate and senior leadership team are now permanent, with ongoing efforts in culture change and workforce development.</li> <li>A robust monitoring framework is being implemented, including detailed tracking, regular progress reviews, and formal escalation procedures. This will have oversight by the COO and the QPS Team.</li> <li>Staff training and development are prioritised to enhance accountability and ensure timely delivery of actions.</li> </ul> Expected Evidence of Implementation: <ul style="list-style-type: none"> <li>Staff engagement events scheduled.</li> <li>Participate in National events.</li> </ul> <ul style="list-style-type: none"> <li>Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices.</li> <li>Robust audit and risk processes.</li> </ul>	Divisional Director, General Manager, Divisional   Nurse (Triumvirate), Directorates	30/09/2025			Completed	Completed	1	November 2025: "Many aspects of the Improvement plan are now incorporated as BAU. Division has formal inks to Corporate QPS team with attendance at regular meeting QPS/ Risk management meetings Training team has been realigned to deliver Divisional priorities, line management moved to Divisional Nurse to ensure CTP, WAARN compliance is visible and improving Incident management process enhanced with daily touchpoint meeting to review and direct action for every reported incident. Additional staff training in respect of concise or comprehensive status Staff engaged in national workstreams as directed by the MH strategic programme Mock HIW process used to assess compliance against a range of metrics, action plans in place with updates at Directorate Assurance Regular reporting at IQPD and WG Performance meetings"	January 2026: Many aspects of the Improvement plan are now incorporated as BAU. Division has formal inks to Corporate QPS team with attendance at regular meeting QPS/ Risk management meetings Training team has been realigned to deliver Divisional priorities, line management moved to Divisional Nurse to ensure CTP, WAARN compliance is visible and improving Incident management process enhanced with daily touchpoint meeting to review and direct action for every reported incident. Additional staff training in respect of concise or comprehensive status Staff engaged in national workstreams as directed by the MH strategic programme Mock HIW process used to assess compliance against a range of metrics, action plans in place with updates at Directorate Assurance Regular reporting at IQPD and WG Performance meetings"	31/12/2025	
ABUHB 2425-09	Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	4.1	Intended outcomes We found progress is being made in implementing the 90-day actions; however, not all actions have been fully implemented, preventing us from determining if the Division is achieving the intended outcomes. Completing a post-plan analysis would be beneficial in outlining the necessary steps to embed these actions once they are all fully implemented.	Agreed Action: <ul style="list-style-type: none"> <li>Tight oversight on Disability Division for serious incidents and governance.</li> <li>Improvement plan sustained.</li> <li>Initiatives in workforce, leadership, performance, risk, and service changes progress.</li> <li>Reporting to key committees and meetings.</li> <li>NHS Executive Colleagues' advisory role continues.</li> </ul> Expected Evidence of Implementation: <ul style="list-style-type: none"> <li>Staff engagement events / staff survey results.</li> <li>Staff retention.</li> </ul> <ul style="list-style-type: none"> <li>Improved inspections and management of serious incidents and improve safeguarding, quality, safety, and governance practices.</li> <li>Robust audit and risk processes/plans in place.</li> <li>Continue regular reporting to committees.</li> <li>Agreed workplan for the MH&amp;LD Committee and plan for the year.</li> <li>Triangulate inspection and audit data, linking it with the wider QPS team and escalate when needed.</li> <li>Continuous monthly IQPD reporting</li> </ul>	Divisional Director, General Manager, Divisional   Nurse (Triumvirate), Directorates	30/09/2025			Completed	Completed	0	November 2025: Improvement for management of serious incidents, now embedded as BAU Division is progressing OCP to revise management structure and ensure alignment to delivery of HB and WG priorities MHA formal quarterly meeting now in place with wider remit, chaired by HB vice chair Cultural change programme commenced June 2025 with a 2 year timescale. Initial priority areas identified Staff vacancies reduced and lower turnover, likely to be fully recruited for nursing early 2026 Positive feedback from HIW inspections, no immediate assurance required on 2025 reports"	January 2026: Improvement for management of serious incidents, now embedded as BAU Division is progressing OCP to revise management structure and ensure alignment to delivery of HB and WG priorities MHA formal quarterly meeting now in place with wider remit, chaired by HB vice chair Cultural change programme commenced June 2025 with a 2 year timescale. Initial priority areas identified Staff vacancies reduced and lower turnover, likely to be fully recruited for nursing early 2026 Positive feedback from HIW inspections, no immediate assurance required on 2025 reports"	31/12/2025	

ABUHB 2425- 12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professional s	Medium	3.1	Record of Legislative and Statutory Requirements There was an electronic Health and Safety Legislative & Statutory Register for all relevant requirements, but this was out of date and should be reviewed. The Health and Safety and Fire Work Plan 25-26 (H&S WP 25-26 -079) included a corresponding high priority action (with a target date of 31 May 2025) to address this, but work had not commenced at the time of the audit.	<p>Agreed Action: The Health and Safety Legislative &amp; Statutory Register has been reviewed and updated. The revised register will be presented at the next Health and Safety Committee in September 2025. The Health and Safety Legislative &amp; Statutory Register will be reviewed annually via the Health and Safety Committee to ensure it is appropriately maintained. Health and safety performance has been and will continue to be regularly reported to the Executive Committee. Expected Evidence of Implementation: • Health and Safety Legislative &amp; Statutory Register • Health and Safety Committee Notes of September 2025 meeting</p>	Head of Health, Safety and Fire	30/09/2025			completed	completed	0	The revised Health and Safety Legal Register was approved at the Health and Safety Committee on 10 December 2025	The Health and Safety Legal Register has been reviewed and updated. The register was approved at the Health and Safety Committee on 10 December 2025 and will be monitored by the Committee for any changes or planned reviews	31/12/2025
ABUHB 2425- 15	Internal Audit	Medical Equipment and Devices	Reasonable	Director of Allied Health Professional s	Medium	4.1	Oversight monitoring of incidents that occur in the Health Board, involving the use of medical equipment or devices, ceased operating in 2023/24 pending re-definition of the remit of the Medical Devices Committee (which had previously fulfilled this control function).	<p>Agreed Action: The Medical Devices Committee has been re-established under the new Quality Management System and is now referred to as the Medical Devices Group. Since the audit, the group has met twice and will continue to meet every two months. The group reports to the Executive-led Quality Management Group (QMG) for assurance purposes and will provide an annual activity report. The standard agenda for each meeting includes: • Review of incidents reported during the period • Trend analysis of medical device issues Updates on the procurement and decommissioning of medical devices. Expected Evidence of Implementation: - Medical Devices Group Terms of Reference, Agenda and minutes/actions from meetings - Annual Activity Report</p>	Chair of Medical Devices Group	30/09/2025			Completed	Completed	0		The Medical Devices Committee has been re-established under the new Quality Management System and is now referred to as the Medical Devices Group. Since the audit, the group has met twice and will continue to meet every two months. The group reports to the Executive-led Quality Management Group (QMG) for assurance purposes and will provide an annual activity report. The standard agenda for each meeting includes: • Review of incidents reported during the period • Trend analysis of medical device issues Updates on the procurement and decommissioning of medical devices.	31/12/2025
ABUHB 2425- 16	Internal Audit	Records Management	Limited	Director of Digital	Medium	1.1	<p>Lesson learnt</p> <p>The escalation process through the Health Board is inconsistent, with issues prioritised differently across the organisation. We observed examples of record management issues raised at the Royal Gwent Hospital (RGH) and Nevill Hall Hospital (NHH), but no formal actions have been initiated resulting in sustained improvement. Furthermore, robotic functionality has been fully implemented to identify data issues with the output generated as an automatic email detailing the problem. While this approach appears sound, in practice, it results in multiple emails being sent to the same individual regarding issues across multiple patients. We note that the volume of the system-generated emails is significant and due to the high number, there is a risk that they may not be fully acknowledged or addressed by responsible individuals.</p>	<p>Agreed Action: Datix is the incident reporting system for the Health board. We will highlight the inconsistent use of this system to the system lead and health and safety manager, and recommend more training offers, to training on documenting the formal actions that have been taken, as part of the management review. We recognise that the output from the robotic functionality requires analysis, and a more targeted follow up is necessary for improvement. Expected Evidence of Implementation: The Health and Safety team and Datix system lead would be required to provide evidence of training. Datix training sessions are scheduled regularly and staff are directed to the training video on the intranet for reporting incidents. We will review the current process with RPA and implement follow up meetings with individual directorates to support action. Documented evidence of this will be available for audit purposes</p>	Health and Safety Manager and Datix System Lead.	30/06/2025			Completed	Completed	1	August 2025: The audit findings were highlighted to The Health & Safety Manager and Datix System Lead who responded "We regularly run sessions for managers on the management review / investigation process and staff are directed to the training video"	We regularly run sessions for managers on the management review / investigation process and staff are directed to the training video	31/12/2025
ABUHB 2425- 22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	4.1	Management should ensure that the project to replace the SFN tool used within the Planning division is delivered, with appropriate representation from the division to fully feed in their needs.	A formal governance structure is in place chaired by the Director of Strategy, Planning & Partnerships and the Director of Digital. This project group contains representations from digital, planning and service leads and is managing the replacement for the SFN product.	Director of Digital	31/03/2025			Completed	Completed	0	January 2026 - development work has progressed into phase 2 focused on supporting and training the team within planning	Audit recommendation has been completed in that a governance structure is well established and in place	31/12/2025
ABUHB 2425- 22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Low	5.1	Management should ensure that the source data is retained that was used to generate the entries in the Health Board's MDS submission regardless of the model employed to generate the forecasts.	For all MDS measures derived from the Health Board corporate data warehouse, the source data is retained and is replicable. For MDS measures derived from sources outside of the Health Board corporate data warehouse, the Planning team will implement a process to ensure that this source data is retained.	Director of Digital	30/04/2025			Completed	Completed	0	January 2026 - this recommendation has been completed	Source data is now retained for measures derived from the Datawarehouse	31/12/2025
ABUHB 2425- 27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	2.1	<p>Binding service levels</p> <p>The GMS regulations 2023 require all services covered by the GMS contract to be included – including any services added through the update of the regulations. Whilst not a requirement of the Welsh Health Circular/ GMS Contracts Regulations, where possible, provider contracts and/or monitoring arrangements should incorporate the material, metrics and commitments made during the bidding process.</p>	<p>Agreed Action: The GMS Contract is a nationally agreed contract and amendments to the core contract are not within Health Board control. Alternative contractual arrangements, such as the Alternative Provider Medical Services contract (APMS), would provide a contracting route to enable Health Boards to contract outside of a standard GMS Contract, but this would provide variation to GP service provision in ABUHB. The Division recognises the importance of ensuring providers adhere to commitments made during the procurement process and as such, will implement a mandatory period of enhanced 4 monitoring upon successful contract award where evidence of such compliance will be reviewed. Expected Evidence of Implementation: Development and implementation of an enhanced monitoring framework to compliment the SOP (MA 1). As part of the procurement process, bidders will be required to acknowledge and commit to participating in enhanced monitoring arrangements.</p>	Head of Primary Care	31/07/2025			Completed	Completed	0		Final SOP in place to support the management of vacant GP practices, incorporating a robust enhanced monitoring framework. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025).	31/12/2025

ABUHB 2425- 27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	3	<p>Applicant business case scoring model</p> <p>The business case scoring model was amended mid-use to bring in a previously unscored element. It is recognised that this did not affect the overall result, as it was applied to all candidates. Scoring models should not be changed during the process to reduce the risk of any potential challenge to the award from unsuccessful parties. Where changes are made, the associated rationale and approvals should be fully documented.</p>	<p>Agreed Action:</p> <p>The Division acknowledges the finding regarding the scoring model, accepting that this did not affect the overall result. The Division recognises the importance of scoring model integrity, a formal approval process will be introduced for any unavoidable scoring adjustments. The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to reflect these Regulations. Any future letting will be in accordance with these Regulations and will be managed in conjunction with NHS Wales Shared Services Partnership Procurement.</p> <p>Expected Evidence of Implementation: Amendment of existing Vacant Practice Policy to reflect The Health Services (Provider Selection Regime) (Wales) Regulations 2025. Development of SOP, aligned to the 2025 Regulations (MA 1) to include:</p> <ul style="list-style-type: none"> <li>A formal approval process will be introduced for any unavoidable scoring adjustments, requiring senior management</li> </ul>	Head of Primary Care	31/07/2025			Completed	Completed	0		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	31/12/2025
ABUHB 2425- 27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	4.1	<p>Applicant interview questions</p> <p>Interviews for the Brynmawr practice should have been held with each applicant using the same questions but were not. Whilst the questions fell within similar themes, the individual questions differed significantly in depth/breadth – making comparison difficult. Conversely, a standardised approach was observed for the letting of the Tredegar practice letting. A standardised approach reduces the risk of challenge to the award from unsuccessful parties.</p>	<p>Agreed Action:</p> <p>The Division acknowledges that whilst themed questioning was used to accommodate different presentation content and avoid duplication, ensuring consistency in structure across all interviews provides fairness and transparency. Recognising the importance of both structured assessment and thematic flexibility, enhancements to interview standardisation will be introduced.</p>	Head of Primary Care	31/07/2025			Completed	Completed	0		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	31/12/2025
ABUHB 2425- 27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	5.1	<p>Applicant interview scoring model: There was a disconnect between interview question responses and interview scores attributed and we were unable to establish a mapping between the interview questions and the themes that were scored.</p>	<p>Agreed Action:</p> <p>Recognising the need for transparent scoring, enhancements will be implemented to strengthen interview frameworks, ensuring clear mapping between responses and scores, to mitigate risks associated with any potential inconsistency.</p> <p>Expected Evidence of Implementation: Supported by procurement and in accordance with PSR, scoring criteria will be developed and explicitly mapped to interview questions, ensuring a direct correlation between responses and evaluation metrics. A structured scoring matrix will be implemented to ensure transparency, consistency, and fairness in assessments. The SOP will include further detail on this.</p>	Head of Primary Care	31/07/2025			Completed	Completed	0		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	31/12/2025
ABUHB 2425- 27	Internal Audit	Health Board Managed Practices - Advisory	Not Rated	Chief Operating Officer	N/A	6.1	<p>Shortened practice launch timetable</p> <p>There was a tight practice launch timetable (contract signed on 15th December 2023 for a contract commence date of 1st January 2024), which may have impacted new service delivery. Whilst the Policy sets out a three month period for the transfer lead in time, the Health Board can also agree to a reduced timetable, dependent upon the circumstances. Likewise, there is a preference to align the transfer to the end of a financial quarter. Therefore, there should be scrutiny over the feasibility of the timetable proposed and / or justification documented.</p>	<p>Agreed Action: The Division has confirmed that the agreed commencement date of the 1 January 2024 in respect of Tredegar Medical Practice was to align with the opening of the new Health and Wellbeing Centre, in order to minimise any disruption to staff and patients as far as possible. This was in full agreement with the incoming partnership. Whilst flexible timelines are sometimes necessary, the Division acknowledges that ensuring feasibility and documenting justifications are crucial to maintaining transparency, mitigating risks, and safeguarding service continuity.</p> <p>The Health Services (Provider Selection Regime) (Wales) Regulations 2025 were laid in February 2025, which supersede existing arrangements for the letting of vacant practices. The Division will review the Vacant Practice Policy and amend to reflect these Regulations. Any future letting will be in accordance with these Regulations and will be managed in conjunction with NHS Wales Shared Services Partnership Procurement.</p> <p>Expected Evidence of Implementation:  <ul style="list-style-type: none"> <li>Amendment of existing Vacant Practice Policy to reflect 2025</li> </ul> </p>	Head of Primary Care	31/07/2025			Completed	Completed	0		Final SOP in place to support the management of vacant GP practices, incorporating the revised Vacant Practice Policy and clear scoring criteria. Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)	31/12/2025
ABUHB 24-25- 28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	1.1	<p>Revenue costs</p> <p>Health Board ongoing annual revenue costs have been estimated to increase as follows: While utilisation by Park Surgery remained uncertain, their nonoccupation would add circa 20k to the net costs above. However, this may present further opportunity for services and estates rationalisation across the Newport estate.</p> <p>The total increase in annual revenue costs is currently estimated at £416k p.a. (£870k - £454k). The above does not account for associated costs or efficiencies in reductions or ongoing occupancy in the owned &amp; rented estate e.g., Clytha Clinic.</p> <p>There was therefore a need for the Health Board to confirm occupancy, revenue costs and their ongoing affordability, together with a review and confirmation of the wider services and estate occupancies in the Newport locality.</p>	<p>Agreed Action:</p> <p>Whilst it is acknowledged that revenue costs have increased to the original business case, these costs have been factored into the IMTP and therefore form part of the Health Board's financial plan. This is recognised within the Full Business Case (FBC).</p> <p>Expected Evidence of Implementation: Included within approved IMTP</p>	Clinical Futures Finance Manager	30/09/2025			Completed	Completed	0	<p>Agreed Action:</p> <p>Whilst it is acknowledged that revenue costs have increased to the original business case, these costs have been factored into the IMTP and therefore form part of the Health Board's financial plan. This is recognised within the Full Business Case (FBC).</p> <p>Expected Evidence of Implementation: Included within approved IMTP</p>	Inclusion of revenue costs within IMTP	31/12/2025
ABUHB 24-25- 28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	2.1	<p>Delivery</p> <p>Target workforce &amp; GPs</p> <p>The business case identified insufficiency of both workforce and GP provision. This conclusion was reinforced by feedback from a survey of patients at Park Surgery.</p> <p>The business case also targeted increased referrals to the new support services (for which access to GPs and practice nurses etc would be a key facilitator). The benefits realisation appendix to the business case stated: and that "the benefits realisation plan will be analysed and used in order to facilitate non-cash releasing benefits and provide efficiencies using a value-based healthcare approach where possible to mitigate the costs indicated above."</p> <p>Accordingly, the Health Board have commented that the new estate should theoretically improve this risk, with the assumption that GP sessions can also be undertaken through other staffing where appropriate.</p> <p>Noting on-going lease / occupancy negotiations with Park Surgery, there is a need to review the benefits realisation model to maximise intended benefits based on actual delivery. Services The approved business case anticipated a number of inclusions within the build including a community café within the adjoining Hub, which it stated would: o promote health</p>	<p>Agreed Action:</p> <p>The Health Board acknowledges the business case's conclusion regarding GP workforce. It is important to note that the GP practices operate under an independent contractor model, commissioned through a nationally determined General Medical Services (GMS) contract in accordance with The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023. As such, while the Health Board does not directly manage GP workforce within the practices, it is anticipated that the new estate will provide a more conducive environment for collaborative working and enhanced service delivery. In the absence of a contractually binding national position, the Health Board has a local benchmark expectation of practices delivering one GP equivalent session per week, per 200 registered patients. Based on current list size this equates to; Park Surgery – 31 sessions (6,1560 registered patients) Ringland Medical Practice – 45 sessions (8,923 registered patients) Usual contractual performance management processes are in place for both practices. Both practices are compliant with</p>	Head of Primary Care	30/09/2025			Completed	Completed	0	Routine GMS contract management processes are in place for both practices as described and both are compliant.	Routine GMS contract management processes are in place for both practices as described and both are compliant.	31/12/2025

ABUHB 24-25- 28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	5.1	<p>Contracts and Service Level Agreements: The Health Board interests should be safeguarded by formal contracts and Service Level Agreements to assure costs and benefits. At the time of concluding the audit the Health Board had advised: It was noted at the audit visit held on 3rd March 2025, that a range of dental staff were in occupancy stocking the storeroom/ completing handover. Noting the well documented lease issues with Park Surgery, the audit did not conclude that any similar issues pertained in relation to dental services. However, there was a need to conclude and confirm lease and SLA arrangements.</p>	<p>Agreed Action: The Health Board acknowledges that future project leases and SLA negotiations will require negotiations to start earlier and to be concluded prior to the estate opening to the public. This will be taken forward with future capital projects. Expected Evidence of Implementation: Evidence of early engagement meetings document through diary invites • Comprehensive project scope and confirmed timescales with detailed milestone tracking • Dated Heads of Terms and SLA documentation</p>	Divisional Director Estates & Facilities / Community Estates Manager	30/09/2025		Completed	Completed	0	Closed - This will be applied to future projects. There are currently no projects at this stage.	This will be applied to future projects. There are currently no projects at this stage.	31/12/2025
ABUHB 24-25- 28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	6.1	<p>Decarbonisation The WG approval letter (Schedule 1) stated that "The funding includes £0.638m funding support for decarbonisation measures listed below: - • Utilisation of rooftop photo-voltaic (PV) cells; • Passivhaus design principles (thermal breaks to building fabric/structure: more insulation; airtightness); • Triple glazing to external windows; • AHU heat recovery efficiency; and • Electronic Vehicle (EV) charging points"</p> <p>The Supply Chain Partner have confirmed the inclusion of the above elements within the build, though not the value. The Health Board have clarified that the building was not designed to Passivhaus standards but adopted some of its design principles (such as those described above). A BREEAM (Building Research Establishment Environmental Assessment Method) sign-off also remained to be provided. Recognising the decarbonisation requirements, achievement for the delivery of the same could usefully form part of the planned Post Project Evaluation to inform future projects (e.g. the achievement of Passivhaus principles).</p>	<p>Agreed Action: Future projects will include (where necessary) a separate report for decarbonisation to demonstrate value for money. Expected Evidence of Implementation: A document has been shared with Internal Audit that had been prepared by the Trust Cost Accountant for 19 Hills (Newport East). The information set out the carbon reduction measures included within the design and specification for Newport East HWBC. It also included information extracted from payment assessments, final accounts and specifications. Some of the information included values, to demonstrate the value enhancement. For example, the extra over cost for the third pane of glass, the additional thickness of wall and roof insulation and the cost differential for this thickness is, what the extra over cost of structural supports would be as we do not have the design. A Separate report for decarbonisation to demonstrate value for money will be included in all future capital projects, where necessary.</p>	Assistant Director of Strategic Capital Planning & Divisional Director Estates & Facilities.	30/09/2025		Completed	Completed	0	Closed- This will be applied to future projects. There are currently no projects at this stage.	This will be applied to future projects. There are currently no projects at this stage.	31/12/2025

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
2020	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted and an options paper will be developed for consideration by the Board.		31/12/2025	30/06/2026		Overdue	Overdue	4	January 2026 Update - Shadow ICT audit is underway and will report back shortly. Proposal following any recommendations to be discussed at Executive Committee.			31/12/2025
2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensure validity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.		30/04/2026	31/05/2026		Overdue	Overdue	5	WRIS is managed via DHCW who continue to monitor this.	DHCW will manage WRIS until RISP completion		31/12/2025
2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.		30/11/2025	31/05/2026		Overdue	Overdue	5	ETR is linked with RISP go live and is on track for May 26			31/12/2025
2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver's lists from the Health Board and action these also. The success of the process will be tracked and evaluated to ensure it is working.		01/12/2025	31/05/2026		Overdue	Overdue	5	Limited information passed to the PACS team for clinicians outside of Radiology. Those within Radiology are managed whilst employed and removed when they leave.			31/12/2025
2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Board should request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.		01/12/2025	31/05/2026		Overdue	Overdue	5	No change but RadIS will be replaced in May 26 under RISP			31/12/2025

2021.1	Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted. The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	01/12/2025	31/05/2026	Overdue	Overdue	5	Plans in place for disaster recovery under RISP. No change to current system. Local solutions to downtime still in place.	31/12/2025
2022.1	Internal	Records Management	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2025	30/06/2026	Overdue	Overdue	1	January 2026 Update - records removed from St Cadocs and other areas being reviewed as required.	31/12/2025
2022.1	Internal	Records Management	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	"a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented."	31/10/2025	30/06/2026	Overdue	Overdue	1	January 2026 Update - Additional record types digitised in 2025: 221 Paediatric Diabetes records, 10,000 Cardiac Rehab & Heart Failure records, 467 childrens epilepsy records, 3,500 Lymphoedema Records, 20,000 Podiatry Records and 24,000 Physiotherapy Records. Expansion of digitisation initiatives in 2026 are focused on 78,988 District Nursing Records (commenced 12/01/2026), 75,162 Mental Health Records (commenced 07/01/2026) 149,413 Dietetic Records, 30,728 Speech and Language Therapy Records and 3,900 Adult Weight Management Records will commence digitisation on 02/02/2026. These records have been prioritised due to the risks with the current storage areas in St Cadocs (Stores, Goldcliffe ward & Langstone Hut) and St Woolos. Records are very difficult to physically retrieve due to the poor environmental conditions of these areas. All service managers are responsible for updating information asset registers, what information exists and where this is stored, if granular level record tracking is not feasible.	31/12/2025
2022.2	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	18/09/2025	30/09/2026	Overdue	Overdue	3	Assistant Medical Director is scoping options to increase compliance with completion of discharge notifications. Engagement is underway with DDaT to confirm the prioritisation of this work. A business case is being developed to support the required changes to CWS, and a decision from the Executive Committee is currently awaited.	31/12/2025
2022.2	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	18/09/2025	30/09/2026	Overdue	Overdue	3	"For day case episodes of care, there are multiple diagnostic and treatment areas across a range of specialities, each operating different processes for notifying GPs and patients about the episode of care. This results in variation in practice, with some departments issuing combined clinical documentation that also serves as the discharge summary. We acknowledge that this approach is not standardised across the Health Board.  As part of the Task and Finish Group, the Assistant Medical Director for Planning will ensure that discharge notifications for day case activity are incorporated into a single, standardised process.  For inter site transfers, an SBAR is completed for every patient. This provides a concise summary of the patient's condition, diagnosis, and any actions required by the receiving site, ensuring safe and consistent handover between locations. Improvement opportunities identified as part of 'Our Next Patient' and the 'Winter Sprint' to be taken forward as part of the Discharge Improvement programme."	31/12/2025

2023.3	Internal	Waiting List Management Final Internal Audit Report.	Reasonable	Chief Operating Officer	High	1.1a	Management should review the process of managing waiting lists. A targeted approach to continual validation of patients ensuring they are on the correct pathways and are not duplicates should be undertaken.	The Planned Care Academy purpose is to ensure that education and training of staff becomes embedded into ways of working, to develop and support staff as well as improving the effectiveness and compliance with national requirements relating to management of patients on their pathways. The development of tools, bespoke training packages, policies and standard operating procedures has now been completed. Initial training will provide basic RTT knowledge targeted at new starters and staff whose dealings with patient pathways are minimal. This cohort must still understand the concept of the 26 week pathway and the consequences of failing to record information correctly and in real time. Advanced RTT training is aimed at staff who require a full understanding of the 26 Week Rules. A comprehensive range of WPAS modules have been developed mirroring the patient pathway and designed to be role based i.e. tailored training. The training will include DNA's, how to rebook, the rules around Non-Admitted, Admitted and Incompletes, how to validate a PTL and what to look for within the data of a PTL to help manage pathways. Staff will learn how to record patient pathways correctly using the appropriate National RTT Status codes.		30/11/2025	31/03/2026	Overdue	Overdue	1	The Health Board is undertaking an enhanced validation exercise which includes ophthalmology which is the main complies with the Planned Care Policy - Waiting List Validation Toolkit and Guidance for reportable RTT patients. To contact patients on the new outpatient waiting list over 26 weeks to establish if they still require their appointment. The 26 week outpatient programme will naturally validate patients so will be excluded from this patient contact. Also the regional cataract programme will have a natural validation as part of their booking process. Stage 2 and 3 (diagnostics/follow-ups and therapies) for patients who are waiting over 52 weeks will be administratively validated including the 26 week outpatient element. Stage 4-treatments-patients waiting over 78 weeks but who have been referred onto the treatment waiting list over 6 months will be administratively validated and also patient contact sent out to establish if they still wish to have their procedure. There will be exceptions to these agreed via the directorates. Any patients who wish to be removed will be contacted by the Keeping Well team to establish the reasons why and feedback responses to the directorates before any removals are made to check if there are any issues/concerns. The Health Board will be developing a Validation Strategy by the end of March 2026 which will include:	Enhanced validation Jan 2026. The validation strategy to be completed by March 2026, and depending on support/resource requirements implementation to be determined.			31/12/2025
2021.0 1EA	External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place to ensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.		30/11/2025	31/12/2026	Overdue	Overdue	3		January 2026 As part of the roll out of Patchwork Medical E-Rostering, all Medical and Dental annual leave will be recorded within patchwork and not ESR due to the manual requirements to record Medical and Dental Leave. This follows the same system approach for A4C staff who use allocate rostering. To date 200 Medical & Dental staff have access to ESR to record annual leave. However, Patchwork will provide a more accurate solution The roll out plan for Patchwork has commenced across a number of areas, with full roll out for all areas to be completed by December 2026.			31/12/2025
4002EA 2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	3.1	To become financially sustainable in the longer-term, the Health Board should: develop a detailed longer-term financial plan that is linked to the new long-term strategy currently in development and ensure progress against delivery is reported appropriately.	The long-term financial plan will be developed alongside the long-term strategy and will triangulate service, workforce and financial aspects of the strategy once measures and metrics of change are clarified. This will be iterative to ensure clarity of affordability and outcome benefits expected.	Director of Finance and Procurement	30/06/2025	31/03/2026	Overdue	Overdue	2	The refresh of the IMTP for 2026/27 will outline a new service, workforce, savings and performance plan that will aim to deliver ABUHB service plans within available resources. A revised route map will need to be developed based on the resources available and savings plans developed. Current demand and efficiency delivery will need to be considered and cash savings prioritised. The Board will need to make some difficult decisions to deliver long term financial balance.			31/12/2025	
4002EA 2024	External Audit	Structured Assessment 2024	Not Rated	Director of Finance and Procurement	N/A	3.2	Develop a detailed route-map to support the delivery of the long-term strategy.	As per recommendation 3.1, the financial plan will be developed alongside the service plan.	Director of Finance and Procurement	30/06/2025	31/03/2026	Overdue	Overdue	2	The refresh of the IMTP for 2026/27 will outline a new service, workforce, savings and performance plan that will aim to deliver ABUHB service plans within available resources. A revised route map will need to be developed based on the resources available and savings plans developed. Current demand and efficiency delivery will need to be considered and cash savings prioritised. The Board will need to make some difficult decisions to deliver long term financial balance.			31/12/2025	
4003EA 2024	External Audit	Review of Cost Savings Arrangements	Not Rated	Director of Finance and Procurement	N/A	5.1	The Health Board should continue to refine and update its medium term financial plan (route map) to 2026-27 based on internal and external delivery risks and quickly take corrective action where there is slippage in its planned financial trajectory.	The Health Board's 'Route map to recovery' was approved by the Board in July 2024, as part of the Value and Sustainability Board savings identification process and the annual planning process the detailed actions will be further developed. The 2025/26 Planning process will confirm the delivery plan against the route map.	Chief Executive Officer & Executive Director of Finance	31/03/2025	31/03/2026	Overdue		1	The refresh of the IMTP for 2026/27 will outline a new service, workforce, savings and performance plan that will aim to deliver ABUHB service plans within available resources. A revised route map will need to be developed based on the resources available and savings plans developed. Current demand and efficiency delivery will need to be considered and cash savings prioritised. The Board will need to make some difficult decisions to deliver long term financial balance.			31/12/2025	

4004EA 2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Workforce & OD	N/A	4.2	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: monitoring and reporting on completion rates for the Duty of Quality and Duty of Candour e-learning.	Monitoring of all statutory and mandatory training compliance is published on a monthly basis, including Duty of Candour. Duty of Quality will be included once approved by the Core Learning Advisory Committee.	Director of Workforce & Organisational Development	30/07/2025	31/12/2026	Overdue		2	Duty of Candour has been through the Core Learning Committee and the Staff Segment Report completed, which identifies the staff groups requiring this training in ESR. This information has been sent to the Organisational Development Coordinator to move to stage 4 of the process.  Duty of Quality to go through Core Learning Advisory Committee for approval.	<b>January 2026</b>  Duty of Candour competency to be published and will go live as mandatory learning for all targeted staff groups on 02 February 2026.  Duty of Quality scheduled to go through Core Learning Advisory Committee for approval on Wednesday 25 February 2026. The December meeting was postponed due to winter/system pressures.		31/12/2025
4006EA 2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	8.1	The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Local Authorities in the process of replacing the existing IT client record (WCCS) over the next 18 months. There is potential with a new system for it to link with the Health Board system over time.  There are processes in place to share information to support discharge planning, but this does not amount to a joint IT solution. Health Board progressing with scoping an IT solution to merge the Complex List with CWS2, with sharing of data across Local Authorities to support meaningful, real-time data analysis	Director of Nursing and Director of Digital	31/12/2025	31/12/2026	Overdue	Overdue	1	Partnership working continues with opportunities identified to improve system visibility across organisations at micro-level.  A recent example that demonstrates this is the Health Board enabling WAST Advanced Paramedic Practitioners access to Clinical Work Station, the Health Boards primary Electronic Patient record.  At Macro-level work continues to share access to Local Authority System (WCCIS) who are in the process of replacing it over the next 18 months.		31/12/2025	
4916A2 025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Chief Operating Officer	N/A	5.1	Directory of services R5 To ensure health and care staff can adequately signpost and refer people to the right urgent and emergency services, the Health Board should:  • establish a mechanism to ensure the WAST Directory of Services remains up to date, which includes the identification of an officer with lead responsibility for this task	To strengthen the accessibility and accuracy of urgent and emergency care service information, the Health Board is taking the following actions:  5.1A named lead officer will be appointed to oversee all Health Board contributions to the WAST Directory of Services. This individual will act as the central point of contact for service updates, ensuring timely and coordinated entries across departments.	Chief Operating Officer	30/11/2025	31/03/2026	Overdue		1	The development and maintenance of information held within the community directory of services is being continually reviewed and updated; this forms part of the Single Point of Access governance processes (Navigation Hub Project Group), so that changes made to service information, pathways and processes can be cascaded and / or operationalised in a timely manner.		31/12/2025	
ABUHB- 2425- 11	Internal Audit	End of Life Care	Reasonable	Director of Nursing	Medium	1.1	Framework for the capture and management of patient Future Care Planning documentation  Whilst we appreciate that it is the responsibility of the individual to share FCP documents with the necessary health care providers (Health Board, GP, OOH GP, Ambulance Service, District Nursing service etc.) there is an absence of a policy within the Health Board and / or a supporting procedure to cover the: capture; coordination; and management of these key documents.	Agreed Action: The Health Board are working towards implementing a robust framework for capturing and managing patient Future Care Planning (FCP) documentation. This will include the following elements:  Identification and Targeting: Implement a structured approach to identify patients who would benefit from FCP, such as those with chronic illnesses, frailty, or nearing end-of-life. Tools like the Elderly Risk Assessment score can be useful.  Standardised Documentation: Use standardised forms and templates to ensure consistency in FCP documentation. This can include advance directives, anticipatory clinical management plans, and patient preferences for care.  Multidisciplinary Collaboration: Encourage daily multidisciplinary huddles to discuss and document FCP for identified patients. This ensures that all relevant healthcare professionals are involved in the planning process.  Electronic Health Records (EHR) Integration: Transition to digital ACP plans for better accessibility and efficiency, integrate FCP documentation.	Director of Nursing	30/04/2025	30/06/2026	Overdue	Overdue	1	<b>Update 21.01.2026</b> - Provided by Aoife Gleeson. Aoife Gleeson met with Leeanne Lewis and Claire Harris in September it was agreed that an ABUHB FCP guideline, rather than a policy, would be developed by the FCP facilitators with the support of a subgroup of the FCP workstream. The facilitators, who were extremely new in their posts (2 persons job sharing 1 post) at this time, were updated about this. The facilitators have been updating and streamlining HCP facing information that is available as part of the guideline development work. However, there has been significant developments at all Wales level with regard to the FCP processes, the HB are engaged in active meetings to clarify the ABUHB plans. So, until we have clarification, Aoife does not believe we could finalise a guideline as it may very quickly need to be completely overhauled.		31/12/2025	
ABUHB- 2425- 12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	Medium	2.1	Health and Safety Policies Out of 19 applicable policies: • 13 policies were overdue for review. • Three policies were no longer needed.  • The remaining three policies had recently been reviewed. Six out of the 13 policies were waiting for final sign-off having been through the Health and Safety Committee.	Policies not being up to date resulting in staff not being aware of the correct procedures resulting in patient / staff harm.  Agreed Action: A plan has been developed to review and update all organisational health and safety policies by end of December 2025.  Compliance with health and safety policies will be monitored via the Health and Safety Committee to ensure they are reviewed and have timely assessment.	Head of Health, Safety and Fire	31/12/2025	30/04/2026	Overdue		1	A plan is in place to review all the overdue health and safety policies by 31 March 2026.  The current position is that 2 out of 12 policies are compliant. 4 policies have been presented at the relevant approval groups and are awaiting Executive Team sign off. The remaining 6 policies will be presented to the relevant forums in February and March 2026.		31/12/2025	

ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	4.1	<p><b>RISK ASSESSMENTS</b></p> <p>Of the 1,878 reported risks, the areas where the highest risks were overdue were:</p> <ul style="list-style-type: none"> <li>142 in Corporate Services.</li> <li>123 in Estates.</li> </ul> <p>A sample of 15 risks (relating to COSHH - 9, Sharps - 4 and Health &amp; Safety - 2) was taken from the Datix Report from the Risk Register and the following was observed:</p> <ul style="list-style-type: none"> <li>13 risks were not completed fully (e.g. target risk scores and target risk levels were not completed).</li> <li>Seven risks were outstanding and past their "Next review date" and two risks were close to their "Next review date" (end of May 2025) and outstanding.</li> <li>One high risk was identified in July 2023 and now passed its "Next review date" of April 2025 and is still outstanding.</li> <li>Two low risks were given the status of "new risk" but were raised in March 2024, so should have the status of "current risk" and both have passed their "Next review date" of September 2024 and are outstanding.</li> </ul>	<p><b>Agreed Action:</b></p> <p>A comprehensive review of all health and safety risks recorded within the DatixWeb system will be undertaken by the Corporate Health and Safety Team during Quarter 2 of 2025/26. The findings will be presented to the Health and Safety Committee in September 2025 to inform ongoing assurance and improvement activity, ensure divisional accountability, each division is responsible for actively managing its health and safety risks, including timely review and appropriate mitigation. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>Review of Health and Safety Risks Report</li> <li>Health and Safety Committee Notes of September 2025 meeting</li> </ul>	Head of Health, Safety and Fire	31/10/2025	31/03/2026	Overdue	1	<p>The Corporate Health and Safety Department have conducted a review of the health and safety high or extreme high risks in December 2025 and January 2026.</p> <p>The findings of the review and risk assessment performance will be presented at the Health and Safety Operational Group in February 2026 and to the Health and Safety Committee in March 2026.</p> <p>The revised Health and Safety Policy (awaiting final approval) sets out the roles and responsibilities and reporting arrangements within the Health Board. The policy captures the 'performance management &amp; accountability framework' and the 'health and safety governance framework'.</p> <p>Risk assessment performance is reviewed and challenged in the Divisional Assurance Reviews with the Executive Committee and specific performance failure (non-compliance) is escalated by the Executive Director of AHP &amp; Health Science (Exec Lead for Health, Safety &amp; Fire).</p> <p>Risk assessment performance is also reviewed and monitored at the</p>			31/12/2025
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	5.1	<p>A sample of 15 inspections conducted in 2024/25 were reviewed from the Health and Safety Dashboard. From the 213 actions raised:</p> <ul style="list-style-type: none"> <li>70 were fully complete.</li> <li>19 partially complete (overdue).</li> <li>124 overdue actions (57 RAG rated amber and two RAG rated red).</li> </ul> <p>Of the 15 inspections, eight were completed between October and December 2024 and included 76 of the actions highlighted above. Whilst three of the inspections tested detailed compliance below 90%, AMaT did not include corresponding actions (for example, one of the inspections included an action that was RAG rated red). Discrepancies on the Dashboard could result in actions being missed resulting in significant patient or staff harm. Having been informed of this issue, management advised they were in the process of reviewing and actively addressing this matter. Further consideration should be given to reporting to an appropriate forum those areas that are not planned to be routinely covered by inspections – and the associated rationale/</p>	<p><b>Agreed Action:</b></p> <p>To ensure divisional accountability, all divisions are responsible for ensuring that actions arising from workplace health and safety inspections are managed appropriately, including timely review and closure. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>Health and Safety Operational Group Notes of September 2025 meeting</li> <li>Health and Safety Performance Reports presented to Divisional Quality &amp; Patient Safety meetings</li> </ul>	Head of Health, Safety and Fire	31/10/2025	31/03/2026	Overdue	1	<p>The Corporate Health and Safety Department will conduct a review in January 2026 of the actions arising from health and safety workplace inspections.</p> <p>The findings of the review and performance will be presented at the Health and Safety Operational Group in February 2026 and to the Health and Safety Committee in March 2026.</p> <p>The revised Health and Safety Policy (awaiting final approval) sets out the roles and responsibilities and reporting arrangements within the Health Board. The policy captures the 'performance management &amp; accountability framework' and the 'health and safety governance framework'.</p> <p>Health and Safety Workplace Inspection and Management Audit actions are reviewed and challenged in the Divisional Assurance Reviews with the Executive Committee and specific performance failure (non-compliance) is escalated by the Executive Director of AHP &amp; Health Science (Exec Lead for Health, Safety &amp; Fire).</p>			31/12/2025
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	6.1	<p><b>RIDDOR Reporting</b></p> <p>From the RIDDOR report for 2024/25 there were 73 incidents reported, of which 32 were categorised as 'slip, trip or fall'. The status of these was summarised as:</p> <ul style="list-style-type: none"> <li>70 were closed.</li> <li>Two were under management review / 'make it safe plus'.</li> <li>One was awaiting closure.</li> </ul> <p>From the 11 incidents sample tested, seven were categorised as a 'slip, trip or fall' and the status of these were summarised as:</p> <ul style="list-style-type: none"> <li>seven of the incidents were reported to the HSE within the RIDDOR timescale; but</li> <li>four of the incidents were not reported to the HSE within the RIDDOR timescale. The main reason for non-adherence to the timeframe was because of late notification to the Corporate Health and Safety department.</li> </ul>	<p><b>Agreed Action:</b></p> <p>To ensure divisional accountability, all divisions will be held accountable for ensuring that all workplace incidents are reported and investigated promptly in line with legal requirements under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Timely reporting and investigation are critical to maintaining compliance and protecting staff and service users.</p> <p>The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated.</p> <p><b>Expected Evidence of Implementation:</b></p> <ul style="list-style-type: none"> <li>Health and Safety Operational Group Notes of September 2025 meeting</li> </ul>	Head of Health, Safety and Fire	30/11/2025	31/03/2026	Overdue	1	<p>The Corporate Health and Safety Department will conduct a review of the health and safety high or extreme high risks in December 2025 and January 2026.</p> <p>The findings of the review and risk assessment performance will be presented at the Health and Safety Operational Group in February 2026 and to the Health and Safety Committee in March 2026.</p> <p>RIDDOR compliance is reviewed and challenged in the Divisional Assurance Reviews with the Executive Committee and specific performance failure (non-compliance) is escalated by the Executive Director of AHP &amp; Health Science (Exec Lead for Health, Safety &amp; Fire).</p> <p>RIDDOR compliance is also reviewed and monitored at the following forums:</p> <ul style="list-style-type: none"> <li>Health and Safety Committee</li> <li>Health and Safety Operational Group</li> <li>Divisional Quality &amp; Patient Safety meetings.</li> </ul> <p>The Corporate Health and Safety Department have developed a RIDDOR Awareness eLearning training module. An application to mandate the</p>			31/12/2025
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	Medium	7.1	<p><b>Monitoring Health and Safety Risks at Committee and Board level</b></p> <p>Regular reporting was observed at many different forums including Board, Committees and operational forums in the form of QPS groups and divisional assurance meetings. Discussion was observed regarding outstanding risks and their levels in operational forums but limited escalation of risks which have been outstanding for an extended period. In addition, the Strategic Risk SRD10 has been reduced from a risk score of 16 to 12. Whilst the current risk score exceeds the appetite level, the overall risk should be reviewed in light of the internal audit outcomes reported.</p> <p>In addition, a deep-dive analysis would help provide greater insights on overdue risks and underlying issues.</p>	<p><b>Agreed Action:</b></p> <p>A full review of all health and safety risks recorded in the DatixWeb system will be undertaken by the Corporate Health and Safety Department in Quarter 2 of 2025/26. The outcomes of this review will be presented to the Health and Safety Committee in September 2025 to inform assurance and improvement activity. To ensure divisional accountability, all divisions are responsible for actively managing their health and safety risks – including ensuring timely review, accurate risk grading, and appropriate mitigation. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure health and safety compliance remains a key objective and focus:</p>	Head of Health, Safety and Fire	31/12/2025	31/03/2026	Overdue	1	<p>The Corporate Health and Safety Department have conducted a review of the health and safety high or extreme high risks in December 2025 and January 2026.</p> <p>The findings of the review and risk assessment performance will be presented at the Health and Safety Operational Group in February 2026 and to the Health and Safety Committee in March 2026.</p> <p>The revised Health and Safety Policy (awaiting final approval) sets out the roles and responsibilities and reporting arrangements within the Health Board. The policy captures the 'performance management &amp; accountability framework' and the 'health and safety governance framework'.</p> <p>Risk assessment performance is reviewed and challenged in the Divisional Assurance Reviews with the Executive Committee and specific performance failure (non-compliance) is escalated by the Executive Director of AHP &amp; Health Science (Exec Lead for Health, Safety &amp; Fire).</p> <p>Risk assessment performance is also reviewed and monitored at the</p>			31/12/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	2.1	<p><b>Paper records</b></p> <p>From our sample review of records for 90 patients we found evidence of poor records management.</p> <p>We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.</p>	<p><b>Agreed Action:</b></p> <p>Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training, this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive</p>	Head of Health Records - DHR	31/12/2025	30/06/2026	Overdue	2	<p>The Corporate Health and Safety Department will conduct a review of the health and safety high or extreme high risks in December 2025 and January 2026.</p> <p>The findings of the review and risk assessment performance will be presented at the Health and Safety Operational Group in February 2026 and to the Health and Safety Committee in March 2026.</p> <p>The revised Health and Safety Policy (awaiting final approval) sets out the roles and responsibilities and reporting arrangements within the Health Board. The policy captures the 'performance management &amp; accountability framework' and the 'health and safety governance framework'.</p> <p>Risk assessment performance is reviewed and challenged in the Divisional Assurance Reviews with the Executive Committee and specific performance failure (non-compliance) is escalated by the Executive Director of AHP &amp; Health Science (Exec Lead for Health, Safety &amp; Fire).</p> <p>Risk assessment performance is also reviewed and monitored at the</p> <p><b>January 2026 update - 63 Ward visits completed between April &amp; November 2025.</b> Feedback received from ward clerks and action taken in response to this to support and share best practice. The DHR service launched The Health Records Support Network via Microsoft Teams now with almost 100 members. This network provides a space for sharing records management resources, access to policies, standard operating procedures, best practice guides and access to video resources created by the service on the NHS Wales Records Management Code of Practice. From October 2025, Health Records Management is presented in The Journey of Excellence Corporate Induction for newly qualified nurses, The FP1 programme for junior doctors and in presentations to new cohorts of overseas nurses focusing on effective records management and best practice. Bi-monthly health records awareness sessions continue to be scheduled in collaboration with colleagues from clinical coding, Information Services, Cyber security and Information Governance. The Deputy Head of Nursing agreed that records management training will be added to the compliance criteria for ward accreditation. The ABUHB Employee Handbook has been updated with details for new staff joining the organisation on how to access health records awareness sessions,</p>			31/12/2025

ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	<p>System alerts</p> <p>We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes.</p> <p>This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.</p>	<p>Agreed Action:</p> <p>We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation:</p> <p>Evident in training and guidance documentation for all staff.</p>	Head of Health Records - DHR	30/06/2025	30/06/2026	Overdue	Overdue	2	<p><b>January 2026:</b> Adding alerts to the patient record to ensure this is reflected in CWS is a topic discussed and demonstrated in health records awareness sessions. Updated lesson plans, user guides and standard operating procedures are complete and meetings are ongoing with services to review best practice and booking processes. Going forward, a new WPAS team will be in place to manage version control and publish guides ahead of January 2026 go-live and the Patient Policy will be finalised as part of the Planned Care Academy. The WPAS system manager will submit a request in WPAS for functionality to prompt users to check keynotes for alerts.</p>			31/12/2025
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	<p>Access to paper records</p> <p>We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues:</p> <p>Ref Description of the issue Number of patients</p> <p>1 The alive / deceased patient file was not sent for scanning. - 47</p> <p>2 The patient was not formally discharged within 24 hours after left the hospital in CWS, and physical records were left behind at the ward. - 4</p> <p>3 The Patient was transferred without physical patient record within the HB. - 4</p> <p>4 The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS. - 4</p> <p>5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10</p> <p>6 Various supplementary paper records left behind after the patient's DHR file was sent for scanning. - 8</p> <p>We note that many of the issues outlined above resulted from the prolonged absence of the local ward clerk (for example:</p>	<p>Agreed Action:</p> <p>The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites.</p> <p>A board development session will also be undertaken on records management to improve support by the executive team and independent members.</p> <p>Expected Evidence of Implementation:</p> <p>A Microsoft list with information on all wards and scheduled</p>	Head of Health Records - DHR	31/12/2025	31/03/2026	Overdue		3	<p><b>January 2026 Update</b> - As part of our approach to maximise engagement at health records awareness sessions, a proposal on health records awareness training to be considered for mandatory status was submitted to the Core Learning Committee (meeting scheduled 09/12/2025 cancelled, to be rescheduled in 2026). The DHR service continues to embed records management and best practice in Corporate Induction Programmes for newly qualified nurses and junior doctors. The Health Record Keeping Survey was launched in November 2025, this data will be analysed to identify gaps in records management and inform improvement plans. The DHR service has liaised with Divisional Nurses and developed a contingency procedure for ward clerk absences to ensure continuity of records management when a ward clerk is absent long term. Best Practice guidance, Policies and Standard Operating Procedures are shared and new monthly "Spotlight on....." features from 2026 to increase engagement.</p>			31/12/2025
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	2.2	<p>Quality of approved job plans</p> <p>Our testing of approved job plans showed:</p> <ul style="list-style-type: none"> <li>10 out of the 20 job plans did not contain personal outcomes for individuals even though this is stipulated in the guidance. The L2P function for recording service outcomes is not currently activated and thus, not being recorded. This position should be reviewed once the compliance position with contracted sessions and personal outcomes has been improved. These aspects need to be improved to ensure contractual obligations are adhered to and they are completed correctly.</li> </ul>	<p>Agreed Action: The Service outcome section in L2P will be activated once all consultants have an up-to-date job plan on the system and have identified personal job planning outcomes. Personal outcomes are based on the individual doctor's needs (career development etc.) and the service needs are discussed at the job plan review meeting.</p> <p>Expected Evidence of Implementation:</p> <p>SMART objectives are evident in the operational section of each job plan. Job plans are not signed off until these are complete.</p>	Medical Director/ Director of Workforce & OD	31/10/2025	31/12/2026	Overdue	Overdue	1	<p>This requirement was not part of our original contract with L2P however the company has 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.</p> <p>The SMART element 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. (Update provided to ARAC Jan 2026).</p>	Unknown as requires L2P action and completion of job plans.		31/12/2025
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	<p>A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.</p>	<p>A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data &amp; Technology to provide assurance over implementation and compliance.</p>	Chief Information Officer	31/05/2025	31/03/2026	Overdue	Overdue	2	<p><b>January 2026</b> - Policy development earning completion following organisational change process in Information Services.</p>			31/12/2025
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	High	2.1	<p>Switch Patching</p> <p>There is currently no report or process to monitor patching compliance within the switching estate. Our testing noted that not all switches are running the latest approved software, with some running old versions which contain security vulnerabilities, including critical ones.</p>	<p>Agreed Action:</p> <p>Partially Agreed. ABUHB does have a network patching framework process in place which is in line with ABUHB Cyber Security Patch Management Policy. As part of our network support contract, we will be implementing network collector that provides patching compliance.</p> <p>Expected Evidence of Implementation:</p> <p>Through the cyber security report</p>	Head of ICT	31/10/2025	31/03/2026	Overdue		1	<p><b>January 2026 Update</b> -The implementation of the Network Collector as part of our Network support contract is still being progressed. This has been delayed due network &amp; firewall rules that needed to be understood and worked through.</p>			31/12/2025

ABUHB-2526-17	Internal Audit	Safeguarding	Reasonable	Director of Nursing	Medium	3.1	<p><b>Safeguarding Strategy</b></p> <p>The Corporate Safeguarding Team had developed a Safeguarding Strategy for 2022-25. The document would benefit from an update to better reflect the breadth of work being undertaken across the Health Board. A refreshed strategy would not only showcase the current achievements but also clearly outline future safeguarding priorities. There is also an opportunity to update the document to reflect changes in approach e.g. the changed reporting framework, level 3 safeguarding training requirements.</p>	<p><b>Agreed Action:</b></p> <p>We acknowledge the need to refresh the Safeguarding Strategy to ensure it reflects the breadth of safeguarding activity across the Health Board and aligns with current priorities and frameworks.</p> <p><b>Actions will include:</b></p> <ul style="list-style-type: none"> <li>• Ratification of the new Safeguarding Strategy for 2025–2028 at the Safeguarding Strategic Group on 18 November 2025.</li> <li>• Incorporation of a review of progress against the 2022–2025 strategy and inclusion of measurable objectives for the new period.</li> <li>• Alignment with the overarching Quality Strategy and integration of recent developments, including the revised reporting framework and Level 3 training requirements.</li> <li>• Publication of the approved strategy on AB Pulse and dissemination through appropriate communication channel</li> </ul> <p><b>Expected Evidence of Implementation:</b></p> <p>Minutes from the Safeguarding Strategic Group</p>	Head of Safeguarding	30/11/2025	17/02/2026	Overdue	1	The Strategy has been updated, with sign off anticipated at the February meeting of the Safeguarding Strategic Group		31/12/2025
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Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway		Barriers to implementation	Evidence to complete or close recommendation	Reporting Date
Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted and an options paper will be developed for consideration by the Board.		31/12/2022	30/06/2026		Overdue	Overdue	4	May 2025: No update awaiting Internal Audit work. "January 2025 Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan.  The organisational change process for Service Management structures is underway and due to complete April 2025. "June 2024: Phase 1 of the structural changes are underway to support formalisation of Service Management structures and WPAS product team. Job description development is underway for senior roles across the directorate. January 2024: The target operating model has been reviewed by the new Director of Digital and a proposal on the revised structure will be presented to the Executive Committee in April 2024. This structure will bring forward some options on the current decentralised model in some departments.			31/12/2025	
Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R9	R9 A network of champions across the organisation should be established. The Digital Strategy should be re-issued alongside the roadmap. This should form the basis for engaging the network of champions to drive the Strategy forward.	Accepted-The Channel 3 report also identified a need for more emphasis on Clinical Leadership, Design and Business Partnering. This is subject to additional investment although recently the appointment of a full time CNO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Execs on overarching exec level oversight which is intended to both strengthen accountability but also ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.		30/09/2021	31/03/2026		Overdue	Not Yet Due	6	September 2025 - Digital strategy development now commenced following Board approval of Gwent 2035 strategy. Executive Team presentation completed with further engagement across the Health Board planned. April 2025 - Data & Analytical Strategy approved by the Executive Committee and work on component strategies underway for Health & Care Record, Information Governance / Cyber Security and Technical Infrastructure.  The Digital Strategy will be reissued following the publication of the Health Board's 10 year strategy. " " January 2025 Digital champions across all in-patient areas for WNCR Digital Clinical Council reformed and meeting 5th Dec '24, Reporting to Clinical Advisory Forum  At the request of Planning, the development of a new Digital Transformation Strategy for ABUHB will commence once the ABUHB 10 year strategy has been agreed. An OCP has been agreed and will be consulted on in Q4 2024/25 that includes a refreshed strategy, planning and engagement function that will further develop stakeholder engagement at local, regional and national level. " " August 2024: Digital Champions in place through the M365 Team.				
Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.		31/12/2021	31/03/2026	18/09/2025	Overdue	Not Yet Due	4	January 2024: No progress, wider asset management approach and configuration management approach to be formalised during 2024/2025 financial year. Aug 2023: Awaiting next HBOTS meeting.				
Internal	Pathology	Reasonable	Chief Operating Officer	Low	R8	R8 The Health Board should complete a refresh of the latest workforce planning exercise (including associated laboratory space and equipment), to ensure the service requirements can still be met over the next five years and beyond. Where additional resourcing / facilities are required, these should be factored into the IMTP process.	To review and update workforce plans as appropriate. Workforce is factored into the IMTP		24/02/2022	01/09/2026	08/02/2024	Overdue	Not Yet Due	3	January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to be repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24).  Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25).  Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper, JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 31/03/24.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	Agency staff being utilised at a cost. Overtime being utilised at a cost. Scrutiny forms and SBARS submitted to request additional staff that are urgently required prior to implementation of revised workforce plans.		
Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensure validity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.		30/04/2022	31/05/2026		Overdue	Not Yet Due	5	June 2025 - Same as previous RadIS is no longer being developed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis. January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.			31/12/2025	

Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.		31/03/2022	31/05/2026	09/07/2024	Overdue	Overdue	5	<p>June 2025- Software Development in ABUHB are developing an electronic request for that will integrate with the new RIS (Soliton) we will have as a part of RISP. The electronic request from CWS will cover all requests made in CWS in Secondary Care. This was planned for our go live date of 24/11/2025 but is no longer achievable and is planned for early stage of 2026. WCP are rolling out their electronic requesting solution through primary care and currently have 6 GP practices in ABUHB requesting electronically. This Risk will remain until we have the new RIS (Soliton) to replace RadIS and the electronic form has been developed by ABUHB in CWS and DHCW have completed the roll out in primary care with the WCP electronic form.</p> <p>June 2024- we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we process the request electronically. We will be looking to roll this out in another two GP practices over the next 6 months. This is the chosen solution of RISP or whatever we currently have. There will be discussions with software development and the CCIO over the summer along with Philips and Soliton our new PACS/RIS providers to discuss true electronic requesting. Integrated electronic requesting was a part of RISP. The solution provided by Soliton the new RIS provider was not selected. There will be meetings between ABUHB and Philips/Soliton to discuss a live fully integration electronic requesting solution for the go live date of November 2025.</p> <p>March 2024: Position remains the same as started with January 24 Assurance report,</p>	<p>Aug 2023: Required scoping, testing and development and planned for software development. Needs to be agreed locally and product developed to suit ABUHB</p>		31/12/2025
Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R7	R7 The success of the use of the leavers list should be monitored to ensure that it works as anticipated and that all leaver accounts are removed on a timely basis.	We monitor this as much possible in Radiology. We have recently started receiving consultant leaver's lists from the Health Board and action these also. The success of the process will be tracked and evaluated to ensure it is working.		30/04/2022	31/05/2026		Overdue	Overdue	5	<p>June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers.</p> <p>Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard.</p> <p>June 2024- the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB.</p> <p>March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24.</p> <p>January 2024: Please refer to completed assurance report.</p> <p>Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundary electronic requesting if they are still working within the</p>			31/12/2025
Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Board should request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.		31/03/2022	31/05/2026		Overdue	Overdue	5	<p>June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS.</p> <p>Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality.</p> <p>June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution.</p> <p>March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,</p>	<p>Time and resource in RadIS. As well as pending RISP program may not help development.</p>		31/12/2025
Internal	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be revisited and formally set out. ABUHB have a VMware environment where this is hosted. The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.		30/04/2022	31/05/2026		Overdue	Overdue	5	<p>June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and falling over to kit in a primary DC in GUH if there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution.</p> <p>Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominantly cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUH and a smaller backup in our YAB DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continuity.</p> <p>June 2024- the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the YAB datacentre if there are issues with the GUH datacentre.</p> <p>March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24.</p> <p>January 2024: Please refer to completed</p>	<p>Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.</p>		31/12/2025
Internal	Records Management	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.		31/12/2023	30/06/2026	20/05/2025	Overdue	Overdue	3	<p>"April 2025 - Following recent refreshed audit into Records Management a task &amp; finish sub-group is being setup to ensure any physical issues are identified and remediated where possible.</p> <p>The scanning of Mental Health paper records has commenced." August 24 - Continuing issue with mould and water ingress, danger of holes in glass roof within storage area in St Cadocs requires immediate attention as will not be permitted to retrieve or track records from this area following visit by health and safety. Urgent remediation work required and inroads into the digitisation of mental health records as they require long term storage and no suitable premises have been identified.</p> <p>June 2024: Will be considered as part of WPAS product team support and changes, discussions are underway with Chief Operating Officer and Executive Director of Nursing so this can be aligned with the ward accreditation process.</p> <p>Mar 24- Closure of another library of records achieved at Llangennech and move of some mental health, children service records to vacated Antenatal Basement Library to relieve pressures. - Unable to provide a revised timescale at this stage.</p>			31/12/2025

Internal	Records Management	Limited	Director of Digital	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	30/06/2026	18/09/2025	Overdue	Overdue	7	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment. Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Exep system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.			31/12/2025
Internal	Discharge Planning	Limited	Director of Nursing	High	R3.1	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	01/04/2024	30/09/2026	18/09/2025	Overdue	Overdue	3	May 2025: CWS technical change due to be delivered in 2025/2026, ongoing discussions with Medical Director and Director for Data and Digital to streamline generation of discharge notifications in CWS, only generated on discharge not stepdown/transfer. Assistant Medical Director to pilot 'perfect week', ongoing engagement with medical staff re completion of discharge notifications, identify areas to focus on for improvement by site/ward, link with ops team to re measurement/patient flow, streamlining of mandatory field to reduce time completing. "January 2025: CWS technical change to be completed by end of quarter 4, 'perfect week' to be delivered in January/February, linking with Divisions and operational teams, standardised approach to be complete end October 2024: Assistant Medical Director to pilot 'perfect week', ongoing engagement with medical staff re completion of discharge notifications, identify areas to focus on for improvement by site/ward, link with ops team to re measurement/patient flow, streamlining of mandatory field to reduce time completing, CWS technical changes due early next year			31/12/2025
Internal	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	01/04/2024	30/09/2026	18/09/2025	Overdue	Overdue	3	May 2025: New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, survey to staff to evaluate the new process reported into the Safety Flow operational group. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' with completion of a standardised approach Q1 2025/26" January 2025: New SBAR/step down process rolled out w/c 6th January, review of new process at regular interval to flag any areas of concern, update at Integrated Discharge Board on 28th January, survey to staff at 3/6 months to evaluate the new process. Assistant Medical Director to focus on ensuring that discharge notifications form part of standardised approach through pilot of 'perfect week' in January/February with completion of a standardised approach end of March 2025 June: SBAR documentation is embedded and used as standard in all inter site transfers. SBAR has review periods to make sure it is current and user friendly to ensure the correct information is on the document. The SBAR was reviewed May 2024 and new version will be rolled out August 2024			31/12/2025
Internal	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	31/03/2024	30/09/2026	20/05/2025	Overdue	Not Yet Due	3	November 2025: Work is underway to re-establish estate baseline information in order to then align with strategy. Alongside this the specification for the Facet Survey is being developed in order to procure a company to undertake the surveys on behalf of the Health Board. This work will commence in the new year and is likely to conclude in approx 6-8 months. Following this findings will then be aligned in order to develop the Health Boards Estates Strategy. May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development session on Estates. Estates Strategy to follow Organisational Strategy. June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital prioritisation complete. Estate Strategy will follow org. strat."			
External	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	Director of Workforce & OD	High	R1	The Health Board should review the arrangements in place to ensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	30/04/2022	31/12/2026	20/05/2025	Overdue	Overdue	3	April 2025 The Health Board are currently in the early stages of entering sickness absences via the roster following a period significant development and testing with Patchwork and ESR. Within the next 6 months the testing of annual leave recording will be undertaken via rostering into ESR. The intention will be to roll this out to all Divisions following successful testing. March 2024: "The Medical Workforce Rostering System will be implemented in the Health Board on a phased basis over an 18 month period. The absence management function of the new rostering system will enable the Health Board to record annual leave entitlements and will have a rolling balance of annual leave taken for individual doctors. The Health Board is in the process of setting up a new interface between ESR and Patchwork Rota to ensure all absence transfers from the new system to ESR. The implementation plan is being progressed and is phased by division and directorate. The plan is for the full implementation to be completed by April 2025. At that point all annual leave should be held on both rostering and ESR systems. The current medical annual leave policy is under review and a decision will be required before implementation on how annual leave will be recorded days/hours/sessions. " November 2023: Procurement completed. Draft Implementation plan being discussed with Divisional Directors. Roll out to commence in January 2024.	Aug 2023: Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full. Given current pressures on staff it is not felt that a interim system change of 12 months would be beneficial Cultural issue anticipated that it will take longer than June 2023 to realise in full.	Aug 2023: Executive Team. Legal and Procurement advice	31/12/2025

Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.		30/11/2024	31/03/2026	18/09/2024	Overdue	Not Yet Due	4	August 2025 - Work continues but lack of resources within directorate is hindering progress, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.	January 2025 CMDB is now much more mature, with over 54000 assets and may interdependencies recorded allowing a service view to be taken of large elements of infrastructure.  Further review to be undertaken in the summer.		
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**CYFARFOD BWRDD IECHYD PRIFYSGOLN  
ANEURIN BEVAN  
ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
MEETING**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	12 February 2026
<b>CYFARFOD O: MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	<b>Financial governance, reporting &amp; control</b>
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	<b>Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare</b>
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	<b>Robert Jones, Assistant Finance Director – Financial Systems &amp; Services</b>

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA  
SBAR REPORT**

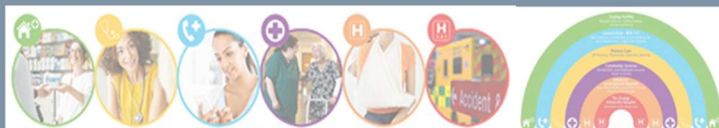
**Sefyllfa / Situation**

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

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

The Audit, Risk and Assurance Committee is requested to:

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



- Purchasing Card (Appendix 1)
- Engaging Off Payroll Workers (Appendix 2)
- Patients' Property (Appendix 3)
- Procurement (Appendix 4)
- Grant Funding (Appendix 5)

The Financial Control Procedures presented were considered and approved by the Executive Committee at their meeting on the 22<sup>nd</sup> January and are now being presented to the Audit, Risk and Assurance Committee for approval.

## **Cefndir / Background**

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

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

## **Asesiad / Assessment**

### **1. Financial Control Procedures (FCP)**

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

The FCPs to be reviewed at this Committee are:

- Purchasing Card (Appendix 1)
- Engaging Off Payroll Workers (Appendix 2)
- Patients' Property (Appendix 3)
- Procurement (Appendix 4)
- Grant Funding (Appendix 5)

Together with a summary of all FCP review dates.

#### **1.1 Purchasing Card**

Owner: Director of Finance, Procurement and Value  
Review Date: February 2026



The main objective of the Purchasing Card Scheme is to facilitate the payment of immediate, small one-off payments, or one-off online purchases, which are not covered by any purchasing agreements or contracts.

The procedure details the principles underlying the control over the Aneurin Bevan University Health Board's (ABUHB's) use of purchasing cards.

The document has been circulated for comment as follows:

- Assistant Head of Financial Services and Accounting
- Head of Financial Services & Accounting
- NWSSP Audit and Assurance

Section	Name	Main Changes
1	Introduction	Small payments defined as less than £5,000
2	Policy Statement	Links updated to reflect related procedures: Procurement, Accounts Payable, Standing Orders and SFIs
6	Roles and Responsibilities	6.1 Director of Finance, Procurement and Value – Expanded to include all responsibilities included in the SFIs in relation to effective and adequate controls  6.3 Administration Team – Expanded to include monthly reconciliation process
10	Purchasing Card Application Process	10.3 PDF Forms – ABB_Treasury email address added  10.4 Paper Forms – Contact address amended from Mamhilad House to Ty Gwent
12	Process for using the Purchase Cards	12.1 Requirement added that prior approval from the Purchasing Card holder before a requisition is raised added  12.4 Card Declined – Consequences added for not contacting the administrator if card declined  12.6 Rejection of Goods/Goods Incorrect – The risks associated with using Purchasing Cards highlighted

## 1.2 Engaging Off-Payroll Workers

Owner: Director of Finance, Procurement and Value  
Review Date: February 2026

UK rules relating to taxation of off-payroll workers is governed by IR35. The legislation is designed to ensure that individuals who work through an intermediary, such as a personal service company, pay broadly the same Income Tax and National Insurance contributions as direct employees under the Pay As You Earn (PAYE) system.

The responsibility for assessing the employment status of a worker lies with the engaging organisation.

The document has been circulated for comment as follows:

- Corporate Finance Accountant



- Workforce and OD
- NWSSP Payroll
- NWSSP Audit and Assurance

Section	Name	Main Changes
4	Objectives	Definition and examples added of what constitutes an Off Payroll worker
5	Scope	Paragraph amended to state that the primary point of contact, when determining employment status, is Workforce with support from Procurement
6	Roles and Responsibilities	6.1 Recruiting Managers – Payroll contact email added
		6.2 Medical Staffing Co-ordinators – Expanded to include staff employed through Managed Practices
		6.3 Accounts Payable – Expanded and clarified AP responsibilities
		6.4 Finance – Expanded to include that CMA contact all agencies annually to remind them of their responsibilities under IR35
		6.6 NWSSP Procurement – Expanded to include Insourcing
	To Note	Updated legislation is anticipated, with regard to Umbrella Companies, approx. April 2026

### 1.3 Patients' Property

Owner: Director of Finance, Procurement and Value  
Review Date: February 2026

The Health Board has a legal responsibility to protect any patients' property that is deposited for safekeeping and to return it to the patient on demand.

The Health Board has an additional responsibility to safeguard property and clothing retained by patients on wards, and to safeguard and administer patients' monies.

This responsibility extends from admission to discharge of the patient.

The document has been circulated for comment as follows:

- Assistant Head of Financial Accounting
- Head of Financial Services and Accounting
- General Office Staff
- Facilities Managers
- Senior Nurses
- NWSSP Audit and Assurance

Section	Name	Main Changes
1	Introduction	1.1 Paragraph added to reflect the reasons why Patients may take monies and property onto health Board premises



3	Roles and Responsibilities	3.1 Health Board – Expanded responsibilities to include all SFI requirements 3.2 Chief Executive – Expanded responsibilities to include all SFI requirements 3.3 Director of Finance, Procurement and Value – Expanded responsibilities to include all SFI requirements
4	Planned Admissions	4.4.2 Patients’ Property Books – Paragraph added to explain the function of a General Office 4.4.10 Examples of authorised staff who may require inspections of the Patients’ Property Book added
5	Income	5.1.6 Mental Health Capacity Act 2005 – link added 5.1.7 Safeguarding Adults Procedures – link added
6	Investments	Paragraph added to define when the investment of patient monies is legally required and appropriate
11	Estates of Deceased Patients	11.2 Funeral Expenses – Paragraph added to explain the responsibilities of the Health Board
14	Appendices	Finance Contact Details – address updated from Mamhilad House to Ty Gwent and email added

## 1.4 Procurement

Owner: Director of Finance, Procurement and Value

Review Date: September 2026

The procurement of goods and services is a key process supporting the delivery of high-quality patient care whilst ensuring value for money is achieved.

The procedure details the responsibility and processes to follow to ensure compliance with the aims of public procurement ‘to ensure accountability in the public sector and transparency in decision making.’

The document has been circulated for comment as follows:

- Head of Procurement
- Assistant Finance Director – Systems and Services
- NWSSP – Audit and Assurance

## 1.5 Grant Funding

Owner: Director of Finance, Procurement and Value

Review Date: New

It is the Health Board’s responsibility to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary.

Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations.



Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.

The document has been circulated for comment as follows:

- Corporate Finance Accountant
- Research and Development Manager
- Finance Business Partner – Commissioning
- Head of Financial Services and Accounting
- Assistant Finance Director – Systems and Services
- NWSSP Audit and Assurance

## Summary Position on Financial Control Procedures

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

Financial Control Procedure	Year Due	Approved	Committee Approved	Review Date	Notes
Engaging Off Payroll Workers	25/26	Due for review	Feb-23	02-Feb-26	Presented in Feb 26
Patients' Property	25/26	Due for review	Feb-23	02-Feb-26	Presented in Feb 26
Purchasing Cards	25/26	Due for review	Feb-23	02-Feb-26	Presented in Feb 26
Procurement Policy	26/27	Amendment	Sep-23	12-Sep-26	Presented in Feb 26
Grant Funding	New	New	New	New	Presented in Feb 26
General Ledger	26/27	Y	Apr-23	18-Apr-26	
Policy and Governance approach for Commissioning Additional (External & Insourced) Non NHS Clinical Services	26/27	Y	Apr-23	18-Apr-26	
Capital Procedures and Guidance Notes	26/27	Y	Nov-23	28-Nov-26	
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	
Petty Cash	26/27	Y	Feb-24	08-Feb-27	
Petty Cash - Mental Health	26/27	Y	Feb-24	08-Feb-27	
Accounts Receivable	27/28	Y	Apr-24	16-Apr-27	
Contract Management	27/28	Y	Apr-24	16-Apr-27	
Capital Assets and Charges	27/28	Y	Jul-24	09-Jul-27	
Salary Sacrifice	27/28	Y	Sep-24	02-Oct-27	
Policy for Out of Area Referrals to Secondary Care	27/28	Y	Sep-24	02-Oct-27	
Recovery of Overpayments to Employees	27/28	Y	Nov-24	12-Nov-27	
Accounts Payable	27/28	Y	Nov-24	12-Nov-27	
Counter Fraud Bribery and Corruption Policy	27/28	Y	Feb-25	18-Feb-28	
Approval of Orders over £100K	27/28	Y	Apr-25	22-Apr-28	
Overseas Visitors	27/28	Y	Apr-25	22-Apr-28	
Digital Procurement	28/29	Y	Apr-25	22-Apr-28	
Charitable Funds	28/29	Y	Apr-25	22-Apr-28	
Budgetary Control Policy & Procedure	28/29	Y	Sep-25	18-Sep-28	
Losses and Special Payments	28/29	Y	Sep-25	18-Sep-28	
Stores & Stocks	28/29	Y	Sep-25	18-Sep-28	

## 2. Technical Accounting Issues

### Technical updates

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

Update Note 4 covered the following area:



- **2025-26 Discount rates for general provisions, post-employment benefits, financial instruments and leases (under IFRS 16)**

Announcement of the new discount rates to be applied for the 2025/26 Financial Year.

The new rates will be applied for 31<sup>st</sup> March 2025, and the impact reflected in the 2025/26 Financial Position. The impact of the Post-Employment benefits discount rates has seen an in-year reduction to forecast.

- **Disclosure of Senior Managers' Remuneration (Greenbury) 2026**

Guidance for submitting the disclosure requests for Senior Manager's Remuneration (Greenbury) and deadlines for submission. Submissions to the NHS Pensions are to be made between 5<sup>th</sup>-31<sup>st</sup> January.

The Corporate Finance Team submitted the request on behalf of the Health Board on the 5<sup>th</sup> January, and are awaiting the detailed information in return. The Greenbury information supports the reporting of Senior Managers' Remuneration in the Remuneration Report of the Annual Report.

Update Note 5 covered the following areas:

- **Amendments to 2025-26 Strategic Cash Requests**

Guidance and submission deadline issued to organisations who will be required to amend their original submission to Welsh Government for Strategic Cash, in line with operational deficit, which was due by the start of December 2025.

The Health Board is currently forecasting an operational deficit for 2025/26 financial year, and therefore we submitted a request to Welsh Government for strategic cash in line with the operational deficit.

The Health Board did not require to amend that submission, as the forecast deficit position did not change between the end of Month 08 and Month 09 reporting.

The deadline for submitting the Accountable Officer letter noting any amendment required was the 9<sup>th</sup> January 2026.

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

Guidance and submission deadline issued to organisations that require an amendment (increase) to the original working capital cash submission that was submitted in December 2025.

The Corporate Finance team continue to review the Health Board's cash position monthly, alongside the Capital Finance team as part of the Monthly Monitoring Returns process. It was identified that the Health Board is likely to be in a position where working balances cash support may be required in March 2026. However, it was identified that no increase was required to the Health Board's original request.



### 3. Draft Manual for Accounts and Key Dates for Annual Accounts 2025/26

The 2024-25 draft Manual for Accounts was issued by Welsh Government on the 19<sup>th</sup> of December 2025. The draft manual has been reviewed internally, with comments and clarifications sent back to Welsh Government by the deadline.

The key changes are highlighted below.

Area of Change	What Has Changed	Impact on the Accounts
<b>Annual Report – Remuneration Report</b>	Salary in “single total remuneration” to be reported after salary sacrifice; salary sacrifice to be shown as benefit.	Impacts Senior Managers who have Salary Sacrifice arrangements: - Salary column reduces; - Benefit in kind increases by salary sacrifice amount; - New footnote discloses gross salary.
<b>Remuneration Relationship Note</b>	Must report in £ not £000; nil rows hidden not deleted.	Numerical disclosure values appear 1,000× larger, though underlying costs unchanged
<b>Financial Statement Templates</b>	Capital note sections moved; revenue headings removed unless reinstated by WG.	Presentational in the note ordering and structure.
<b>Asset Valuation Framework</b>	Adoption of “operational capacity” basis; IAS 16 cost model withdrawn; prospective only.	PPE values may shift during next indexation or revaluation; classification and measurement basis updated; no prior-year restatement.
<b>Land &amp; Building Indices</b>	Updated indices to 2030.	Indexation adjustments impact revaluation reserve and closing PPE carrying values.
<b>Capital Provisions</b>	Requirement to separately disclose capital provisions.	Provisions note expands to include new capital headings; presentation changes but totals unchanged.
<b>IFRS 17 – Contract Assessment</b>	Annual review required.	Expected nil impact, continuing prior assessment. <i>Would be changes to timing and method of revenue recognition.</i>
<b>Interparty Leases (IFRS 16 Template)</b>	New Part 1 (NHS to NHS) and Part 2 (NHS to Public Sector)	Potential to identify previously unmatched lease arrangements, requiring adjustments to ROU assets and lease liabilities.
<b>FR14 Lease Liability Return</b>	Removed several data fields (funding split, cash/non-cash, agent role).	Supplementary disclosure reduced; no change to primary statements or IFRS 16 figures.
<b>Losses &amp; Tribunal Settlements</b>	‘Approval in principle’ permitted when urgent settlement is required.	Will only impacts accounts if required. <i>Would accelerate recognition of special payments or legal settlement costs.</i>
<b>Capital Scheme Derecognition Method</b>	Pragmatic derecognition of replaced parts; desktop valuation process formalised.	Potential to reduce derecognition losses. <i>AME or revaluation entries affected depending on scheme classification; PPE additions split between enhancing/non-enhancing.</i>



<b>Intangible Asset Valuation</b>	Revaluation model withdrawn; historic cost basis adopted prospectively.	Revaluation reserve movements cease for intangibles; future values remain stable apart from amortisation.
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The main deadlines, proposed Audit, Risk & Assurance Committee review and Board approval dates are shown in the following table.

The dates are based on the initial timescales from Welsh Government and are potentially subject to change. They are expected to be finalised in February.

Provisional Annual Accounts & Report 2025/26 - Key Dates		2026
First draft Performance Report and Accountability Report for consideration by Executive Team	Thur	30-Apr
<b>Unaudited accounts and associated returns to Welsh Government</b>	<b>Fri</b>	<b>01-May noon</b>
<b>Draft Performance Report Overview, Accountability Report and Remuneration Report to Welsh Government</b>	<b>Fri</b>	<b>08-May noon</b>
Draft Reports to Audit Committee Members	Tue	12-May
<b>Audit, Risk &amp; Assurance Committee meeting to Consider Draft Accounts and Draft Accountability Report</b>	<b>Tue</b>	<b>19-May</b>
Final Accounts & Accountability Report to Audit Committee Members	Tue	16-Jun
<b>Audit, Risk &amp; Assurance Committee meeting to Consider Final Accounts, and Accountability Report</b>	<b>Tue</b>	<b>23-Jun</b>
<b>Board meeting to approve Final Accounts and Accountability Report</b>	<b>Wed</b>	<b>24-Jun</b>
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Tue	<b>30-Jun noon</b>
<b>Annual General Meeting – to receive the Annual Report and Accounts</b>		<b>TBC</b>



### **3. Public Sector Payment Policy (PSPP)**

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

<b>Category</b>	<b>Invoices</b>	<b>In Mth %</b>	<b>YTD %</b>
NHS	Value	99.8	98.6
	Number	96.5	92.7
Non-NHS	Value	96.6	97.0
	Number	97.0	97.2

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

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

As reported to the previous committee meeting, an issue was identified, and subsequently addressed, regarding invoices relating to the NHS Salary Sacrifice Scheme administered by Northumbria NHS Trust. Due to the volume of invoices, this had an impact on the NHS PSPP figure in May, June and July which has had a subsequent effect on the cumulative figure.

#### **All Wales Performance**

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

<b>Category</b>	<b>Health Board</b>	<b>In Month %</b>	<b>YTD to Dec-25 %</b>	<b>RANK</b>
Non-NHS by Number	<b>Aneurin Bevan UHB</b>	<b>97.0</b>	<b>97.7</b>	<b>1st</b>
	Betsi Cadwaladr UHB	98.1	96.9	2nd
	Cardiff & Vale UHB	97.4	96.6	3rd
	Cwm Taf Morgannwg UHB	95.7	95.8	
	Hywel Dda UHB	98.0	96.6	3rd
	Powys tHB	91.0	91.9	
	Swansea Bay UHB	97.7	96.4	

### **4. Payments in Excess of £100K**

There were no exceptional issues to report.



## **5. Standing Financial Instructions**

A Standing Financial Instruments self-assessment exercise was previously completed with the Health Board identified as being 92% compliant. A summary of the exercise was reported to the Audit, Risk & Assurance Committee, along with the following actions to be completed:

### **Section: 10.6 Prepayments - Payments on Account** (Appendix 4)

**SFI requirement:** Should be exceptional and only considered if value for money case can be demonstrated. A written request should be sent from the Executive Director to the Director of Finance, Procurement and Value for approval. Budget Holders are responsible for ensuring items due are received and managed.

**Explanation:** The requirement is followed in practice, however, no guidance is documented.

**Action:** A section explaining the prepayment process to be added to the Procurement Financial Control Procedure

### **Section: 13 Grant Funding** (Appendix 5)

**SFI requirement:** Non-procured payments to external bodies or individuals for activities. Payments made to fund or reimburse expenditure on agreed items or functions with legally binding conditions.

**Explanation:** Regional Partnership Board activity and Charitable Funds have been identified as Grant Funding according to the SFI requirement. The Health Board currently has no guidance or policies documented.

**Action:** A policy for grants funding to be created.

### **Section 2.2 The Chief Executive and Director of Finance- Responsibilities and Delegation**

**SFI requirement:** The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

**Explanation:** The Scheme of Delegation financial limit up to 50k states job titles as 'Divisional Directors/General Managers/Assistant Directors.' Job titles in ESR and on internal systems can differ which can increase the risk of financial limits being assigned incorrect individuals.

**Action:** Executive review of all 50k budget holders.

The Health Boards' self-assessment review of the SFI's is now complete, following the implementation of these actions.

## **Argymhelliad / Recommendation**

The Audit, Risk and Assurance Committee is requested to approve the following FCPs included in this report.

- Purchasing Card (Appendix 1)
- Engaging Off Payroll Workers (Appendix 2)
- Patients' Property (Appendix 3)
- Procurement (Appendix 4)
- Grant Funding (Appendix 5)



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

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators SFI – Standing Financial Instructions
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper?</b>



**Resource Assessment:**

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

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

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

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

**No does not meet requirements**

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

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

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

Choose an item.  
 Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives





## **Aneurin Bevan University Health Board**

# **Financial Control Procedure Purchasing Cards**

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

## **Purchasing Cards – One Page Summary**

### **Do's**

- Use the Purchasing Card only for official Health Board business purposes.
- Follow the approval process before making purchases, including obtaining an approved requisition and Purchase Order.
- Ensure purchases fall within delegated limits and permitted categories.
- Keep the card secure at all times and report any loss or theft immediately to Barclaycard and the administrator.
- Use approved suppliers where required and retain all supporting documents.
- Submit monthly spend information within 2 days of month end.
- Return the card when changing job roles, departments, or leaving employment.
- Complete required training and sign the Cardholder Agreement before first use.

### **Don'ts**

- Do not use the Purchasing Card for personal purchases under any circumstances.
- Do not purchase prohibited items such as fuel, restaurant/bar purchases, cash withdrawals, mobile phones, or items under existing contracts.
- Do not exceed monthly or per-transaction limits.
- Do not share the card or card number with anyone else.
- Do not make online or one-off purchases without a prior approved Purchase Order.
- Do not process retrospective purchases unless truly exceptional and approved via email.
- Do not ignore card discrepancies—report issues immediately.

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## 1. Introduction

The main objective of the Purchasing Card Scheme (the 'scheme') is to facilitate the payment of immediate, small (>£5,000) one-off payments, or one-off online purchases, which are not covered by any purchasing agreements or contracts.

This document provides guidance for the issuing and governance of the Purchasing Card (the 'card').

The Health Board has selected to use the Welsh Procurement Purchasing Cards, which are endorsed by Welsh Government and issued by Barclaycard. This enables purchases and credit limits to be monitored via the online card management system.

## 2. Policy Statement

The procedure details the principles underlying the control over the Aneurin Bevan University Health Board's (ABUHB's) use of purchasing cards.

The procedure should be read in line with other relevant Financial Control Procedures, such as [Procurement](#) of goods and services and [Accounts Payable](#).

Each cardholder is issued with a copy of this document and their individual spending limits under which they can use their card. All purchases should be made in accordance with these procedures and Aneurin Bevan University Health Board [Standing Orders](#) and [Standing Financial Instructions](#).

The cardholder may only use the card for business purposes and may under no circumstances use the card for private transactions. If the cardholder requires any further clarification or information regarding this, they should contact the Purchasing Card Administrator (the 'administrator') in the first instance.

## 3. Aims

To ensure that relevant Health Board employees are aware of the requirements with regard to the application, security and use of purchasing cards.

## 4. Objectives

This document sets out the process to be adhered to within the Health Board when required to use a purchasing card and covers the following objectives.

- To outline the card holders' responsibilities
- To provide guidance on setting up and using purchasing cards
- To provide a detailed procedure for making purchases
- To give guidance on the appropriate use of purchasing cards
- To provide guidance on the types of purchases allowed
- To outline the administration process for the use of purchasing cards
- To outline action to be taken if misuse is detected
- To outline how to report the loss of a purchasing card

## 5. Scope

### 5.1 The Procedure covers:

- The authorisation and use of purchase cards for purchasing goods and services
- Security of purchase cards
- Reporting loss and/or misuse of purchase cards
- Administration and documentation
- Recording of expenditure and reconciliation to the general ledger

### 5.2 All ABUHB Purchase Card holders have a general responsibility for the security of the Health Board Purchasing Card and the appropriate use of the card.

### 5.3 All ABUHB Purchase Card holders have a responsibility to report the loss of the Purchasing Card to their manager and the administrators of the Purchase Card scheme using the documentation outlined in this procedure.

## 6. Roles and Responsibilities

### 6.1 The Director of Finance is responsible for:

- Ensuring effective and adequate control systems are in place for the use of Payment Cards and to minimise the risk of misappropriation
- Ensuring appropriate systems are in place to record purchases made with the Purchasing Card.
- Ensuring appropriate systems are in place to facilitate the reporting of lost Purchasing Cards.

- 6.2** The Purchasing Card Holder is responsible for the security of the purchasing card, the correct usage, recording all transactions made, and notifying the administration team and manager in the event that the card becomes damaged or lost.
- 6.3** The Administration team which consists of the Head of Financial Services and Accounting, the Assistant Head of Financial Services and the Treasury Manager are responsible for:
- Ensuring that all purchases are reflected in the General Ledger on a monthly basis.
  - Reconcile the General Ledger to source information on a monthly basis
  - Ensuring that all purchases made with the Purchasing Card are in accordance with the procedure.
  - Ensuring that all paperwork is routinely received to facilitate the above.
  - Notifying the card holder/manager of any discrepancies or inappropriate use of the card.
- 6.4** General Managers and Directors:
- Must ensure that processes are in place to ensure the security of the Purchasing Card and that all Card Holders are aware of the procedures regarding the use of the card.
- 6.5** All Managers:
- Are responsible for ensuring that the Purchasing Card within their division (if applicable) is used appropriately in line with this procedure.

## **7. Delegated Limits**

- 7.1** The Health Board will hold two Purchasing Cards, which will be in the name of the following individuals:
- Director of Corporate Governance
  - Assistant Director of Finance – Financial Systems and Services
- 7.2** All Purchasing Cards will have a delegated purchasing limit of £5,000.

## 8. Overview of the Purchasing Card process

- 8.1 Each cardholder must provide details as requested in the Cardholder Specific Form (attached in Appendix 1). A permanent record of each Purchasing Card issued will be held by the administrator.
- 8.2 Cardholders must satisfy themselves that approved suppliers are used for certain types of goods and services. The Procurement department will provide advice on request.
- 8.3 The card issuing bank will pay suppliers within 4 working days of the transaction.
- 8.4 Monthly statements from Barclaycard Banking Services will be received by the Health Board. These will provide an overall summary and individual statements which will detail the transactions that have been made by the cardholder.
- 8.5 Appendix 2 details the process to be followed when making each purchase using the Purchasing Card.

## 9. Card Housekeeping

- 9.1 Purchasing Card Scheme – The scheme is held in the name of Aneurin Bevan University Health Board (ABUHB) and will be maintained and monitored by a nominated authority. The nominated authority will be the Purchasing Card Administrator.
- 9.2 Purchasing Card Administrator – The nominated Purchasing Card Administrators (the ‘administrators’) are the Head of Financial Services and Accounting and the Assistant Head of Financial Services who are based within the Corporate Finance Department in Ty Gwent.
- 9.3 Purchasing Card Amendments – The cardholder must inform the administrators if for any reason the cardholder’s name (e.g. marriage, etc.) or other details require amending. The obsolete card should be cut in half across the magnetic strip and returned to the administrator, following receipt by the card holder of the new card.
- 9.4 Purchasing Card Renewals – When the card reaches the expiry date, a replacement card should be received approximately 14 days prior to the renewal date. Non receipt should be advised immediately to the administrator.
- 9.5 Security of the Purchasing Card – The card issued to the cardholder is to be used by the cardholder only and should not be used by any

other individual. The security of the card is the responsibility of the cardholder who must ensure that it is retained in a secure location and that the card number is not revealed to any unauthorised person(s). The card must be used for business purposes only and must not be used for personal use in any circumstances. If in the unlikely event of the card being used for personal use in error, the administrator must be informed immediately and the appropriate action taken (e.g. full investigation, recovery of money and any necessary disciplinary action taken).

On receipt of the purchasing card the cardholder and line manager/budget holder will be required to sign the 'Cardholder Agreement Form' to confirm that the cardholder understands and consents to the card procedures detailed herein. A copy of the Cardholder Agreement Form can be found at Appendix 3.

- 9.6** Lost/Stolen Cards – If the card is lost or stolen, the issuing bank, Barclaycard, must be advised immediately by telephone on the 24-hour customer service helpline:  
Telephone Number – 0800 008008

The card lost/stolen incident report must be completed and a copy forwarded to the administrator for review and action accordingly. A copy of the Lost/Stolen Incident report form can be found in Appendix 4.

- 9.7** Job Change/Department Change – Upon notice of a change of job and/or department, the administrator must be informed as soon as possible. A decision will be made by the budget holder as to whether the card is still required. If it is confirmed that the card is still required, the relevant forms will need to be completed to request a new card to be set up in the name of the new post holder authorised by the budget holder.
- 9.8** Leaving Employment – Upon leaving employment of the Health Board, the card must be cut in half across the magnetic strip and returned to the administrator. The administrator must receive the card at least 14 days before the leaving date.
- 9.9** Cardholder Liability/Credit Status – Whilst the card is embossed with the cardholder's name: the account, and therefore the financial liability, is in the name of ABUHB. Consequently, there is no impact on the cardholder's personal credit status.

However, it is important to note that the cardholder remains personally responsible for the use of the credit card and ensuring that it is used in accordance with these Purchasing Card Procedures.

**9.10 *Training / Guidance*** – A pre-condition for the use of the card is that the cardholder should have received appropriate guidance for using the card (with the cardholder’s line management/budget holder in attendance if required). The training should be given over the telephone/Teams with the purpose to introduce the cardholder to the scheme by explaining the procedure. The cardholder must complete the Cardholder Agreement form in Appendix 3 which includes agreeing that they understand the procedures.

## **10. Purchasing Card Application Process**

**10.1** Upon receipt of a request by the Department Manager for a card, a decision must be made as to who will be the cardholder within the department.

**10.2** A request from the Head of Department/Departmental Manager will be made to the administrator. A cardholder application form will be sent to the individual with an explanatory memorandum attached, these will include:

- a) Cardholders application forms – both Barclaycard form and Appendix 1 (Cardholder Specific Details form - to be completed by the cardholder).
- b) Financial Control Procedure – Purchasing Card.
- c)

Once the forms have been completed, they can be printed as a PDF, signed electronically and emailed to the Card Administrator at ABB\_Treasury (Aneurin Bevan UHB - Finance)  
<ABB.Treasury@wales.nhs.uk>

**10.3** Alternatively completed and signed paper forms can be returned to the Card Administrator at the following address:

Assistant Head of Financial Services  
Aneurin Bevan University Health Board  
Finance Department  
PO Box 163  
Cwmbran  
NP44 9EJ

**10.4** The authorised forms will be sent to the card issuing bank. The bank will despatch the card and pin number under separate cover directly to the Finance department in Ty Gwent who will be responsible for ensuring that the card and pin are handed to the named card holder within the Health Board.

**10.5** The Administrator will make a record of the card number, name and division of the new cardholder and will personally deliver the card and pin number to the named card holder to avoid any risk of the card or pin number being mislaid in the post or not received. The cardholder and line manager/budget holder must sign and return the Cardholder Agreement form (Appendix 3) acknowledging receipt of the card and PIN, agreeing to comply with the use of the cards terms and conditions.

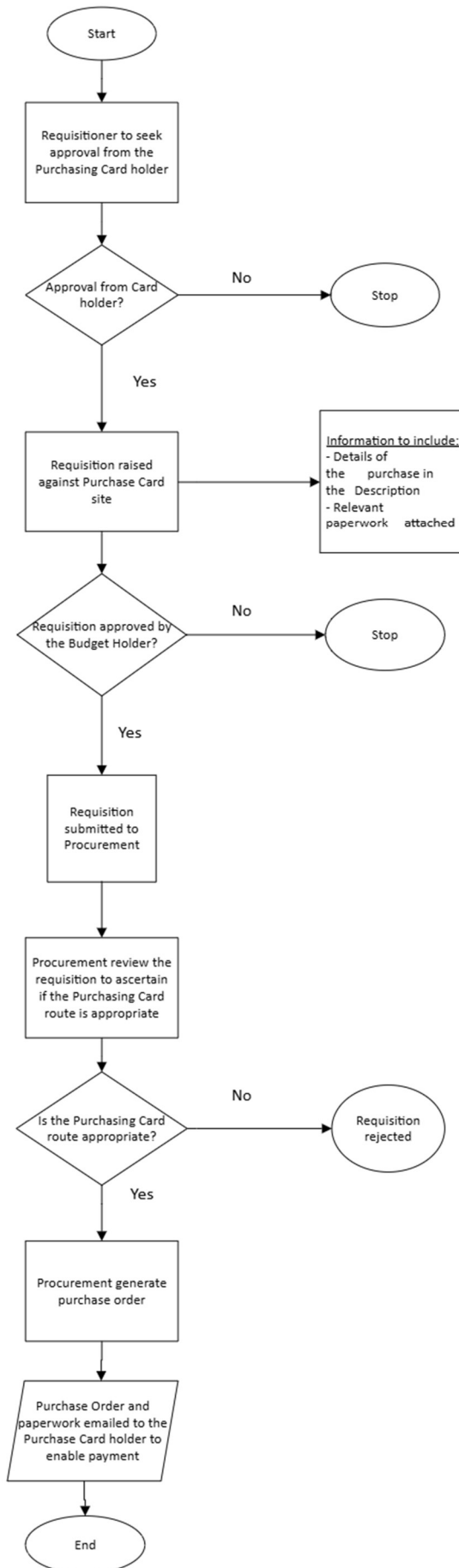
## **11. System Administration**

**11.1** The Health Board will nominate two Systems Administrators, neither of whom will be issued with a Purchase Card.

**11.2** The Systems Administrators will be responsible for ensuring agreements are signed.

## **12. Process for using the Purchasing Cards**

**12.1** The process for paying for goods and services using the Purchasing Card is restricted to payments processed in accordance with the below:



**12.2** Online one-off purchases - Where the purchase is to be actioned directly online the card holder will need to adhere to the above procedures, with the requirement to obtain an approved purchase order and associated backing documents, prior to the online payment being made.

**12.3** Where the online payment is a recurring annual payment a new purchase order must be approved on an annual basis to approve/verify the charge being made against the Purchasing Card.

**12.4** Card Declined - If a transaction is declined, the cardholder must contact the administrator.

Potential reasons for a card being declined are exceeding monthly card limit, exceeding individual transaction limit or using a supplier that is within a category disallowed by the Health Board.

If the cardholder, does not contact the administrator, the purchasing card cannot be used to pay for the goods or services.

**12.5** Ordinarily the Health Board will only pay for goods or services that have been received. The use of Purchasing Cards heightens the risk of a payment in advance. Therefore, extra care should be taken to ensure that the benefit of the purchase is received.

**12.6** Rejection of Goods/Goods Incorrect - If the goods are rejected for any reason, the cardholder must ensure that the supplier is informed directly, as it is the supplier who will arrange a credit to the Purchasing Card account. The credit will appear on the cardholder's record of transactions, and it is the responsibility of the cardholder to carry out regular checks to ensure the credit is received correctly.

If there is a dispute and the cardholder is unable to reach a mutual agreement with the supplier, the cardholder must contact the administrator immediately.

**12.7** Billed but Goods not Received - If the cardholder is billed for purchases that have not been received, the cardholder should contact the supplier to ensure that the goods have been despatched. It is the issuing bank and the Purchasing Card's regulations that transactions are not processed until the goods are despatched. The administrator must be informed by the cardholder immediately if this directive has been breached.

**12.8** Appendix 2 details the process to be followed when procuring and paying for goods using a Health Board purchasing card.

## 13. Exceptions

**13.1** Items and Commodities not to be purchased – The following items/ commodities must not be purchased using the Purchasing Card:

- Automotive fuel
- Purchases from restaurants and bars
- Cash
- Goods available from Welsh Health Supplies, Central Stores in Newport
- Mobile phones
- Items covered by Purchasing Agreements or Contracts
- Regularly used items or services

It must be noted that purchases using the card are subject to the same procedures that control other Health Board purchases.

**13.2** Retrospective Approval of Purchasing Card use – It is acknowledged that in exceptional circumstances, it may not be possible (e.g. due to time/ short notice) for the approval process detailed in 12.1 above to be followed.

In these circumstances, the requestor of the Purchasing Card must receive direct approval from the appropriate Authorised Signatory and Purchasing Card holder by way of email, before the Purchasing Card can be used.

It is the responsibility of the card holder to ensure that following the use of the Purchasing Card, a retrospective Purchase Order is raised, following the same process outlined in 12.1 above.

## 14. Monthly submission of spend information

**14.1** On a monthly basis each card holder will be required to submit details of any spend incurred during the month by using the Purchasing Card Monthly Account summary attached in Appendix 5.

This must be sent to the administrators within 2 days of the month end.

**14.2** Monthly reconciliation to Barclaycard Management System (BSM) - The Treasury manager will access the BSM system to download the Barclaycard statement on a monthly basis.

The monthly Barclaycard statement must be reconciled to the monthly submission of spend information and posted coded into the General Ledger accordingly.

**14.3** The Finance department will undertake a monthly review of all transactions to ensure compliance with the guidelines. Card holders will be contacted if there are queries on any of the items. Further investigations will be undertaken if necessary.

## **15. Summary**

The Purchasing Card Scheme is designed to provide a payment mechanism in the rare circumstances where the Health Boards standard process is not the most appropriate. This is most likely to be for certain online purchases or where there is a critical timescale.

It is important that appropriate controls and procedures are followed, as detailed in this document.

The cardholder is requested to exercise good judgement and to act responsibly when using the card. The card is issued in the cardholder's personal name and all activity will be assumed to have been incurred by the named cardholder.

To ensure controls are adhered too, random audits will be conducted for both card activity and retention of transaction reports, receipts and invoices. Suspension of the card or disciplinary procedures will be invoked for any improper use of the card facility.

Appendix 2 provides a summary of the Purchasing Card process.

## **16. Further Information**

Enquiries regarding this procedure should be directed to either Assistant Director of Finance - Financial Systems and Services or the Head of Financial Services and Accounting

## **17. Audit**

The procedure will be subject to internal audit review from time to time.

## **18. Review**

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

## APPENDIX 1

### ANEURIN BEVAN UNIVERSITY HEALTH BOARD

#### CARDHOLDER SPECIFIC DETAILS

Employee Number:	
Full Name: (including middle)	
Security Password: (between 6-15 characters)	
Home Address:	
Nationality:	
Date of Birth:	
Work Email:	
Home Email:	
Business Telephone Number:	
Home Telephone Number:	
Mobile Telephone Number:	

Cardholder Signature:	
Date:	
Line Manager/Budget Holder Signature:	
Date:	

## APPENDIX 2

### ANEURIN BEVAN UNIVERSITY HEALTH BOARD

#### SUMMARY OF PURCHASING CARD PROCESS

1. Each request for a card must be made to the administrator by the line manager/budget holder in the first instance.
2. The Purchasing Card Financial Control procedure along with the relevant Barclaycard Application forms will be sent to the requesting officer.
3. The Purchasing Card Financial Control Procedure must be read and the relevant forms (Barclaycard application form and Appendix 1 Cardholder Specific Details form) must be completed and signed by the appropriate budget holder and returned to the administrator.
4. The administrator will return the completed application forms to the issuing bank when authorised.
5. The issuing bank will send the card and PIN to the Purchasing Card Administrator on acceptance. The administrator will register the card details and arrange for the card and pin to be delivered in person to the cardholder. The issuing bank will send the PIN number under separate cover to Finance.
6. On receipt of the card by the cardholder, Appendix 3 (Cardholder Agreement) must be duly completed by the cardholder and budget holder and returned to the administrator prior to any use of the card.
7. By the 2nd working day of the following month, Appendix 5 (Purchasing Card Monthly Account) must be completed and sent to the Treasury Manager.
8. Aneurin Bevan University Health Board will receive the Purchasing Card Statement from the issuing bank by the 8<sup>th</sup> of the month and payment will be made 14 days later.
9. The Treasury Manager will reconcile all transactions from the Purchasing Card Monthly Accounts to the statement from each cardholder and resolve any queries in a timely manner.
10. If the Purchasing card becomes lost or stolen, please contact Barclaycard 24-hour customer service helpline immediately. The Lost/Stolen Incident Report (Appendix 4) must be completed and countersigned by the line manager/budget holder and then sent to the card administrator.

### APPENDIX 3

## ANEURIN BEVAN UNIVERSITY HEALTH BOARD CARDHOLDER AGREEMENT

I acknowledge receipt of NHS Purchasing Card Number \_\_\_\_\_ and PIN.

As a cardholder I agree to comply with the following terms and conditions regarding my use of the Purchasing Card (the 'card').

- a. I have received and understood that I am being entrusted with a card and will be making financial commitments on behalf of Aneurin Bevan University Health Board. Where stipulated I will be using designated suppliers as identified by the Purchasing Department.
- b. I understand that the Aneurin Bevan University Health Board is liable to the card provider for all the charges made on the card.
- c. I agree to use this card for Aneurin Bevan University Health Board business purchases only and agree not to charge personal purchases. I understand that the Trust will audit the use of this card and report and take appropriate action on any discrepancies.
- d. I will follow the established procedures for the use of the card. Failure to do so may result in either revocation of my privileges and/or any other disciplinary action, including termination of employment.
- e. I have been given a copy of the Purchasing Card Guidance and Procedure document and understand the requirements for the use of the card.
- f. I agree to return the card immediately upon request or upon termination of employment (including retirement). Should there be any organisational change, which cause my purchasing requirements to change, I agree to return my card and arrange for a replacement, if appropriate.
- g. If the card is lost or stolen I agree to notify Barclaycard immediately and the Purchasing Card Administrator as soon as possible thereafter.

Cardholder Signature:	
Date:	
Line Manager/Budget Holder Signature:	
Date:	
Purchasing Card Administrator Signature:	
Date:	

**APPENDIX 4**

**ANEURIN BEVAN UNIVERSITY HEALTH BOARD**

**LOST/STOLEN CARD INCIDENT REPORT**

<b>CARD NUMBER</b>	
<b>CARDHOLDER NAME</b>	
<b>CARDHOLDER DEPT</b>	
<b>DATE OF INCIDENT</b>	
<b>INCIDENT DETAILS</b>	
<b>ACTION TAKEN</b>	
<i>To be completed by cardholder:</i>	
<i>To be completed by administrator:</i>	

Cardholder Indemnity

I certify that the above describes an accurate reflection of the incident that has occurred.

I confirm that I have undertaken all the necessary actions to mitigate the incident actually occurring.

Cardholder Signature:	
Date:	
Line Manager/Budget Holder Signature:	
Date:	
Purchasing Card Administrator Signature:	
Date:	

**APPENDIX 5**

**ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
 PURCHASING CARD MONTHLY ACCOUNT SUMMARY**

CARD NUMBER		CARDHOLDER NAME		MONTH ENDED	
-------------	--	-----------------	--	-------------	--

DATE	PO NUMBER	SUPPLIER/NARRATIVE	COST CENTRE	SUBJECTIVE	AMOUNT (£)
				<b>TOTAL</b>	

**Authorised Purchasing Card Transaction Request forms have been obtained for all above transactions**

<b>Signed:</b>		<b>Date:</b>	
----------------	--	--------------	--

*Please send completed forms to:*

Treasury Manager  
 Aneurin Bevan University Health Board  
 Finance Department  
 PO Box 163  
 Cwmbran  
 NP44 9EJ

Or Email to ABB\_Treasury (Aneurin Bevan UHB - Finance) [ABB.Treasury@wales.nhs.uk](mailto:ABB.Treasury@wales.nhs.uk)



## **Aneurin Bevan University Health Board**

# **Financial Control Procedure**

## **Engaging Off Payroll Workers**

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

## **Engaging Off Payroll Workers – One Page Summary**

### **Do's**

- Ensure employment status is assessed for every off-payroll worker before engagement.
- Retain a copy of the HMRC 'Check Employment Status for Tax' tool for all non-employed individuals.
- Seek advice from Finance, Procurement or Workforce if unsure about employment status.
- Retain all documentation related to status determination, including contracts and evidence.
- Provide a Status Determination Statement (SDS) to the worker or agency before work starts.
- Ensure HMRC required Tax and NI deductions are applied when IR35 rules apply.
- Follow recruitment or procurement processes as appropriate.
- Engage off-payroll workers via approved frameworks where possible.

### **Don'ts**

- Do not engage an off-payroll worker without completing an employment status check.
- Do not assume self-employed or agency-supplied workers are exempt, always assess.
- Do not process payments (e.g., invoices) without a contract for services or purchase order.
- Do not ignore inconclusive HMRC assessments—undertake an internal review.
- Do not allow outcomes to be contrived to reach a desired employment status.
- Do not delay informing Payroll when an individual must be enrolled for IR35 deductions.
- Do not use non-framework agencies without Procurement involvement.

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## 1. Introduction

UK rules relating to taxation of off-payroll workers is governed by IR35. The legislation is designed to ensure that individuals who work through an intermediary, such as a personal service company, pay broadly the same Income Tax and National Insurance contributions as direct employees under the Pay As You Earn (PAYE) system.

The rules aim to combat 'disguised employment,' where a worker operates as a contractor for tax benefits while their working arrangements mirror that of a permanent employee.

The responsibility for assessing the employment status of a worker, providing services to a public body through an intermediary lies with the engaging organisation ie Aneurin Bevan University Health Board (ABUHB).

Engaging workers through an intermediary, changes the nature of the relationship from one of an employer/employee to a contractual relationship and presents a significant risk to the Health Board including:

- Potential breach of employment tax regulations, which can lead to financial penalties being imposed on ABUHB
- Reputational risk of being deemed to condone potential tax avoidance schemes
- Non-compliance with prevailing procurement legislation
- Lack of assurance that all necessary documents are in place for an individual employed through an intermediary e.g. professional registration and relevant background checks

## 2. Policy Statement

The Health Board is committed to ensuring that it is compliant with its duty in relation to payment of remuneration and deduction of taxation and national insurance as required by law. It is also committed to full compliance with prevailing procurement law and its internal procurement procedures when placing business with suppliers.

The procedure sets out the process for engaging workers under IR35 rules established in the Income Tax (Earnings & Pensions) Act 2003 (ITEPA).

### **3. Aims**

To ensure:

- Compliance with HMRC legislation
- That employment status is established for all workers

### **4. Objectives**

The purpose of this document is to outline the ABUHB responsibilities for engaging off-payroll workers.

Workers identified as Off-Payroll are defined as those employed through:

- Services provided by an Intermediary (e.g. Agency)
- Self-Employed
- Insourcing

This procedure will provide guidance to the Health Board in identifying and correctly accounting for off-payroll workers to avoid non-compliance with Her Majesty's Revenue and Customs (HMRC) rules.

### **5. Scope**

This procedure relates to workers who carry out work for the Health Board but are not employed by the Health Board ie those individuals for whom we receive invoices for their services. Such as staff engaged through an agency or other labour provider, where the agency/labour provider has itself engaged the worker via an intermediary.

The agency/labour provider is responsible for establishing the employment status of staff. The Health Board is responsible for ensuring the agency/labour provider deduct Tax and NI prior to the payment to the staff member.

The Health Board is responsible for establishing the employment status of all workers.

There are some exemptions to the HMRC rules, but these are specific. Advice should be sought primarily from Workforce, who will engage with Procurement, if necessary, before making a decision regarding employment status.

The procedure does not relate to staff who have an employment contract, or to ad-hoc workers e.g. bank staff engaged via 'terms of engagement' and subject to tax and National Insurance deducted under the Pay As You Earn system (PAYE). It does not apply to suppliers who are genuinely self-employed.

The HMRC government employment status check can also be used to check if the services provided by a supplier are genuinely provided on a self-employed basis.

## **6. Roles and Responsibilities**

The Health Board must assess, where a worker is paid through an intermediary, whether HMRC off-payroll working rules apply. The Health Board will provide a Status Determination Statement (SDS) to the worker, agency or other provider. This must be done before the contract or work starts whichever is later.

The Health Board also has an obligation to have a dispute resolution process in place.

Where the off-payroll working rules apply, the Health Board must ensure that Tax and National Insurance will be deducted from the VAT exclusive invoice value paid to the intermediary. Deductions must be paid over to HMRC within published timescales.

### **6.1. Recruiting Managers**

All recruiting managers must establish whether the off payroll working rules apply when engaging workers outside of the Payroll system.

Any staff not employed must be assessed individually. The recruiting manager must follow either the recruitment policy/process or procurement policy/process

Recruiting managers have a responsibility to:

- Carry out an employment status check jointly with the Head of Financial Services and Accounting or their nominated deputy with reference to the worker's contract and working arrangements

- Use the HMRC '[Check employment status for tax - GOV.UK \(www.gov.uk\)](https://www.gov.uk)' online assessment for all individuals not directly employed
- Forward a copy of all documentation to the Head of Financial Services and Accounting to allow inspection by HMRC
- Ensure that the resulting outcome is not contrived to arrive at a desired outcome
- Seek relevant advice from Workforce, Procurement and/or Finance Business Partner

Before seeking advice, the recruiting manager must ensure that all relevant information is available [See 7.3].

If the outcome of the employment status assessment confirms that IR35 applies to the service being provided, the documentation attached in Appendix 2 and 3 must be completed on receipt of the first invoice from the supplier and sent to [payroll.services2@wales.nhs.uk](mailto:payroll.services2@wales.nhs.uk) for processing.

NWSSP Payroll Services will calculate the tax and NI to be deducted from the invoiced value and will pay this over to HMRC.

Appendix 1 provides guidance on how to complete the forms attached in appendix 2 and appendix 3.

If, however, the outcome of the employment status assessment confirms that the IR35 does not apply, the normal procurement process for requisitioning services must be followed.

## **6.2. Medical Staffing Co-ordinators**

Medical staffing co-ordinators may only engage off-payroll workers through an agency. Workers supplied by an agency but paid through an intermediary must be assessed for employment status. If there is any doubt, Finance and/or Workforce and/or Procurement, must be contacted for advice. The Procurement Department must be contacted for advice on procurement requirements and thresholds.

Where the Health Board have a responsibility for Managed Practices, a review should also be undertaken for the employed, to ascertain whether they are self-employed, or if IR35 applies, prior to commencement of the contract.

### **6.3. Accounts Payable**

NWSSP Accounts Payable must be aware of the off payroll rules. Staff must decline any payment requests (e.g. invoice) if there is no specific contract for services (e.g. purchase order).

Accounts Payable should highlight and liaise with both Procurement and Corporate Finance colleagues in all instances where there is a concern that an off-payroll arrangement is undertaken and an assessment has not been carried out.

### **6.4. Finance**

Corporate Finance must ensure that off payroll payments are recorded for mandatory annual disclosure to Welsh Government and for inspection by HMRC where required.

Corporate Finance must regularly analyse the ledger for suppliers which may have the characteristics of an intermediary.

Corporate Finance will be responsible for jointly (with the Recruiting Manager) carrying out the HMRC 'check employment status'. They will to the best of their knowledge ensure that assessments are carried out accurately and in accordance with the law.

A copy of each employment assessment outcome, along with any supporting evidence (e.g. the contract, evidence of discussions with the worker and recruiting manager etc.), must be saved by the Finance department.

The Central Management Accounting (CMA) team contact existing framework agencies annually to remind them of their responsibilities under Engaging Off Payroll Workers.

Corporate Finance will ensure that this procedure is communicated to managers in NHS Wales Shared Services Partnership (NWSSP) Accounts Payable.

Business Partner Accountants (BPAs) must be aware of the rules relating to off payroll workers and support recruiting managers in obtaining the relevant advice.

## **6.5. Workforce and Organisational Development**

Workforce and Organisational Development will ensure that this procedure is communicated to managers in the Health Board and NHS Wales Shared Services Partnership (NWSSP) Payroll, recruitment services and to any departments involved in engaging medical or other staff.

Workforce Business Partners must be aware of the rules relating to off payroll workers and support recruiting managers in obtaining the relevant advice.

## **6.6. NWSSP Procurement**

Procurement must ensure that the relevant contracting and procurement advice is provided to recruiting managers for off-payroll engagements. This includes contracts in relation to insourcing.

A list of framework agencies must be maintained as per the [Procurement Manual](#).

Procurement staff must be aware of the HMRC rules relating to off-payroll workers.

## **6.7. NWSSP Payroll Services**

Payroll Services must ensure that staff have full knowledge of this procedure to enable them to provide the appropriate advice, should enquiries arise.

When informed by the recruiting manager, payroll services must enrol individuals assessed as holding employment status onto the payroll system, coded to the IR35 element. The individuals must be clearly and easily identifiable.

They must make the appropriate level of deductions for Tax and NI and prepare relevant information to enable payment of deductions to HMRC.

## **7. Procedure for Engaging Staff in an Off Payroll Capacity**

Changes in legislation introduced in 2017 placed responsibility on all Public Sector Organisations for determining employment status for all off payroll employees provided through an intermediary. An

intermediary can be an individual e.g. partnership or limited company, or any other labour providing body. Where a worker is provided by an agency, the Health Board must establish whether they are directly employed by the agency (the IR35 rules do not apply in this case) or whether the agency is supplying the worker through an intermediary. Under previous legislation the responsibility for determining employment status was with the intermediary.

In all but the most exceptional cases (and on the express advice of HMRC), off payroll workers must be engaged and remunerated through the payroll system and be subject to tax and national insurance deductions at source, in line with tax and NI thresholds.

## **7.1. Process**

### **7.1.1. Testing for Employment Status**

When an (off payroll) individual is required, a test for employment status must always be carried out using the HMRC online tool. The test for employment status must be carried out jointly between the (ABUHB) recruiting manager and Head of Financial Services and Accounting or their nominated deputy.

A record of the outcome must be kept for reference and HMRC inspection regardless of the result. The HMRC tool can be accessed by clicking on the following link:

[Check employment status for tax - GOV.UK](#)

This is an important step and must be carried out before the individual is engaged.

If it is determined that the rules apply, and Tax and NI must be deducted (calculated by Aneurin Bevan's payroll provider in accordance with HMRC PAYE rules). Both the individual and the intermediary must be informed of the decision immediately in writing. This must be done before the contract or work starts whichever is later.

If the off payroll rules are not complied with, the Health Board may incur financial penalties in the following circumstances:

- If an individual who has been assessed by the Health Board as 'not employed' is then assessed by HMRC to hold employment status

- If the Health Board fails to test employment status and a worker is later assessed by HMRC to hold employment status. In such cases, the Health Board risks liability for the full cost of the employee's tax and NI contribution **plus** any penalty levied by HMRC

Penalties for not following the rules would only be avoided if the Health Board can evidence to HMRC that it had taken "reasonable care" in assessing the worker's status.

Employment status must be assessed by the Health Board for each role, however where groups of workers carry out largely the same function, it may be appropriate to carry out a 'mass' assessment. However, if an individual requests to be tested for employment status, the Health Board is obliged to carry out a test for employment status.

Any decision made on specific employees/groups of employees, must be reconsidered if any changes are made to the practices of the engagement. If any changes are made, the employment status check online tool must be completed again.

## **7.2. Using the HMRC Employment Status Tool**

To enable HMRC employment status assessments to be carried out, before the contract or work starts, the following details should be collated before contacting Corporate Finance:

- Contract of engagement
- The worker's responsibilities
- Who decides what work needs doing
- Who decides when, where and how the work's done
- How the worker will be paid
- If the engagement includes any benefits or reimbursement for expenses

The tool is designed to assess a number of factors, including:

- Control – right to control what the worker has to do, where it has to be done, when it has to be done and how it has to be done
- Personal services – Mutuality of obligation – obligation to pay the worker and the worker is obliged to provide work or a skill rather than send a substitute

The tool is intended to help an employer to ascertain whether the worker is an employee, for whom statutory deductions must be made. HMRC will honour the results of the test providing that the information is accurate. It is vital that the answers provided reflect the written contract and how the working arrangement operates in practice. Any deviations from the contract will supersede the written contract for status determination. A record of all employee status checks, along with any supporting evidence, must be kept by Corporate Finance for inspection by HMRC, if required.

If results are achieved through contrived arrangements to get a particular outcome, this would be treated as evidence of deliberate non-compliance and will attract higher penalties.

If an agency provides ABUHB with a worker who is a sole trader, i.e. there is no intermediary it is the responsibility of the Agency to assess employment status.

### **7.3. When to use the HMRC Employment Status Tool**

The first step must always be to understand the relationship between the organisation and the worker.

#### **7.3.1 Self-Employed**

It is important to note that when directly engaging a self-employed person or sole trader, employment status must always be checked.

#### **7.3.2 Intermediaries**

The Health Board must establish whether there is an intermediary. This can be:

- A company
- A partnership
- Other labour provider

Directly engaged off-payroll individuals must always be assessed under the IR35 rules

If none of the above apply, they may be exempt from the legislation. In any case the engaging manager must always seek advice from Workforce, who will engage Procurement, if necessary.

## **7.4. Procedure following HMRC Employment Assessment**

### **7.4.1. Workers engaged through an intermediary via an Agency or Other Labour Provider**

If an agency or any other labour provider supplies an individual or group of individuals assessed to hold employment status through an intermediary, you must confirm that they (the provider) deduct Tax and National Insurance as if they (the worker) were an employee.

You should pay the supplier invoice for providing the worker according to the contract with them.

The recruiting manager must always check with Procurement that:

- The agency or labour provider is on a Procurement framework
- If the agency or labour provider is not on a Procurement framework, Procurement must inform both the individual and intermediary in writing confirming the employment status of the worker before the contract or work starts.

### **7.4.2. Individuals assessed as employed**

In cases where the Health Board pays an intermediary, but the individual is deemed as having employment status, they must be enrolled through payroll.

All payment requests must be submitted to payroll (this will often be in the format of an invoice) electronically, providing them with all relevant information. Payroll will make the necessary deductions and supply the appropriate information to enable pay over of deductions to HMRC.

### **7.4.3. Sole Traders**

If a sole trader is providing their services directly to ABUHB as an individual, an employment status check must always be carried out. If the HMRC tool returns a result of employed, they must also be enrolled on the payroll system and relevant deductions made.

#### **7.4.4. Inconclusive Assessments**

If the HMRC employment status tool returns an inconclusive result, the Health Board recruiting manager and Head of Financial Services and Accounting or their nominated deputy must undertake an in house employment status assessment. Where an inconclusive result has been returned, the Health Board will usually make the decision to assume employee status applies.

If the in-house assessment returns a self-employed status, all relevant documentation must be retained along with reasons for conclusions regarding employment status as evidence (e.g. contracts and correspondence with the individual or intermediary), in the event that HMRC make inquiries.

### **8. Audit**

This policy will be subject to internal audit review from time to time.

### **9. Review**

This procedure will be reviewed, at a minimum every three years, unless significant changes require a review before this.

### **10. Related Procedures**

It is important that recruiting managers are familiar with ABUHB procedures for:

- [Recruitment](#)
- [Procurement](#)

Appendix 1

Off-Payroll Worker  
Guidance for Ad-Hoc Staff



Once a **Service Requirement** has been identified you will need to complete the HMRC Employment Status Tool.

This can be found at [www.tax.service.gov.uk/check-employment-status-for-tax/setup](http://www.tax.service.gov.uk/check-employment-status-for-tax/setup)

**Question: Is the engagement classified as employed for tax purposes?**

**No**

You will need to send the requirements to your local Procurement Department so that they can start the procurement process.

**Yes**

You will need to complete an "**Off-Payroll Enrolment Form (Ad-Hoc)**" and submit it to your local Payroll Services Department as soon as the person is engaged.

The Payroll Services Team will create an ESR Payroll Record and send you the workers **Assignment Number** and an **Off-Payroll Payroll Electronic Workbook**. It is very important that you record this number as you will need to include this when requesting payment for invoices from the worker via


On receipt of the invoice from the worker, please complete the "**Off-Payroll Electronic Workbook**". You will need to complete all the relevant fields to include Assignment Number, Cost Centre, Invoice Details, Payments and Allowances plus VAT details. This will need to be submitted to the Payroll Services Department in line with your local payroll deadlines. See additional tab for guidance on completing the workbook.

The Payroll team will load the workbook into ESR via Web ADI and checking processes will be completed during the retry period.

Remittance/pay slips will be produced by the payroll system and directed back to the relevant **Payroll team**. These will be posted to correspond with the payment date for your local Health Board.

All TAX and NI will be reported to HMRC via the daily RTI interface included in the Payroll Departments processes.

Appendix 2

<b>Aneurin Bevan UHB Off-Payroll Enrolment Form</b>		 Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	
<b>Section 1</b>		<b>Personal Information</b>	
Title			
Surname			
Forename(s)			
NI Number			
DOB			
<b>Section 2</b>		<b>Address &amp; Contact Information</b>	
Home Address Line 1			
Home Address Line 2			
Home Address Line 3			
Town			
Postcode			
Contact Number			
Email Address			
<b>Section 3</b>		<b>Bank / Building Society Details</b>	
Bank / Building Society Name			
Account Name			
Bank Account Number			
Bank Sort Code			
Building Society Roll Number (if applicable)			
<b>Section 4</b>		<b>HMRC Declaration</b>	
<p><b>Please read all the following statements carefully and enter 'X' in the one box that applies to you.</b>                      Please note that you will already have a primary employment with your own company so the services you provide will be treated as a secondary employment.                      It follows then that declaration C is the option that would normally be used.</p>			
A - This is my first job since last 6 April and I have not been receiving taxable Jobseeker's Allowance or taxable Incapacity Benefit or a state or occupational pension.			
B - This is now my only job, but since last 6 April I have had another job, or have received taxable Jobseeker's Allowance or Incapacity Benefit. I do not receive a state or occupational pension.			
C - I have another job or receive a state or occupational pension.			
<b>Section 5</b>		<b>Employee/Worker Declaration</b>	
Print Name		Signature	
Date			
<b>Section 6</b>		<b>Health Board Manager Declaration</b>	
DOB Verified (Yes/No)		Signature	
DOB Verification Document			
Print Name			
Date			
Please note: Initially TAX will be deducted at basic rate unless otherwise informed by HMRC			
Payment will be credited to accounts on the Health Board's normal payday, subject to all information being correct and submitted on time.			
Please send this form to:		Or click here to email to Payroll:	
NWSSP Payroll Services Floor 4, Companies House Crown Way Cardiff. SA1 5AW		<a href="#" style="color: white; text-decoration: none; padding: 5px 10px;"><b>Email Form to Payroll Services</b></a>	
For Payroll Use Only Authorised by:			





**Aneurin Bevan University Health Board**

# **Financial Control Procedure Patients' Property**

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

Issue date: DRAFT  
Review by date: DRAFT  
Policy Number: ABUHB/Finance/0279

- **Patients' Property – Do's and Don'ts**

- **Do's**

- Advise patients not to bring valuables for planned admissions.
- Ensure valuables are deposited for safekeeping and recorded in the Patients' Property Book.
- Display disclaimer notices prominently at admission points.
- Ensure two staff examine and sign for property of unconscious/incapable/deceased patients.
- Store property securely and transfer to General Office promptly.
- Ensure all entries in the Patients' Property Book are accurate, signed, and stored securely.
- Ensure benefits, monies, and receipts are handled in accordance with procedure.
- Ensure proper authorisation for withdrawals based on value thresholds.
- Record and reconcile ward-held cash regularly.
- Ensure property and monies are returned promptly on discharge or transfer.

- **Don'ts**

- Don't accept responsibility for property not deposited for safekeeping.
- Don't use terms like 'gold' or 'diamond' when describing valuables – use neutral descriptors.
- Don't allow staff to take cash/valuables home for safekeeping.
- Don't issue petty cash or payments without verifying funds and proper forms.
- Don't loan one patient's cash to another patient.
- Don't hand property to anyone other than the patient without written consent.
- Don't process claims for lost/damaged property outside the Losses & Special Payments procedure.
- Don't dispose of unclaimed property without making efforts to trace next of kin and recording details.

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## **1 Introduction**

- 1.1** When a patient is admitted to hospital either by planned or unplanned admission (emergency), any monies and belongings (property) not needed by the patient should be handed by the patient to a relative or friend at the point of admission to be removed safely from the hospital. Where this is not possible, property may be handed over to the Health Board for safekeeping
- 1.2** The Aneurin Bevan University Health Board (Health Board) has a legal responsibility to protect any patients' property that is deposited for safekeeping and to return it to the patient on demand.
- 1.3** The Health Board has an additional responsibility to safeguard property and clothing retained by patients on wards, and to safeguard and administer patients' monies.
- 1.4** The Health Board's responsibility for protecting patients' property extends from admission until discharge of the patient.

## **2 Aim**

- 2.1** The aim of this procedure is: -
- To ensure that the interests of the patient, the staff and the Health Board are fully protected.
  - To assist staff in the safeguarding and administration of patients' property and monies that are deposited for safekeeping
  - To assist staff in fulfilling the Health Board's legal responsibility for patients' property and monies.
- 2.2** The term "patient" is used throughout this procedure.
- 2.3** A short term stay in hospital should not require administration; these services are normally provided for long stay patients.
- 2.4** This procedure should be read in conjunction with other financial procedures.

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### **3 Roles and Responsibilities**

#### **3.1 Health Board**

**3.1.1** Provide safe custody for money and other personal property handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival

**3.1.2** In all cases where property, including cash and valuables, of a deceased patient is of total value in excess of £5,000, the production of Probate or Letters of Administration shall be required before any of the property is released

**3.1.3** Where the total value of property is £5,000 or less, forms of indemnity shall be obtained

**3.1.4** Staff should be informed, on appointment, of their responsibilities and duties for the administration of the property of patients

**3.1.5** Where patient property is received for specific purposes and held for safekeeping, it should be used only for that purpose, unless any variation is approved by the patient

#### **3.2 Chief Executive**

**3.2.1** Ensuring that patients, or their guardians, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official record is retained as a receipt

#### **3.3 Director of Finance, Procurement and Value**

**3.3.1** Provide detailed written instructions on the collection, custody, recording, safekeeping, investing and disposal of patient property

**3.3.2** Where Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under

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arrangements agreed by the Director of Finance,  
Procurement and Value

## **4 Patients' Property**

### **4.1 Planned Admissions**

- 4.1.1 The Health Board must ensure that all patients are advised not to bring valuables into hospital wherever possible by including a note to this effect within the literature/letters that are sent to all patients prior to admission.

### **4.2 Unplanned Admissions (Emergency)**

- 4.2.1 Staff in Charge must inform the patient on admission that the Health Board cannot be held responsible for items not deposited for safekeeping.
- 4.2.2 Property and valuables belonging to patients who are admitted unconscious or whose condition warrants assistance should be deposited for safekeeping in the General Office/Administration Office using the Patient Property Book (see 4.4 below).
- 4.2.3 Staff may be required to dispose of soiled or damaged patient's clothing.
- 4.2.4 If the patient is confused or in any way incapable of managing their own affairs on admission, the nurse should discuss the safekeeping of the property with the next of kin.

Any decision taken on behalf of the patient must be in the patient's best interest and clearly documented in the patient's notes. In case of doubt, reference should be made to the [Mental Capacity Act 2005](#).

If the next of kin wishes the patient to retain his/her personal effects, the risk involved should be explained to them and that the Health Board cannot accept responsibility for loss and/or damage to any valuables not handed in for safekeeping.

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The next of kin must be asked to sign as the patient's representative in the Patients' Property book.

Where there are no next of kin decisions, property should be clearly documented in the patients' medical record.

### **4.3 All Admissions**

- 4.3.1 A chart demonstrating the key steps of admission can be found in Appendix 1.
- 4.3.1 Disclaimer notices must be displayed prominently at admission points, wards, departments, clinics and general offices to explain the extent of the Health Boards liability (Appendix 2).
- 4.3.2 Patients should be advised to give any property not required to a relative or friend at the time of admission.
- 4.3.3 On admittance to hospital the inpatient should sign a disclaimer in the Patient Care Record (PCR) stating they are keeping property at their own risk.
- 4.3.4 Hospital staff should inform, as soon as possible after admission, the appropriate Authority (e.g., Police, Social Services etc.) where they have knowledge of patient's property outside the hospital requiring protective action.
- 4.3.5 Care should be taken when patients are moved, especially early morning or late at night when, potentially no next of kin is present and access to a safe place for property, may be reduced.

### **4.4 Patients' Property Books**

- 4.4.1 Patients' Property Books (sample shown in Appendix 3) are controlled stationery and only one book should be in use at any one time in each location. A guide showing how to complete the property book is shown in Appendix 4.
- 4.4.2 The pages in the books are sequentially numbered and in triplicate; the top copy is to be handed to the patient;

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the second copy should accompany valuables passed to the General Office and the third copy remains in the book.

The General Office is an administrative/cash office that currently sits under the Facilities Directorate, usually located at the front entrance of a hospital. It is a point of contact for the hospital to accept cash such as donations, payments for hearing aids and scans from the general public and also to accept cash from departments such as dining room takings. They also pay out travel expenses to patients on benefits via petty cash. They usually have large secure safes to allow the safekeeping of items for patients.

- 4.4.3 Staff should enter the details of all property handed over for safekeeping in the Patients' Property Book.
- 4.4.4 Property handed over for safekeeping should be examined, listed and signed for by a member of staff.
- 4.4.5 The patient or their representative should sign the book indicating their agreement that the list is accurate and complete
- 4.4.6 Where patients are unconscious, or are incapable of looking after themselves, or if the patient is dead on arrival, the Health Board has a duty to have the contents of their clothing examined and all items placed in safe custody. This check should take place in the presence of two members of staff both of whom should sign the property record.
- 4.4.7 Care should be taken to describe the items accurately, for example, jewellery should be described as "yellow metal", "white metal", "white stone", etc. The words "gold", "silver", "diamond", etc. must not be used. This approach assists in preventing disputes or claims regarding the value of items, reduces the risk of theft or fraud and ensures accurate documentation without implying ownership of precious metals or stones.
- 4.4.8 Spoilt entries in the Patients' Property Book should be marked "cancelled" and retained in the book.
- 4.4.9 A disclaimer has been added to the Patient's Property

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Book stating that the Health Board will accept no responsibility for personal items not handed over and not recorded.

- 4.4.10 Ward staff must keep the Patients' Property Book in safe custody and it must be available for inspection by authorised staff, such as Audit, Finance and Senior Nursing staff.
- 4.4.11 Once the entry in the Patients' Property Book has been completed, the valuables should be placed under lock and key until such time it is convenient to hand over to the General Office, who will place the items within the General Office safe.
- 4.4.12 Ward staff must take the Patients' Property Book together with the property held for safekeeping to the General Office as soon as possible.
- 4.4.13 General Office staff should verify that the items being handed over by ward staff for safekeeping are listed in the Patients' Property Book, sign the book and then remove their copy of the record.

#### **4.5 Admissions outside office hours**

- 4.5.1 Ward staff must place all valuables handed in for safekeeping, outside office hours, in an envelope. The envelope should then be sealed, signed, timed and dated by two members of staff, signing their names in full across the seal. The envelope should be deposited in the hospital night safe, if available, if not, kept under lock and key with the Patients' Property Book and transferred to the General Office on the next working day.

#### **4.6 General Office**

- 4.6.1 General Office staff will record details of property held for safekeeping in a pre-printed sequentially page numbered book as detailed in Appendix 5.
- 4.6.2 The property must be placed in an envelope, or other container, and in the office safe. The envelope and/or container must be sealed, labelled with the patient's full name, patient property book reference number,

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date and time, witnessed by two members of staff who should sign their names in full across the seal.

- 4.6.3 General Office staff must complete a Cash Receipt and Bank Deposit sheet (C&D) for all cash receipts. Cash receipts from patients must be banked into the Patients' Monies bank account as soon as possible but no later than five working days after the date of receipt.
- 4.6.4 General Office staff must open an ABUHB patient account by completing a New Patient Account Form PPM/10 (Appendix 6) for patients whose cash has been banked. The completed sheet should be forwarded to Corporate Finance.
- 4.6.5 General Office staff in acute hospitals should delay the actions in 4.6.3 and 4.6.4 above for five working days when patient's length of stay is expected to be short.

#### **4.7 Claims in Relation to Lost or Damaged Property**

- 4.7.1 In the result of any lost or damaged property, the patient is required to follow the guidance in the [Losses and Special Payments procedure](#) and complete the form in Appendix 7.

### **5 Income**

#### **5.1 Benefits Receivable**

- 5.1.1 Most benefits from the Department of Work and Pensions (DWP) are paid directly into an individual's bank account but patients who do not have a bank account obtain their benefits from a Post Office Card Account (POCA) by using a card similar to a bank account and keying in their unique PIN number (Personal Identification Number).
- 5.1.2 Staff must not collect any benefits using a patient's Post Office Card Account (POCA).
- 5.1.3 Ward Staff must establish, as soon as practicable, whether the patient is in receipt of any statutory benefits, and who, if anyone is managing the patient's affairs.

- 5.1.4 Patient's relatives or friends may attend to the patient's affairs during their stay in hospital with the patient's consent.
- 5.1.5 If the patient is confused or in any way incapable of managing their own affairs on admission, the nurse should discuss the issue of benefits with the next of kin. If there is no next of kin, then the Social Worker should be notified.
- 5.1.6 Any decision taken on behalf of the patient must be in the patient's best interest and clearly documented in the patient's notes. In case of doubt, reference should be made to the [Mental Capacity Act 2005](#).
- 5.1.7 Where ward staff are concerned that a patient is not adequately provided for when a relative or friend attends to the patient's affairs, they must refer to [Safeguarding Adults](#) procedures. General Office staff will inform the Patients' Monies Manager (Charitable Funds/PPM Manager – Corporate Finance) if they have applied to the DWP for the Health Board to act as Corporate Appointee for patients unable to appoint a relative or friend to manage their affairs.
- 5.1.8 The Patients' Monies Manager will act as Corporate Appointee for the Health Board

## **5.2 Miscellaneous Receipts**

- 5.2.1 Cash and/or cheques received by patients during their stay in hospital should be dealt with in accordance with the guidance in this procedure.

## **6 Investments**

**6.1** The Health Board has a legal responsibility for investing all monies surplus to meet the day-to-day requirements of patients. The Assistant Director of Finance (Financial Systems and Services) is accountable for investing the monies.

**6.2** Interest earned on patients' accounts should be credited to those accounts regularly. Any bank charges relating to

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patients' accounts should be deducted.

**6.3** The individual accounts should be monitored, to ensure that large static amounts are not held, receiving little or no interest. This may apply in the case of long-stay patients where a patient accumulates a balance far more than that needed to meet their immediate needs. Special arrangements need to be put in place for handling the money of such long stay patients, such as using a savings account

**6.4** Finance Staff must:

- Apportion monthly, the interest received from investments to each patient's account in relation to the balance held in each account
- Apportion monthly, bank charges received to each patients' accounts in relation to the balance held in each account. Where the interest falls below the level of the bank charge, the bank charge will be borne by revenue budget
- Reconcile balances on all the accounts to the value of investments held.

**6.5** The Assistant Head of Financial Accounting must countersign the reconciliation.

## **7 Expenditure**

### **7.1 Withdrawals**

7.1.1 General Office staff will complete a Miscellaneous Payment Form PPM/13 (Appendix 7) to pay for ad hoc requests.

7.1.2 The Miscellaneous Payment Form must be signed by the patient and witnessed by one member of the nursing staff and one member of the General Office. Patients who are physically incapable of signing their name must make a mark on the form; the mark must be witnessed in the same way.

7.1.3 A note should be made on the Miscellaneous Payment Form when a patient signs their name differently to the

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name by which they are known by.

- 7.1.4 General Office staff will forward the completed form to Patients' Monies Section, Finance Department.
- 7.1.5 Finance Department staff will verify that the patient has sufficient funds in their account prior to processing the payment.

## **7.2 Withdrawals for Patients unable to manage their own Affairs**

- 7.2.1 Ward staff should consult with relatives of patients, who are unable to manage their own affairs, to assess whether the patient requires any goods, services or cash.
- 7.2.2 Ward staff should complete a Residents' Monies Request Form PPM/01 (Appendix 8) listing those items a patient requires. The form should be authorised as follows: -

Items <= £50	Ward/Residential Manager
Items > £50 to <= £250	Senior Nurse Manager/ Lead Nurse
Items > £250	General Manager

- 7.2.3 Ward staff should take the completed form to the General Office.
- 7.2.4 General Office staff must check that there are sufficient monies in the patient's account prior to issuing the cash requested.
- 7.2.5 General Office staff must obtain the signature of the staff member collecting the cash on the Cash Receipt Form PPM/03 (Appendix 9). This transaction must be witnessed by and countersigned by another staff member.
- 7.2.6 General Office must also issue the ward staff with Residents' Monies Receipt Form PPM/02 (Appendix 10) to enable them to account for the cash issued. It is acknowledged that on shopping trips, holidays and day trips it may not be possible to obtain receipts for all purchases, e.g., food from a "snack" bar, drinks from a

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drink's dispenser etc. However, all items purchased must be accounted for.

- 7.2.7 Ward staff must return the completed PPM/02 form and receipts, together with any change, to the General Office.
- 7.2.8 General Office staff must re-bank any cash returned into the patient's account.
- 7.2.9 Custody of cash during holidays is the responsibility of the senior nurse on the trip.
- 7.2.10 Ward Staff should raise purchase requisitions, where possible, to purchase goods from named shops. The requisition should state the name of the resident and that payment will be made from the patient's own account.
- 7.2.11 Patients whose benefit(s) are being paid into a patients' monies account operated by the Health Board, must purchase their own clothing. However, the Health Board's exchequer funds (budget) can be used to purchase clothing if a patient has less than £100 in their account.
- 7.2.12 Where a patient receives no benefits and has no other means of obtaining clothing, it is at the discretion of the Ward Manager as to whether they use their departmental budget to purchase these items.
- 7.2.13 Relatives or friends who manage a patient's affairs are responsible for ensuring that adequate clothing money is provided to the patient.

### **7.3 Petty Cash**

- 7.3.1 Patients may request a small amount of cash for incidental sundry items. The General Office will issue the cash from the patients' monies petty cash providing it does not exceed £50. The patient must sign the petty cash voucher on receipt of the cash, and a member of General Office staff should sign that they have witnessed the patient receiving the cash.

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## **7.4 Pocket Money**

- 7.4.1 Ward Staff are responsible for assessing the weekly incidental sundry (pocket money) needs of those patients who are not capable of looking after their own affairs.
- 7.4.2 Ward Staff must notify General Office staff weekly of the pocket money requirements.
- 7.4.3 General Office staff will complete a Weekly Pocket Money Form PPM/04 (Appendix 11) and forward the completed form to the Patients' Monies Section, Finance Department.
- 7.4.4 Finance Department staff will: -
- Arrange for a direct debit to be deducted from the patients monies bank account to our nominated cash security company
  - Arrange for the Security Company to deliver the cash to the General Office
- 7.4.5 The General Office will: -
- Issue the cash to two members of Ward Staff
  - Obtain the signatures of the two members of Ward Staff.
- 7.4.6 Any unspent pocket money, providing it is less than £10 is to be retained on the ward. Monies exceeding this amount should be re-banked into the patient's account via the General Office and the amount of pocket money requested should be reviewed.
- 7.4.7 Patients that do not receive benefits (serving custodial sentences in hospital) may receive pocket money for sundry items at the discretion of the ward manger. This money is provided to their patient's monies account by the revenue budget. Surplus monies must be returned to the budget.

## **7.5 Cash Held on the Ward (Long Stay Patients)**

- 7.5.1 Cash held on wards must be kept in a locked container in a locked drawer/safe.
- 7.5.2 Cash held on behalf of one patient must not be loaned

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to another patient

- 7.5.3 Cash held on the ward on behalf of patients must be recorded in a record book, detailing the following for each resident: -
- Date
  - Amount paid in/out
  - Balance
  - Reason for payment
  - Signatures of staff/resident
- 7.5.4 The patient should sign for monies withdrawn from ward balances if possible, otherwise two members of staff should sign, at least one of whom is a Registered Nurse.
- 7.5.5 The Ward Sister/ Charge Nurse and a member of Ward Staff must reconcile the cash book balance to the cash held in the cash box at least once a week, and record the following: -
- Date and time of reconciliation
  - Balance recorded in cash book
  - Cash held in the cash box
  - Signatures of the two members of staff performing check.

Reconciliation discrepancies must be formally investigated and explained.

## **8 Long Stay Patients**

### **8.1 Inventory of Property**

- 8.1.1 Ward Staff will be responsible for recording property acquired by patients during their stay in hospital in the Patients' Property Book.
- 8.1.2 Details entered in the property book should be in accordance with the guidance contained in paragraph 4.4 of this procedure.
- 8.1.3 Ward Staff will also record details of property condemned or lost in the Patients' Property Book.
- 8.1.4 Ward Staff will ensure that all items of clothing and

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property are tagged or marked with the owner's name and stored in a safe and secure environment.

## **8.2 Stock-checks**

- 8.2.1 Two members of staff, one of whom must be the Ward Sister/Charge Nurse, are to carry out stock-checks of the Patients' Property Book to verify accuracy, at least on an annual basis
- 8.2.2 The results of stock-checks must be documented, signed and dated in the patients' property book.
- 8.2.3 A stock-check on a third of the records should be undertaken each quarter with a full stock-check undertaken annually.
- 8.2.4 All discrepancies between items held and those recorded should be fully & formally investigated.

## **9 Patients' Balances**

### **9.1 General**

- 9.1.1 General Office staff must keep an electronic record of the balance of monies held on behalf of each patient.
- 9.1.2 General Office staff must use the relevant form to notify the Patients' Monies Section, Finance Department.
- 9.1.3 Finance Staff will be responsible for: -
  - Updating the patients account on the Financial Management System
  - Reconciling the patients account balance to the monies held
  - Forwarding the updated account balances to the General Office for verification.
- 9.1.4 General Office staff will be responsible for: -
  - Verifying the balances notified
  - Investigating any discrepancies
  - Reporting their findings to Finance
- 9.1.5 Finance Staff must also forward a copy of the patients' balances to the respective Divisional Manager.

- 9.1.6 Finance Staff have sole responsibility for providing patients' monies balances to the patient's appointee. The respective Divisional Manager and/or General Office staff must forward details of any such requests to Finance Staff to process.

## **10 Discharge and Transfer of Patients**

### **10.1 Discharge of Patients**

- 10.1.1 When a patient is due to be discharged from hospital the ward staff are responsible for returning those items that have been handed in for safe keeping.
- 10.1.2 It is not advisable for Health Board staff to hand over property to anyone other than the patient without written consent.
- 10.1.3 Articles of small value and clothes may be handed to friends and relatives and a receipt obtained.
- 10.1.4 Upon discharge every effort must be made to return funds held in safe custody to the patient directly or if the patient is incapable, to a properly authorised custodian, to another hospital or Local Authority in the event of the patient being transferred into their care. See form in Appendix 3.
- 10.1.5 General Office staff may provide patients who are being discharged from hospital with a maximum of £50 from patients' money petty cash to cover their immediate needs providing the patient has sufficient funds in their account.
- 10.1.6 General Office staff must complete a Discharged Patient Form PPM/17 (Appendix 12)
- 10.1.7 Finance Staff will be responsible for: -
- Verifying the balance notified
  - Rectifying any discrepancies between the two sets of balances
  - Issuing payment to the patient for the balance or
  - Arranging for cash to be available via the General Office where a patient does not have a bank

account.

- Notifying the Department of Work and Pensions (DWP) that the patient has been discharged from hospital if the patient was in receipt of benefits.

10.1.8 General Office staff will: -

- Return any property handed in for safekeeping
- Record the return of the property in the Patient Property book
- Obtain the patient's signature and ensure that a member of General Office staff witness the signature

## **10.2 Transfer of Patients**

10.2.1 Where a patient is transferred from one hospital to another within the Health Board, General Office staff must: -

- Complete a Patient Transfer Form PPM/11 (Appendix 13)
- Forward one copy of the completed form to Patients' Monies Section, Finance Department
- Forward one copy of the completed form to the General Office of the hospital where the patient is being transferred.

10.2.2 Finance Staff will be responsible for: -

- Verifying the balance notified
- Rectifying any discrepancies between the two sets of balances
- Notifying the General Office of the hospital where the patient is being transferred of the balance being transferred.

10.2.3 Ward staff must ensure that all the property listed in the Property book must be transferred with the patient, even if the patient is moving between wards within the same hospital. Where possible and practical the property must be handed back to the patient.

10.2.4 Patients transferred to hospitals outside of the Health Board are classed as discharged.

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## 11 Estates of Deceased Patients

### 11.1 Administration

- 11.1.1 General Office staff must: -
- Complete a Deceased Patient Form PPM/18 (Appendix 14) to notify the Finance Department of the death of a patient where a patients' monies account is in operation. It is important that all known details of next-of-kin and/or Executors are shown on the form
  - Forward the completed form to Patients' Monies Section, Finance Department
- 11.1.2 Ward staff must: -
- Return any monies being held on the ward to the General Office
  - Ensure that only next of kin take any property held
  - Ensure that next of kin sign the Patients' Property book for any property they receive. In this case the property book can be used as an inventory of the deceased patient's property.
  - Ensure that written consent is received from next of kin for any property donated to the hospital
  - Dispose of any personal clothing not claimed by next of kin
- 11.1.3 General Office staff must not use petty cash to pay the deceased's next of kin the money held on the deceased's behalf.

### 11.2 Funeral Expenses

- 11.2.1 The Health Board has a duty to arrange and pay for a contract/public health funeral for patients who have died in our care and whose relatives cannot be traced, or whose relatives cannot afford to pay for the funeral, and do not qualify for social fund funeral payments. The expenses of the funeral can be defrayed by any funds held on behalf of the patient and the Health Board has the right to recoup the cost of the funeral from the deceased's estate.
- 11.2.2 The [Public health funerals: good practice guidance - GOV.UK](#) should be referred to.

- 11.2.2 The member of staff who arranges the funeral must complete the certificate given on "Registration or notification of death" and send to the DWP where necessary.
- 11.2.3 General Office staff must notify the Patients' Monies Section, Finance Department of funeral arrangements made.
- 11.2.4 Finance staff must ensure that, where sufficient funds are available, the funeral cost is charged to the patient's account. The Health Board will bear the cost of a contract funeral when insufficient funds exist.
- 11.2.5 Finance staff are permitted to settle funeral accounts of deceased patients where sufficient funds are available and the funeral arrangements have been made by relatives or friends of the deceased. Payment can be made direct to the Funeral Director upon presentation of the original invoice for the funeral.

### **11.3 Property of Deceased Patients**

- 11.3.1 Finance Staff must:
  - Write to the next of kin or Executor informing them of the monies and/or property held
  - Enclose a Form of Indemnity PPM/08 (Appendix 15) and a Form of Enquiry PPM/07 (Appendix 16)
- 11.3.2 Finance Staff must take the appropriate action upon receipt of the completed Form of Indemnity and Form of Enquiry. Current legislation states that:
  - **Where there is a will and the value of property held exceeds £5,000** no action should be taken until a Grant of Probate has been obtained.
  - **Where there is no will and the value of property held exceeds £5,000** no action should be taken until Letters of Administration have been obtained.
  - **Where there is no will and the value of the property held does not exceed £5,000** Finance staff will
    - establish the relationship of the claimant

- obtain written authority from all equally entitled persons to release the monies to the claimant
- obtain a signed Form of Indemnity PPM/08 from the claimant.
- **Where there is no will and there is no next of kin and the property held is over £500** Finance staff will notify the Treasury Solicitor
- **Where there is no will and there is no next of kin and the property held is under £500** Finance staff will treat the property as unclaimed property, see paragraph 12 below.

#### **11.4 Exceptional Circumstances**

- 11.4.1 General Office staff must liaise with Finance staff to resolve any financial issues that relatives may raise during their period of grief.

## **12 Unclaimed Property**

### **12.1** General Office and Ward staff must:

- Make every effort to trace and return property to next of kin
- Keep unclaimed property for a month before arranging its disposal.
- Record the details of property to be disposed in the property book
- Send the property with a copy of the property book to the Patients Monies section of the Finance Department for disposal.

### **12.2** Finance Staff must: -

- Credit unclaimed cash and the proceeds of the sale of any unclaimed property to the Health Board's revenue unclaimed patients' monies account from whence the patient should be reimbursed if a subsequent claim is made
- Ensure that the payments of claims received in the future for monies originally credited to the unclaimed patients' monies account are charged to

that account.

- Maintain a register of monies credited to and paid from the unclaimed patients' monies account.
- Write to banks, building societies etc, to inform those organisations of the patient's death.
- Seek expert advice, if appropriate, to establish whether the property is valuable

### **13 Accounts**

- 13.1 Patients' monies should be included in the Health Board's annual accounts under third party assets.

## Appendix 1

### Admissions

#### Planned Admissions

- Prior to admission all patients are to be advised not to bring valuables into hospital

#### Unplanned Admissions

- Patients are to be advised to give property to relatives and friends to take home
- Patients are to be asked to sign a disclaimer to say they are keeping their property at their own risk or
- Patients hand property in for safekeeping and recorded in the Patient Property Book

#### All Admissions

- Where patients are unconscious, incapable of looking after themselves, or if the patient is dead on arrival, the contents of their clothing should be examined and all items placed in safe custody.
- The items should be recorded in the Patient Property Book and signed by two members of staff



## PRIVATE PROPERTY

Please note that Aneurin Bevan University Health Board accepts no responsibility for the loss of or damage to personal property of any kind, including money, in whatever way the loss or damage may occur unless an official receipt is obtained from the Health Board for property which has been handed in for safe custody.

**Appendix 3**

**Patients' Property Books**

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

31151

.....Hospital	<b>FOR OFFICE USE</b>
<b><u>PERSONAL PROPERTY, CASH AND VALUABLES</u></b>	
Patients Name..... Address..... Date of Admission..... Ward.....Unit No..... Date of Receipt of Property.....	Patients Property File Number.....  Indemnity File No.....  Other Reference .....
TO BE COMPLETED AT THE WARD	To be signed by Officer receiving cash/articles from ward.
(a) Cash £	Received the sum of £.....  Signed.....Date.....
(b) Valuables..... ..... ..... .....	Received the articles listed in Section (b)  Signed.....Date.....
(c) Other Personal Property..... ..... ..... .....	Received the articles listed in Section (c)  Signed.....Date.....
CERTIFIED that that the above is a correct list of cash and property handed over for safe custody.  Signed Nurse..... Date .....	To be signed by the patient or his/her representative on return of articles.
I agree that the above is a correct statement of the property handed by me today to the person whose signature appears above.  Signed Patient/Witness.....Date.....	RECEIVED the following: (a) Sum of £  (b) Valuable listed in Section (b)  (c) Other Personal Property as listed in Section (c)
This receipt must be produced when claiming the above property. No property will be handed to any person other than then patient unless it be a person authorised by the patient in writing to collect it.  The Health Board will accept no responsibility for personal items not handed over and not recorded above.	Signed..... Patient/Representative  Date.....  If property is not handed back to patient state:- Relationship to Patient..... Address..... ..... Signed..... Officer Issuing Property

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## Aneurin Bevan University Health Board    Appendix 4

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### Patients' Property Book – Instructions for Completion

1. Each ward must have its own Patients' Property Book. New books can be obtained from Oracle as a catalogue item, using code WNN091G.
2. This book should only be completed where property is physically handed in for safe keeping. It should not be used as an inventory for the patient's belongings on admission.
3. The receipt should be completed as accurately as possible – clothing and non-valuable items need not be itemised.
4. Terms such as "gold", "silver", "diamond" etc. must **not** be used and the description "yellow metal", "white metal" and "white stone" etc. must be used instead.
5. A receipt entry must be completed for each patient (using the **left-hand side** of the book). This receipt will be pre-numbered and in three parts
  - The top copy (blue) to be handed to the patient/relative as a receipt
  - Second copy (also blue) to be handed to either
    - a) the General Office with the cash/valuables handed over for safekeeping. They will sign to acknowledge receipt.Or
    - b) the patient if discharged before the property is handed into the General Office. The patient/representative to sign to acknowledge return.
  - Third copy (white) to be retained in the Patients' Property Book
6. Staff must sign the receipt together with the patient, or their representative, confirming the entry is accurate and complete.
7. Spoilt receipts (all copies) should be marked "Cancelled" and retained in the book.
8. Cash/valuables **must** be kept in a locked unit (safe, cupboard, drawer) in the ward/department until it is convenient to take to the General Office.
9. Ensure that the items are placed in an envelope marked with the patient's name and property book reference and that it is sealed and signed, timed and dated by two members of staff across the seal.
10. The Patients Property Book **must** be stored in a locked location and

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be available for inspection by authorised staff.

## **Aneurin Bevan University Health Board**

### **What do I do next?**

11. Take cash/valuables to the General Office along with the completed Patients' Property Book, as soon as possible after admission.
12. The General Office will sign the book to acknowledge receipt of the items.
13. Cash received will be banked into a Patients Monies account held by the Health Board and an internal account assigned to each patient
14. If a significant amount of cash (over £500) has been handed in, please take to the General Office **immediately**.
15. Outside of office hours, a night safe or drop box should be used, **if available**, to deposit patients' property. Ensure that the second blue copy from the Patients' Property Book is placed in the envelope containing the property and that the envelope is sealed and signed, timed and dated by two members of staff across the seal.
16. If a night safe is unavailable the envelope should be kept under lock and key and handed to the General Office on the next working day.
- 17. Do not take cash/valuables home for safe keeping.**
18. When the patient is discharged, please ensure their property is returned to them and the relevant Property Book entry signed by both patient or their representative and staff member to confirm return.
19. Any cash that has been banked by the General Office will be reimbursed to the patient via the Patient Monies Section (Finance Department) in the form of a cheque or bank transfer, upon receipt of a Discharge Form supplied by the General Office.
20. In the event of a patient being admitted unconscious, or incapable of looking after themselves, or dead on arrival, the Health Board has a duty to have the contents of their clothing examined and all items placed in safe custody. This check should take place in the presence of two members of staff both of whom should sign the property book receipt. The above procedures still apply.



**Appendix 6**

**PPM/10**



**Aneurin Bevan University Health Board  
 Patients' Private Monies  
 NEW PATIENT**

**To:** Patients' Monies Officer, Financial Services,

**From:**

The following patient has been admitted to this hospital and I would be grateful if you could set up an account in accordance with financial procedures.

Cheque / Cash / Other on admission £ \_\_\_\_\_

Note: Please ensure that details relating to one patient only are shown on this form

Surname:		Next of kin Address	
First Names:			
Title:			
Address:			
Ward:		Relationship	
Account No:			
Date of Admission		NI Number	

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



**Appendix 8**

**PPM/01**



**Aneurin Bevan University Health Board  
 Patients' Private Monies**

**To:** General Office **Ext No:** \_\_\_\_\_

**From:** Name: \_\_\_\_\_ **Ext No:** \_\_\_\_\_

Signature: \_\_\_\_\_

Ward: \_\_\_\_\_

Date: \_\_\_\_\_

**RESIDENTS' MONIES REQUEST**

The following resident(s) would like money withdrawn on their behalf as follows:-

	Date Required	Amount £	Patient Name	Account No	Reason for Request	Family Involvement
1						
2						
3						
4						
5						
			Total			

Receipts must be retained and forwarded together with form PPM/02 (blue) within 7 days to the General Office

**Authorising Signature**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Ward Manager (for withdrawals of up to £50 per resident)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Senior Nurse (for withdrawals of between £50 and £250 per resident)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 General Manager (for withdrawals of over £250 per resident)

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**Appendix 9**

**PPM/03**



**Aneurin Bevan University Health Board  
Patients' Private Monies  
CASH RECEIPT FORM**

Received from \_\_\_\_\_

the sum of \_\_\_\_\_

in respect of \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
General Office



**Appendix 11**

**PPM/04**

**Aneurin Bevan University Health Board**



**Patients' Private Monies  
 Pocket Money**

**To: Patients' Monies Officer, Financial Services,**

**From: General Office**

**Ext No:** \_\_\_\_\_

Please would you raise an open cheque for pocket money for week ending \_\_\_\_\_

for an amount of \_\_\_\_\_ made payable to \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

	Name	Account No	Amount £	Changes Notified	Notes	Ward
1						
2						
3						
4						
5						
6						
	<b>Total</b>		<b>0.00</b>			
1						
2						
3						
4						
5						
6						
7						
8						
	<b>Total</b>		<b>0.00</b>			
1						
2						
3						
	<b>Total</b>		<b>0.00</b>			
1						
2						
3						
	<b>Total</b>		<b>0.00</b>			
	<b>TOTAL</b>		<b>0.00</b>			

For Finance use only

Input on System by: \_\_\_\_\_ Date: \_\_\_\_\_

Month \_\_\_\_\_ Cheque No.: \_\_\_\_\_

**Appendix 12**

**PPM/17**



**Aneurin Bevan University Health Board  
Patients' Private Monies  
DISCHARGED PATIENT**

**Patients' Monies Officer, Financial Services,**

**To:**

**From**

**PAYMENT**

The following patient has been discharged from this hospital and I would be grateful if you could release monies held in accordance with financial procedures.

**Cheque to be made payable to:** \_\_\_\_\_

**Cheque total:** £ \_\_\_\_\_

**Note: Please ensure that details relating to one patient only are shown on this form**

Patient Name	_____	_____	Balance @ last statement
Address:	_____	_____	Payments notified
	_____	_____	Receipts notified
	_____	_____	
Ward:	_____	_____	Payments not yet notified
Account No:	_____	_____	Receipts not yet notified
Date of discharge	_____	_____	Total

**Reconciled by Finance**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**For Finance use only**

Cheque actioned by: \_\_\_\_\_ Date: \_\_\_\_\_

Input on System by: \_\_\_\_\_ Date: \_\_\_\_\_

Month: \_\_\_\_\_ Cheque No: \_\_\_\_\_

**Appendix 13**

**PPM/11**



**Aneurin Bevan University Health Board  
 Patients' Private Monies  
 PATIENTS' TRANSFER**

**To: Patients' Monies officer, Financial Services,**

**From:**

**TRANSFER**

The following patients have either been transferred to another ward within this hospital or to another hospital  
 Please would you amend your records accordingly

Date	Ward	Patient Name	Account No	Balance £	Transferred to	
					Ward	Hospital

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**For Finance use only**

Input on System by: \_\_\_\_\_ Date: \_\_\_\_\_

Month: \_\_\_\_\_

**Appendix 14**

**PPM/18**



**Aneurin Bevan University Health Board  
 Patients' Private Monies  
 DECEASED PATIENT**

**To:** Patients' Monies Officer, Financial Services,  
 Tel No. 01495 765412

**From:**

**PAYMENT**

The following patient has died at this hospital and I would be grateful if you could release monies held on their behalf in accordance with financial procedures.

Note: Please ensure that details relating to one patient only are shown on this form

<p><b>Next of Kin</b></p> <table border="1" style="width: 100%; height: 60px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p>Patient Name: <input style="width: 90%;" type="text"/></p> <p>Address: <input style="width: 90%;" type="text"/></p> <p> </p> <p> </p> <p>Ward: <input style="width: 90%;" type="text"/></p> <p>Account No: <input style="width: 90%;" type="text"/></p> <p>Date of death: <input style="width: 90%;" type="text"/></p>					<p><b>Solicitors</b></p> <table border="1" style="width: 100%; height: 60px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p><input style="width: 60%;" type="text"/> Balance @ last statement</p> <p><input style="width: 60%;" type="text"/> Payments notified</p> <p><input style="width: 60%;" type="text"/> Receipts notified</p> <p><input style="width: 60%;" type="text"/> Payments not yet notified</p> <p><input style="width: 60%;" type="text"/> Receipts not yet notified</p> <p><input style="width: 60%;" type="text"/> Total</p>				

**Reconciled by Finance**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**For Finance use only**

Cheque actioned by: \_\_\_\_\_

Date: \_\_\_\_\_

Input on System by: \_\_\_\_\_

Date: \_\_\_\_\_

Month: \_\_\_\_\_

Cheque No: \_\_\_\_\_

PPM/08



**Aneurin Bevan University Health Board  
Form of Indemnity  
Estates of Deceased Patients**

Re the Late ..... of ..... Hospital

PLEASE COMPLETE IN FULL

I the undersigned (Name) .....

Of (Address) .....

Declare that the said .....

Died intestate (without a will) and that Letters of Administration have **not** been obtained.

I further declare that I am the ..... (please state relationship)  
Of the deceased and as such am entitled to the whole/part of the £..... Monies held for  
safekeeping.

In consideration of the payment by you to me of the aforesaid, I undertake to indemnify  
and keep Aneurin Bevan University Health Board indemnified from and against all  
claims, demands, costs and expenses in respect thereof or in any way arising there  
from.

Signed ..... Date .....

Witnessed by:

Signed ..... Date .....

Name .....

Address .....

.....

.....

PPM/07



**Aneurin Bevan University Health Board  
FORM OF ENQUIRY  
ESTATES OF DECEASED PATIENTS**

Re: The Late.....

The amount of £..... is held in respect of the above named patient who died at ..... Hospital on ..... and I would be grateful if you could let me know the following information:-  
(Please delete where appropriate).

- 1. Did the deceased leave a Will? YES / NO
  - a) Has probate been obtained or is it intended to be obtained? YES / NO
  - b) Please state the names and addresses  
.....  
of the deceased's Executors. ....
  - c) Please state the name and address  
of the Executor's Solicitor. ....

If you have answered **yes** to question 1.a. proceed to item 9 and complete the Declaration and arrange to forward the Probate Document once available. In these circumstances you are **not** required to complete the Indemnity Form attached.

- 2. a) Have letters of administration been or are intended to be taken out in respect of the deceased's Estate? YES / NO
- b) Please state the names and addresses  
.....  
of the deceased's Administrators or Intended Administrators. ....
- c) Please state the name and address  
of the Administrator's Solicitor. ....

If you have answered **no** to question 1, but **yes** to question 2.a. proceed to item 9 and complete the Declaration and arrange to forward the Letters of Administration once available. In these circumstances you are **not** required to complete the Indemnity Form attached.

---

If you have answered **no** to question 1 and **no** to question 2.a. please complete questions 3 to 8 along with the Indemnity Form attached.

3. Please state the name and address of the person who arranged the funeral (not the Funeral Director) .....
4. Has the funeral account been paid? YES / NO
5. a) What is your relationship to the deceased?.....  
b) Are you over 18 years of age? YES / NO
6. Are you the next-of-kin? YES / NO
7. Are there any other next-of-kin of the deceased known to you? YES / NO

For your information, next-of-kin is normally determined in the following order of priority: Widow / Widower (but not if a decree of judicial separation was in force), Children, Father or Mother, Brothers or Sisters, other relatives.

8. If you have answered **yes** to question 7 please supply the information requested below concerning the next-of-kin (if known)

Name .....  
Address .....  
Age .....  
Relationship To Deceased .....

If there are more than one next-of-kin please provide same information about all next- of-kin in the spaces provided. A separate sheet of paper may be used if necessary.

---

**9. Declaration**

I declare that the replies furnished by me to the foregoing questions are to the best of my knowledge correct.

Signed: ..... Date:.....  
Address: .....  
.....

Please return completed form to: Patients' Monies Manager  
Aneurin Bevan University Health Board  
PO Box 163  
Cwmbran  
NP44 9EJ

Email: - [abb.charitablefunds@wales.nhs.uk](mailto:abb.charitablefunds@wales.nhs.uk)

Telephone Enquiries: 01495 765412



**Aneurin Bevan University Health Board**

# **Financial Control Procedure**

## **Procurement Services**

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

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

Issue date: DRAFT  
Review by date: DRAFT  
Policy Number: ABUHB/Finance/0993

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## **Procurement – Do's and Don'ts**

### **Do's**

- Ensure all purchases comply with Standing Financial Instructions and Treasury public procurement rules.
- Use the approved catalogue as the first source for goods and services.
- Engage Procurement Services early—especially for items not in the catalogue or purchases above £5,000.
- Follow procurement thresholds and obtain appropriate quotations or tenders.
- Check delegated approval limits before authorising purchases.
- Ensure all orders are raised through Self Service Procurement.
- Provide full and accurate information on requisitions to avoid delays.
- Receipt goods and services within 2 days of delivery.
- Seek Procurement Services advice before contract renewals, product trials, or engaging off-payroll workers.
- Ensure payments on account are only used in exceptional, justified cases.

### **Don'ts**

- Do not bypass Procurement Services for purchases above £5,000.
- Do not split contracts or invoices to avoid procurement thresholds or delegated limits.
- Do not purchase goods or services by telephone.
- Do not use retrospective or confirmation orders unless absolutely necessary.
- Do not renew or extend contracts without consulting Procurement Services.
- Do not delay receipting goods or services—this holds up supplier payments.
- Do not assume budget availability—confirm before raising requisitions.
- Do not engage suppliers directly when competitive tendering or quotations are required.
- Do not ignore the No PO No Pay policy—suppliers will not be paid without a valid PO.

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## 1. Introduction

The procurement of goods and services is a key process supporting the delivery of high quality patient care whilst ensuring value for money is achieved. [Standing Financial Instructions \(SFIs\)](#) set out procurement principles and duties of managers, with delegated authority, to commit expenditure on behalf of Aneurin Bevan University Health Board (Health Board).

## 2. Policy Statement

The Health Board is committed to ensuring that the purchase of all goods and services are properly authorised and comply with the requirements as set out in the Treasury rules on public procurement.

NHS Wales Shared Services Partnership Procurement Services (Procurement Services) provide a comprehensive service to the Health Board, focusing on value, safety, excellence, innovation and quality. Procurement Services maintain and follow comprehensive procedures which complement and supplement the [SFIs](#) and encompass all aspects of procurement.

Procurement Services source and supply the Health Board with products and services through collaboration with their customers and partners allowing Health Board staff to focus on patient care. Managers must be aware of their duties and responsibilities in relation to the procurement of goods and services and seek advice where individual purchases reach procurement thresholds as set out in Table 1 below.

## 3. Aims

This Procurement procedure is critical to safeguarding public funds and ensuring that every pound spent delivers maximum value. Non-payroll expenditure represents a significant proportion of our overall budget and managing this effectively is essential to maintain financial sustainability.

By adhering to robust procurement principles, we not only secure best value for goods and services but also uphold transparency and accountability, enabling us to operate within the financial envelope set for the organization.

This commitment ensures that resources are directed where they matter most—supporting patient care and service delivery.

We ask all staff to take ownership of this responsibility: follow the policy, challenge unnecessary spend, and make informed purchasing decisions.

Every action you take helps protect public money and strengthens our ability to deliver high-quality care within our means.

#### **4. Objectives**

- To outline procurement principles
- To outline the Health Board's delegation of authority
- To explain the No PO no Pay policy and how it affects ordering goods and services
- To provide guidance to users on ordering goods and services

#### **5. Scope**

This procedure relates to the purchase of all goods and services and therefore affects:

- All staff who requisition goods
- All authorisers
- Staff involved in procuring services, including engaging agency workers and other workers in an off payroll capacity.
- Health Board staff involved in negotiating and awarding contracts

A separate [Contract Management](#) procedure is in place for tendering and contracting.

#### **6. Roles and Responsibilities**

The Chief Executive is responsible for ensuring procurement procedures are in place.

The Director of Finance, Procurement and Value is responsible for putting in place financial procedures to ensure that goods and services are duly authorised and comply with the [Scheme of Delegation](#)

Authorising staff are responsible for ensuring that they only approve goods and services in line with their service plans and their delegated limits.

Requisitioning staff must attend training before accessing the Financial Management System.

Procurement Services are responsible for establishing tendering and contracting processes and procedures in line with best practice and legislation. They are also responsible for providing support and advice to the Health Board on the purchase of goods and services, where required.

A comprehensive [Procurement Manual](#) is available to support staff with procurement requirements.

## 7. Procurement

### 7.1 Procurement Principles

Where there is a requirement for goods and services, the requisitioner must source from the Health Board’s approved catalogue. Where an item required is not included, advice must be sought from Procurement Services on opportunities to source those goods or services through the public sector control framework.

Procurement Services should be involved in the complete process from early involvement in identifying requirements, identifying the most appropriate procurement strategy, leading the procurement process and supporting contract managers to ensure the successful delivery of all works, goods and services required.

Health Board [SFIs](#) provide further detail on Welsh Government procurement requirements.

#### 7.1.1 Procurement Thresholds

The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition <sup>1</sup>	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders	Formal contract and Purchase Order

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition <sup>1</sup>	Form of Contract
	received if available or appropriate to the procurement route.	
Contracts above £1 million	Welsh Government approval required	Formal contract and Purchase Order

<sup>1</sup> Subject to existence of suitable suppliers

Advice from Procurement Services must be sought for all requirements in excess of £5,000.

The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

## 7.2 Delegation of Authority

In addition to the procurement thresholds, the Health Board [Standing Orders \(SOs\)](#) state that there should be a [Scheme of Delegation](#), detailing the amounts that individuals have delegated authority for approving. Delegated authority relates to total contract value over the life of a contract or individual purchase value. Authorisers must not artificially split contract or invoice values to enable them to authorise higher total values.

The [Scheme of Delegation](#) is designed to enable the day-to-day business of the Health Board, to be carried out effectively, in a manner that secures achievement of the organisation's aims. The [Scheme of Delegation](#) is supported by the [Authorised Signatory List \(ASL\)](#), which sets out comprehensive details of approval amounts and the financial codes against which individuals can authorise the ordering of goods and services. The application to become an authorised signatory can be found [here](#).

## 7.3 No Purchase Order No Payment

Each Welsh organisation has adopted a No Purchase Order No Payment (No PO No Pay) policy. Under the policy, all goods and services must be

supported by a prospective Health Board Purchase Order (PO). Retrospective or confirmation orders should be avoided and only used if absolutely necessary. Purchase orders in ABUHB are used to ensure that all goods and services are duly authorised at the appropriate level within the organisation. POs set out ABUHBs terms of trade, ensure that the purchase to pay (P2P) process is efficient and that suppliers are paid within Welsh Government requirements.

All relevant suppliers have been contacted, stating the No PO No Pay approach. **Invoices received within Accounts Payable (AP) not displaying an official purchase order number will be returned to the supplier unpaid with a request to provide an order number.**

## 7.4 Purchasing Goods and Services

All purchases must be made through the Financial Management System using Self Service Procurement (SSP) available on the Health Board's Applications page.



Access to SSP requires a completed [User Form](#) and attendance at a formal training session provided by Procurement Services. For enquiries, contact details can be found [here](#).

Or visit the [Procurement Intranet Page here](#) for further information.

### 7.4.1 Good Procurement Practice – Tendering

If you are planning to purchase goods or services or renew a contract you must always contact your Procurement Services representative in the first instance. They will provide advice and guidance throughout the process. A list of contacts can be found [here](#).

Things to be considered when planning your purchase or contract:

- You must ensure you have sufficient budget available for this purchase.

- You must adhere to the procurement thresholds as set out within this policy and obtain the required internal and/or Welsh Government authorisation.
- You must identify requirements and consider the complexity and risk of the intended purchase or contract.
- Competitive procurement processes can take between 3 and 6 months (after internal approval).
- Requirements that exceed OEJU thresholds can take up to 12 months to procure depending on complexity and risk of the goods or services required.

Identifying a requirement and planning the procurement is an important step and Procurement Services must be engaged at the earliest opportunity to provide guidance and support needed to ensure compliance is maintained.

Procurement Services, working with end users, will endeavour to maximise competition engaging with the market at earliest stages and design service requirements that are accessible to as many providers as possible.

#### **7.4.2 Good Practice – Ordering Goods and Services**

- All goods and services must be ordered through the Financial Management Service Self Service Procurement (SSP) module (see guidance in section 7.4.4)
- Ensure that all requisitions contain sufficient information to prevent delay in authorisation.
- Contact and discuss any uncertainty or problem with Procurement Services
- Refer to associated guidance where necessary (see section 8)
- Consult with Procurement Services for estimates and quotations.
- Never place an order via the telephone, all goods and services must be supported by a prospective purchase order otherwise it will be delayed for payment.
- Never renew or extend a contract without advice from Procurement Services
- Contact Procurement Services **before** considering undertaking product trials. Guidance can be found in section 8.
- Procurement Services to review all requisitions prior to raising the Purchase Order to ensure the correct VAT treatment with VAT being recovered (where appropriate) at source.

- Procurement Services to review all contract requests for provision of staff to ensure compliance with [engaging off payroll workers](#) guidance.

### **7.4.3 Good Practice – Receipting Goods**

Goods purchased must be receipted in the Financial Management System SSP to enable invoices to be matched and paid within Welsh Government requirements. All goods must be receipted within 2 days of the delivery date.

Services, such as contracts, room rental, course bookings etc, must also be receipted in Oracle otherwise invoices will be put on hold and delayed for payment until the receipting process has been carried out in Oracle.

### **7.4.4 Guidance for Order and Receipting in Oracle**

Comprehensive training guidance and videos with instructions for ordering and receipting goods and services in the Financial Management System SSP can be accessed by clicking [here](#)

## **8. Product Trials**

No product trials or evaluation should be undertaken before being reported and referenced to Procurement Services using the product trial/evaluation form (appendix A).

Procurement Services will ensure that product trials are carried out in a fair, open and transparent process aligned to procurement regulations.

Procurement Services will ensure that free products are covered by a Master Indemnity Agreement (MIA) before trials/evaluations can commence and where required EBME are notified.

Clinical evaluation forms must be completed for all product trials and a report submitted to Procurement Services upon completion of the trials.

Procurement will advise on the best route to market for products.

No products should be purchased until the procurement process has been completed and approval has been granted.

## 9. Payments on Account

A payment on account can be defined as an advanced payment for goods or services that have not yet been matched to a specific invoice and goods or services have not been received.

Payments on account should be exceptional and only considered if a value for money case can be demonstrated.

Payments on account are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the [National Loans Fund \(NLF\)](#) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with the requirements of [Managing Welsh Public Money](#)
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

An examples of a potential payment on account are where partial payments on accounts are required to enable the purchase of raw materials or assembly of products such as lifts.

In exceptional circumstances payments on account can be made subject to:

- a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Health Board if the supplier, is at some time during the course of the prepayment, agreement unable to meet their commitments
- b) The Director of Finance, Procurement and Value is satisfied with the proposed arrangements, before contractual arrangements proceed and
- c) The budget holder is responsible for ensuring that all items due under a payment on account contract are received and inform the appropriate Director or Chief Executive if problems are encountered

## 10. Related Procedures

There are a number of related procedures which can be accessed by clicking

the links below:

[Standing Orders](#)  
[Standing Financial Instructions](#)  
[Scheme of Delegation](#)  
[Application for Authorised Signatory](#)  
[Approval of orders over £100k](#)  
[Engaging Off Payroll Workers](#)  
[Procurement Manual](#)

## **11. Training**

All new requisitioners are provided with initial training before being allowed to access to the Financial Management System SSP. Links to supporting training materials can be found [here](#).

## **12. Audit**

Procurement and the ordering of goods and services is subject to internal audit.

## **13. Review**

This document should be reviewed, at a minimum of every three years, unless material changes require an earlier review.

## Appendix 1

# Product Trial & Evaluation Form

## Purpose of the Product Trial & Evaluation Form

The Product Trial and Evaluation Form is a document designed to ensure that all product trials and evaluations within Aneurin Bevan University Health Board (ABUHB) are suitably documented, and that all trials and evaluation are carried out in line with procurement principles of open, transparent and fair competition.

No product trials or evaluation should commence before this form is submitted to Procurement Services and a reference for the trial has been provided to the requestor.

**From this point forward, the following guidelines must be adhered to:**

### **Mandatory Submission:**

- A fully completed and approved Product Trial & Evaluation Form is mandatory for the Procurement department start work on any requirement.
- The form must be submitted with all required sections completed.

### **Division Responsibilities:**

- The Division initiating the request is responsible for completing and submitting the form in a timely manner.
- All details provided in the form must be accurate and reflect the trials aims and objectives.
- Complete product evaluations forms following the trial
- Submit a report on the outcome of any trials and evaluation to procurement services.

### **Procurement Department's Role:**

- Procurement will review the submitted form to ensure it is complete and if crucial information is missing the form will be return for completion.
- No trial activities must commence until procurement have approved the trial and provided a reference number.
- Procurement will ensure that free products are covered by a master indemnity agreement and that EBME have been informed where products require testing/commissioning before use.

### **Consequences of Delays or Non-Completion:**

- Failure to follow the above approach will result in delays in being able to order alternative products and/or result in non-compliance with procurement regulations.

# 1. Project Overview

**Section A**

*To be completed by Division (all fields are mandatory) if applicable\**

	Project Overview	Response <i>mandatory</i>
1	Completed by (insert name)	
2	Date this document was completed:	
3	Product Trial/Evaluation Title:	
4	Proposed Trial/Evaluation Dates	
5	Trial Co-ordinator/Lead:	
6	Division/Department:	
7	Suppliers and Contact Details	
8	Product (e.g. Description, make model, codes)	
9	What does it replace (make, model, codes)	
10	Clinical rationale & evidence	
11	Intended benefits (quality, outcomes, safety, patient experience, efficiency):	
12	Sustainability impacts (waste, reusability, energy, logistics, packaging):	
13	Digital/IT connectivity (interfaces, cybersecurity, DPIA required?):	
14	Training required (who, format, by whom, at no cost):	

<b>15</b>	<b>Volumes for trial (units / patients / sites):</b>	
<b>16</b>	<b>EBME involvement (date notified; testing slot booked):</b>	

<b>Section B</b>		<b>Procurement To Complete</b>	
<b>Overview</b>		<i>Add Response here mandatory</i>	
<b>6</b>	<b>Indemnity (MIA Wales overarching no. / call off needed):</b>  <b>Procurement route if adopted (All Wales framework / mini comp / tender / PSR Wales for services):</b>		
<b>7</b>	<b>Budget impact if adopted (12 month cost/benefit, funding source):</b>		
<b>8</b>	<b>Procurement route if adopted (All Wales framework / mini comp / tender / PSR Wales for services):</b>		



**Aneurin Bevan University Health Board**

# **Financial Control Procedure**

## **Grant Funding**

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

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

Issue date: DRAFT  
Review by date: DRAFT  
Policy Number: ABUHB/Finance/0997

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## 1. Introduction

It is the Health Board's responsibility to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary.

Grants are defined as payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations.

Grants are distinct from contracts for operational goods or services, they involve specific deliverables, eligibility criteria and require monitoring against set targets.

Payments are made to fund or reimburse expenditure on agreed items or functions.

Grant funding must be approved by an appropriate Assistant Finance Director.

Grant funding will only be approved in exceptional circumstances.

## 2. Scope

The Health Board is responsible for maintaining procedures for all aspects of grant funding.

This procedure complies with the Health Board's [Standing Financial Instruments](#) and where applicable the Welsh Government's [Code of Practice For Funding the Third Sector](#) and [Managing Welsh Public Money](#).

## 3. Grant Funding – Do's and Don'ts

### **Do's**

- Determine whether the activity should be grant funded or procured, seeking legal advice if unsure.
- Ensure grant funding aligns with Health Board strategic and statutory obligations.
- Refer to Standing Financial Instructions and relevant Welsh Government guidance.
- Ensure grant procedures are followed and up to date.
- Carry out proportionate due diligence on all potential delivery organisations.
- Agree clear purposes, targets and measures for the grant.
- Ensure a legally binding funding agreement is in place before awarding funding.
- Authorise grant payments in line with the Scheme of Delegation.
- Evaluate multi-year programmes to ensure they remain fit for purpose and deliver value for money.

## **Don'ts**

- Do not use grant funding when the Health Board is purchasing goods or services for its own direct benefit.
- Do not assume grant funding is suitable when multiple suppliers could competitively deliver the required outcomes.
- Do not fund 100% of project costs without considering whether procurement is more appropriate.
- Do not award funding without completing due diligence checks.
- Do not release payment without an executed funding agreement.
- Do not allow delivery organisations to operate without monitoring compliance with grant terms and conditions.

## **4. Roles and Responsibilities**

### **4.1 Chief Executive**

Ensuring that grant procedures are up to date; conform to statutory and Welsh Government guidance and are consistent with the principles of sustainable development.

### **4.2 Assistant Finance Director**

Reviewing and approving or rejecting applications for Grant Funding. Grant funding will only be approved in exceptional circumstances.

### **4.3 Budget Holders**

Budget holders are responsible for adhering to the grant governance and management principles, as described in this document.

### **4.4 All Staff**

Grant procedures are followed by all relevant staff within the Health Board

## **5. Grants or Procurement - Definitions**

Procurement is the acquisition of goods and services from third party suppliers through tender arrangements under legally binding contractual terms, where all the conditions necessary to form a legally binding contract have been met.

Grant funding is made to bodies where the Health Board wishes to further its strategic objectives and external bodies are best placed to achieve the desired outcomes.

This can be a complex area, and in practice it may be difficult to decide whether procurement or grant funding is the most appropriate approach. If in doubt, advice should be sought from Finance Business Partners and/or Procurement.

## 6. Grants or Procurement – Key Questions

### **Does the Health Board itself have the legal power to carry out the work needed to obtain the outcomes it wants i.e. the ability to employ staff to carry out the work directly?**

If it does not have the statutory authority to undertake the work, it is very unlikely that it would have the authority to acquire them under contractual arrangements.

In these circumstances there is a presumption that the Health Board would pursue its objectives through grant funding other organisations or persons (e.g. local authorities).

### **Are the goods, services or outcomes to be provided of direct benefit to the Health Board?**

If the intention is to secure a direct service for the Health Board in terms of the supply of goods and services (e.g. office supplies; computer equipment or consultancy services) then there should be a presumption in favour of procurement.

Research may well have a wider secondary interest or benefit, but the question of whether the research outcomes are primarily of direct benefit to the Health Board remains relevant.

### **Is there more than one source for the acquisition of goods; services and outcomes?**

If so, there should be a presumption in favour of competitive procurement as the most effective way of appraising the options available and achieving the best value for money.

### **What degree of control does the Health Board wish to exercise in achieving outcomes?**

The more prescriptive the Health Board wishes to be in terms of specifying the service required or the outputs to be obtained, the greater the presumption there is for proceeding via procurement under a legally binding contract that clearly sets out requirements and expectations.

### **Is the Health Board proposing to provide all the funding relevant to the activity?**

If so, the presumption is in favour of a procurement exercise.

Grant funding usually covers only a part of the cost of a project or service, with funding also coming from other sources. This in turn means that other funders also have a stake in determining the direction and outcomes of the work.

## PROCUREMENT OR GRANT FUNDING?

· The Health Board has power to undertake work and achieve outcomes itself

· Outcomes primarily represent a direct service to the Health Board

· Availability of alternative providers

· Whole cost of the service outcomes to be met

· Desirability for full discretion over specification of service and outcomes

PROCUREMENT

· The Health Board does not have legal powers to undertake work relating to the required outcomes

· Work not a direct service; it primarily furthers the specific objectives of a third party

· Proposal initiated by third party and not Health Board

· Only a proportion of the fund being provided by the Health Board

GRANT FUNDING

## 7. Types of Grants

- **Research** – Funding is often topic specific and administered through various schemes.
- **Charitable Funds** – NHS organisations can generate income through their charitable arms. This funding is used for charitable purposes with public benefit, such as improving the hospital environment, funding research or purchasing equipment.
- **Regional Partnership Board (RPB)** – RPBs work in partnership with Health Boards and Local Authorities to ensure effective services, care and support are in place to best meet the needs of their respective population.

## 8. Grants Governance

Grant funding programmes need to be managed as efficiently and cost effectively as possible, to make sure that every penny is spent appropriately and in an accountable manner.

Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success, in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

For grant programmes that span a number of financial years, the Health Board is responsible for evaluating, the programmes, to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.

Health Boards are required to undertake due diligence checks on all potential delivery organisations to determine the economic, financial viability and reliability of the organisation (s).

A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

The Health Board is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

An example of a Grant Award Agreement Template can be found in Appendix 1.

## **9. Grants Management**

Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Health Board's functions ie the activities for which the grant is made are within the scope of authority that the Health Board has a legal remit to undertake;
- The activities would not normally be deemed subject to procurement legislation; and
- A legally binding agreement is made with all delivery organisations.

Grant payments are required to be authorised according to the [Scheme of Delegation](#).

A regulatory framework should be created to ensure:

- Balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure that the funding programme is the optimal solution, targeted where it is most needed and where it can have most impact
- Funded bodies spend the funding efficiently, transparently and for the purpose intended

## **10. Audit**

The policy will be subject to internal audit review from time to time.

## **11. Review**

The procedure will be reviewed every 3 years unless significant changes are required within that timeframe.

## 12. Related Procedures

[Procurement](#)

[Charitable Funds](#)



## 13. Appendix 1

Gwent Regional  
Partnership Board  
C/o Gwent RPB Support Team (PMO)  
St Cadocs Hospital  
Lodge Road  
Caerleon  
NP18 3QX

Click or tap to enter a date.

<SRO NAME>  
<ADDRESS  
POSTCODE>

### Version 1

Copy to: <ADDITIONAL SRO's and FINANCE LEADS>

Dear <SRO NAME>,

As you are aware, Regional Integration Fund (RIF) funding is due to cease at the end of March 2027. To inform decision-making and future resource allocation, the Gwent Regional Partnership Board (RPB) has undertaken impact assessments across its revenue portfolio. All RIF projects were subject to an impact assessment in 2024-25, and a further impact assessment cycle commenced in September 2025 to inform decisions for 2026-27.

The 2025-26 impact assessment focused on strategic alignment with key RPB priorities (strategic priorities, Population Needs Assessment and Area Plan) and impact achieved for the population of Gwent. Senior Responsible Officers completed project impact assessments, with initial assessments undertaken by the Regional Support Team (PMO). These were subsequently reviewed by the Strategic Partnerships, the Regional Leadership Group, and the RPB to make final decisions on funding for 2026-27. The resulting RAG ratings and associated funding and delivery recommendations for each project are outlined below, including the actions required to secure continued 2026-27 RIF funding.

As the RIF funding is due to cease at the end of March 2027, the RPB has requested that all projects give serious consideration on how organisations will manage project continuity or closures post March 2027. RIF exit plans

must include considerations to reduce the impact of the population group and wider system. These plans will be captured in the RIF reporting document.

**Funding for the following project(s) is provided through sources managed by the Gwent Regional Partnership Board:**

Scheme	Funding Source	Impact Assessment RAG Rating	Funding Recommendation	Delivery Recommendation	Required Actions	Gwent RPB Allocation 2026/27
						£
<b>Total</b>						£

### Award of Funding

We are pleased to inform you that funding of up to **£210,000 (two hundred and ten thousand pounds)** is awarded to you for the Purposes (as defined in Condition 3(a)).

The Funding relates to the period **1 April 2026 to 31 March 2027** and must be utilised in full by **31 March 2027** otherwise any unutilised part of the Funding will cease to be available to you. Funding utilised during this financial period will need to be claimed in full no later than **30 April 2027**.

This letter shall become effective on the date of signature evidencing acceptance by you as set out on the acceptance page within.

If you have any queries in relation to this award of Funding or the Conditions, please contact the Gwent RPB Support Team (PMO) who will be happy to assist you.

### Interpreting the Conditions

Any reference in the Conditions to:

**'you', 'your'** is to

**<ADDRESS  
POSTCODE>**

**'Senior Responsible Owner'** is to:

**<SRO NAME>**

**'we', 'us', 'our'** is to the Gwent Regional Partnership Board;

**'Gwent RPB Support Team (PMO)'** is to

Gwent RPB Support Team (PMO)  
St Cadocs Hospital  
Lodge Road  
Caerleon  
NP18 3QX

**'Account'** is to the bank account opened and maintained by you with a UK clearing bank, in your own name and in respect of which you have sole signing rights or such other account as we may approve for the purpose of the Conditions and at our discretion from time to time;

**'Business Day'** is to a day other than a Saturday, Sunday, Christmas Day, Good Friday or a bank holiday in Wales under the Banking and Financial Dealings Act 1971;

**'Conditions'** is to the terms and conditions set out in this letter and the Schedules;

**'Costs Incurred'** is to the cost of goods and/or services you have received regardless of whether you have paid for them by the date of your claim;

**'Costs Incurred and Paid'** is to the invoiced cost of goods and/or services you have received and which have been paid for by you in cleared funds by the date of your claim;

**'Notification Event'** is to any of the events listed in Schedule 1;

**'Indicative Payment Profile'** is to the indicative payment profile set out in Schedule 2;

**'Reporting Schedule'** is the reporting schedule set out in Schedule 3;

**'Personnel'** is to your management/employees and suppliers or any other person appointed or engaged by you in relation to the Purposes;

**'Schedule'** is to the schedules attached to this letter; and

**any reference to any legislation** whether domestic or international law will include all amendments to and substitutions and re-enactments of that legislation in force from time to time.

### Use of the Funding

You must use the Funding solely for the purposes set out in your revenue project application/business case/proposal.

You must achieve the targets and outcomes set out in your revenue project application/business case/proposal.

Any change to the Purposes or Targets will require our written consent which must be obtained from us in advance of implementing any change. Please note that we are not obliged to give our consent, but we will consider all reasonable written requests. Refer to the RPB Revenue Guidance (attached to the email) for the Notification of Event/Change Request process.

You must not use any part of the Funding for: (1) party political purposes; (2) the promotion of particular secular, religious or political views; (3) gambling; (4) pornography; (5) offering sexual services; (6) any kind of illegal activities.

You must not use any part of the Funding for: (1) purchasing capital equipment (other than as specified in the Purposes), (2) your legal fees in relation to this letter, (3) Costs Incurred or Costs Incurred and Paid by you in the delivery of the Purposes prior to the period referred to in Condition 1 (b).

### Funding pre-conditions

We will not pay any of the Funding to you until you have provided us with the following information and documentation:

this letter signed by you;

Confirmation that you are the budget holder, authorised signatory within your organisation, and will manage the award of Funding

Details of organisational finance lead, treasurer, or Section 151 officer

Where you are required to provide information and documentation to us as evidence that you have satisfied a particular pre-condition, Condition or in support of a claim, the information and documentation must be in all respects acceptable to us. We reserve the right to reject any information and documentation which is for any reason not acceptable to us.

## How to claim the Funding

The claiming of partnership resources differs depending on the nature of the Delivery Partner Organisation, as per Welsh Government grant allocation procedures.

<b>Delivery Partner Organisation</b>	<b>Revenue Grant Funding</b>
Aneurin Bevan University Health Board	Funding for awarded projects will be phased equally across 12 months of the year or pro-rata'd according to an approved business case.  Funding will be allocated in advance by delegation of budgets in-line with the above phasing.
Local Authority	Funding for awarded projects will be phased equally across 12 months of the year or pro-rata'd according to the approved business case.  On confirmation from PMO Finance, funding can be claimed quarterly in arrears via an invoice, up to a maximum limit that is in line with the above phasing.
Social Value Sector	Funding for awarded projects will be phased equally across 12 months of the year or pro-rata'd according to an approved business case.  On confirmation from PMO Finance, funding can be claimed quarterly in advance, up to a maximum limit that is in line with the above phasing.
Housing Associations	Funding for awarded projects will be phased equally across 12 months of the year or pro-rata'd according to the approved business case.  On confirmation from PMO Finance, funding can be claimed quarterly in arrears via an

Delivery Partner Organisation	Revenue Grant Funding
	invoice, up to a maximum limit that is in line with the above phasing.

You must claim the Funding in accordance with the dates set out in the Payment Profile. You must claim the Funding promptly. We reserve the right to withdraw any part of the Funding that you do not claim promptly.

Funding is to be claimed as set out in section 5(a). The frequency of claims can be flexible to support the cash flow requirements within social value sector organisations. Please liaise with the Gwent RPB Support Team (PMO) to discuss in more detail.

You must submit your financial monitoring tracker along with the invoice to the Portfolio Management Office via the PMO finance mailbox ([abb.PartnershipPMOfinance@wales.nhs.uk](mailto:abb.PartnershipPMOfinance@wales.nhs.uk)) to claim Funding.

You must use your financial monitoring tracker to confirm your claim and attach:

- i) confirmation that you are operating in all respects in accordance with your constitution; and confirmation that you have appropriate financial, risk and control systems in place before utilising any part of the Funding to provide a grant to or procure any goods or services from third parties;

We will aim to pay all valid claims as soon as possible and typically within 30 days, subject to satisfactory evidence of information received.

You must notify the Gwent RPB Support Team (PMO) as soon as it becomes apparent that an under spend of grant is likely to arise.

Invoices can only be submitted for payment once the appropriate assurance has been obtained and the value available to claim has been communicated to the Delivery Partner. Invoices will need to be addressed to:

Gwent RPB Support Team (PMO)  
Aneurin Bevan University Health Board  
St Cadocs Hospital  
Lodge Road  
Caerleon  
NP18 3XQ

And emailed to: [ABB.PartnershipPMOfinance@wales.nhs.uk](mailto:ABB.PartnershipPMOfinance@wales.nhs.uk)

PMO Finance will aim to process payments as soon as possible, typically within 30 days. Insufficient assurance may lead to delays with payment whilst the appropriate assurance is obtained.

Payments can only be made by PMO Finance once the appropriate assurance has been obtained and approved via the PMO Assurance Meetings and will be communicated from PMO Finance to Delivery Partner Finance leads. Invoice submissions will be requested in conjunction with this communication along with the approved value available to claim.

Aneurin Bevan University Health Board reserve the right to reclaim any unutilised partnership funding on behalf of the Regional Partnership Board. This will be redistributed in line with processes as identified by Regional Leadership Group and endorsed by the Regional Partnership Board.

### Your general obligations to us

Status: DRAFT  
Approved by: Audit Committee

Issue date: DRAFT  
Review by date: DRAFT

You must:

safeguard the Funding against fraud generally and, in particular, fraud on the part of your Personnel and notify us immediately if you have reason to suspect that any fraud within your organisation has occurred or is occurring or is likely to occur whether or not it relates to the Funding. You must also participate in such fraud prevention initiatives as we may require from time to time;

maintain appropriate procedures for dealing with any conflicts of interest in relation to the Funding whether actual, potential or perceived;

comply with all applicable domestic or international laws or regulations or official directives;

maintain adequate insurances to cover against the risks which may arise in connection with any property or any activity undertaken in delivery of the Purposes. We reserve the right to require you to provide proof of your insurance;

maintain appropriate financial, risk and control systems before utilising any part of the Funding to provide a grant to or procure any goods or services from third parties;

co-operate fully with the RPB Support Team (PMO) or other consultant appointed by us to monitor use of the Funding and compliance with the following Conditions;

inform us immediately if any of the declarations made in Condition 7 is incorrect in any respect or, if repeated at any time with reference to the facts and circumstances then existing, would be incorrect;

notify us of any funding received by you from any source which is procured or utilised in conjunction with the Funding to directly support the Purposes including but not limited to your insurance provider (cancellation/business disruption insurance), and/or any Welsh Government fund/scheme and any other funders. The intention of this Condition is to avoid any duplication of funding in respect of the Purposes.

## Declarations

You declare that:

you have the power to enter into and to perform the obligations set out in the Conditions and you have taken all necessary action to authorise the entry into and performance of the obligations under the Conditions;

no limit on your powers will be exceeded as a result of claiming the Funding, or the grant of any security contemplated by the Conditions;

the entry into and performance by you of, and the transactions contemplated by, this letter do not and will not contravene or conflict with:

- i) your constitutional documents;
- ii) any agreement or instrument binding on you or your assets or constitute a default or termination event (however described) under any such agreement or instrument; or
- iii) any law or regulation or judicial or official order, applicable to you;

no Notification Event is continuing or might reasonably be expected to result from the provision of the Funding and no other event or circumstance is outstanding which constitutes (or, with the expiry of a grace period, the giving of notice, the making of any determination or any combination thereof, would constitute) a default or termination event (howsoever described) under any other agreement or instrument which is binding on you or to which any of your assets is subject;

no litigation or arbitration or administrative proceeding is current or pending or, so far as you are aware, threatened, which has or could have an adverse effect on your ability to perform and comply with any of the Conditions;

you have disclosed to us all material facts or circumstances which need to be disclosed to enable us to obtain a true and correct view of your business and affairs (both current and prospective) or which ought to be provided to any person who is considering providing funding to you;

any information, in written or electronic format, supplied by you to us in connection with the Funding was, at the time it was supplied or at the date it was stated to be given (as the case may be):

i) if it was factual information, complete, true and accurate in all material respects;

if it was a financial projection or forecast, prepared on the basis of recent historical information and on the basis of reasonable assumptions and was arrived at after careful consideration;

if it was an opinion or intention, made after careful consideration and was fair and made on reasonable grounds; and

not misleading in any material respect, nor rendered misleading by a failure to disclose other information,

except to the extent that it was amended, superseded or updated by more recent information supplied by you to us.

you have discussed and agreed the Targets with us and you are confident that they are realistic and achievable;

there are no conflicts of interest in relation to the Funding whether actual, potential or perceived;

acceptance of this award of Funding will not result in duplicate funding in respect of the activities required to deliver the Purposes. This includes but is not limited to any payments received by you in relation to the effects of the spread of the Coronavirus (COVID-19) from your insurance provider (cancellation/business disruption insurance), and/or any Welsh Government fund/scheme and any funders.

You will be deemed to repeat the declarations in this Condition 7 on each date you may have any liability to repay the award of Funding to us, and by reference to the facts and circumstances existing on each such date.

### **Notification Events and their consequences**

You must notify us immediately if a Notification Event has occurred or is likely to occur but we also reserve the right to notify you where we believe a Notification Event has occurred or is likely to occur. Refer to the RPB Revenue Guidance (attached to the email) for the Notification of Event/Change Request process.

We will either:

- i) notify you that we consider the Notification Event is not capable of remedy or
- ii) if we consider the Notification Event is capable of being remedied seek to discuss the Notification Event with you with a view to agreeing a course of action to be taken to address the Notification Event.

We will be entitled to take any of the actions listed in Condition 8(d) if:

- i) despite our efforts we have been unable to discuss the Notification Event with you; or we notify you that the Notification Event is not capable of remedy; or a course of action to address the Notification Event is not agreed with you; or a course of action to address the Notification Event is agreed with you but you fail to follow it, or any conditions attached to it are not met (including without limitation the timescale for such course of action); or the course of action fails to remedy the Notification Event to our satisfaction.

Without prejudice to paragraph 12 of Schedule 1, if any of the circumstances set out in Condition 8(c) occurs we may by notice to you:

- i) withdraw the award of Funding; and/or require you to repay all or part of the Funding; and/or suspend or cease all further payment of Funding; and/or make all further payments of Funding subject to such conditions as we may specify; and/or deduct all amounts owed to us under the Conditions from any other funding that we have awarded or may award to you; and/or exercise any other rights against you which we may have in respect of the Funding.

All repayments of Funding must be made to us within 28 Business Days of the date of our demand.

## Monitoring requirements

You must:

provide us with such documents, information and reports which we may reasonably require from time to time in order for us to monitor your compliance with the Conditions including:

Six-monthly Progress Monitoring Returns unless otherwise stated, including performance information and case studies reporting aligned to the original objectives and priorities of the Scheme, risk management and sources of assurance as set out in Schedule 3.

Monthly Financial Monitoring Trackers and projected spend for the remainder of the Scheme timeline.

meet with the RPB Support Team and such other of our representatives as we may from time to time reasonably require;

ensure that the RPB Support Team (or such other person as we may agree) together with any other person we may require attends all meetings with the Project.

## Audit Requirements

You must:

- i) maintain complete, accurate and valid accounting records identifying all income and expenditure in relation to the Purposes;

without charge, permit any officer or officers of the Welsh Government, Wales Audit Office or any UK subsidy enforcement body at any reasonable time and on reasonable notice (in exceptional circumstances, such as the prevention or detection of fraud, it may not be practicable to provide you with reasonable notice) being given to you to visit your premises and/or to inspect any of your activities and/or to examine and take copies of your books of account and such other documents or records howsoever stored as in such officer's reasonable view may relate in any way to your use of the Funding. This undertaking is without prejudice and subject to any other statutory rights and powers exercisable by the Welsh Government, Wales Audit Office or UK subsidy enforcement body or any officer, servant or agent of any of the above.

retain this letter and all original documents relating to the Funding until we inform you in writing that it is safe to destroy them.

Under paragraph 17 of Schedule 8 to the Government of Wales Act 2006 the Auditor General for Wales has extensive rights of access to documents and information relating to monies provided by the Welsh Government. They and their officials have the power to require relevant persons who control or hold documents to give any assistance, information and explanation that they may require; and to require those persons to attend before them for such a purpose. The Auditor General and their staff may exercise this right at all reasonable times.

## Third party obligations

Nothing in the Conditions imposes any liability on us in respect of any liability incurred by you to any third party (including, without limit, employees and contractors).

You must indemnify us against any liabilities, claims, proceedings, demands, losses, costs and expenses suffered or incurred by us directly or indirectly arising as a result of or in connection with any failure by you to perform fully or in part any obligation you may have to a third party.

## Intellectual property rights and publicity

Nothing in the Conditions transfers to us any rights in any intellectual property created by you as a result of the Purposes.

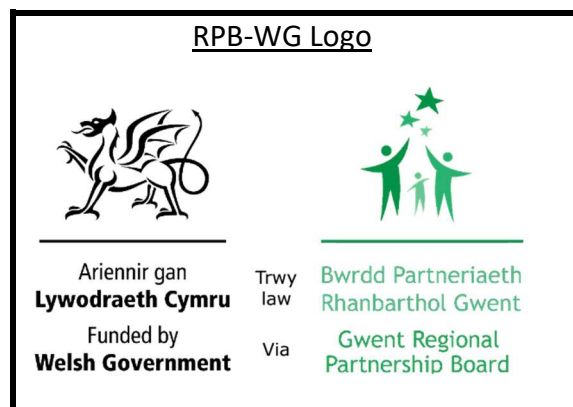
You must acknowledge our support in relation to the Purposes. Such acknowledgement(s) must be in a form approved by us and must comply with the Welsh Government and Gwent Regional Partnership Board's branding guidelines.

You must provide the RPB Support Team with details of all the acknowledgement(s) referred to in Condition 12(b) for our approval before any such acknowledgements are used and you may not use such acknowledgements without our prior written approval. We will endeavour to respond to all written requests for approval within 10 Business Days.

You agree that from the date of this letter until 5 years from the date of the final payment of Funding we may include details about your organisation and business, the Funding and the Purposes in Welsh Government and Regional Partnership Board promotional materials and you further agree to cooperate with our reasonable requests to achieve the production of such materials.

## Promotion and Branding

When producing any materials funded by or/and in partnership with the Gwent RPB, you must include the 'Acknowledgment RPB-WG Logo' (attached below) to acknowledge a grant or commissioning arrangement with the Gwent Regional Partnership Board and Welsh Government.



The 'Acknowledgment RPB-WG Logo' must be used on all types of work produced for, or on behalf of the Gwent RPB to support the development of communications and promotional materials that are developed by partners, including but not limited to:

- Artwork
- Signage
- Posters
- Leaflets
- Social media
- Articles, etc.

Before committing to promotion and branding of any artwork, public facing communications or/and print, you must submit proofs to the Gwent RPB to ensure adherence to the Gwent Regional Partnership Guidance and Welsh Government Logo Guidance 2021.

Currently, not all social media sites allow for the inclusion of an additional logo. However, a logo or acknowledgement in the form of words should be included where possible. This can include the Gwent RPB Social Media handle, **@BoardGwent** or/and Gwent RPB website <https://www.gwentrpb.wales/home>

## Information

You acknowledge that we are subject to the requirements of the Freedom of Information Act 2000 (the "FOIA"), the Environmental Information Regulations 2004 (the "EIR"), the Data Protection Act 2018

(the “DPA”) and the retained EU law version of the General Data Protection Regulation ((EU) 2016/679) (the “UK GDPR”).

You acknowledge that we are responsible for determining in our absolute discretion whether:

- i) to disclose any information which we have obtained under or in connection with the Funding to the extent that we are required to disclose such information to a person making a disclosure request under the FOIA or the EIR; and/or

any information is exempt from disclosure under the FOIA or the EIR.

You acknowledge that we may share any data you provide to us with fraud prevention agencies and third parties for the purposes of preventing and detecting fraud. Any data we collect will be managed in accordance with the Data Protection Regulations (GDPR).

### Buying goods and services

If you decide to buy any goods and/or services to deliver the Purposes, they must be purchased in a competitive and sustainable way so as to demonstrate that you have (i) achieved best value in the use of public funds, and (ii) complied with your conflict-of-interest policy at the relevant time.

We may from time-to-time request evidence from you to demonstrate your compliance with this Condition 15. Such evidence may take the form of evidence of your:

- i) compliance with any procurement regulations, legislation or guidance in place from time to time to which you, or any person carrying out a business or function of the same or similar nature to you, is subject; or
  - i) compliance with your procurement policy in place at the relevant time; or
- obtaining a minimum of three written quotations for the relevant goods and/or services.

You must supply such evidence to us promptly following our written request for such evidence.

### Giving Notice

Where notice is required to be given under the conditions it must be in writing (this does not include email but may include a letter attached to an email) and must prominently display the following heading:

***“Notice in relation to Award of Funding in relation to the Regional Integration Fund: Gwent Regional Partnership Board – Regional Integration Fund 2026-27 Revenue Project – <Project Name>”***

The address and contact details for the purposes of serving notice under the Conditions are as follows:

You: the Senior Responsible Owner at the address stated in Condition 2.

Us: the Gwent Regional Partnership Board at the address stated in Condition 2.

A notice will be deemed to have been properly given as follows: -

Prepaid first-class post: on the second Business Day after the date of posting.

By hand: upon delivery to the address or the next Business Day if after 4pm or on a weekend or public holiday.

By email attachment: upon transmission or the next Business Day if after 4pm or on a weekend or public holiday via the email address: [abb.PartnershipPMO@wales.nhs.uk](mailto:abb.PartnershipPMO@wales.nhs.uk)

## Equality

You must have in place and apply equality policies covering employment, use of volunteers and provision of services, in accordance with the Equality Act 2010.

## Welsh language

The Welsh Government and Gwent Regional Partnership Board is committed to supporting the Welsh language and culture and the Cymraeg 2050: A million Welsh speakers Welsh language strategy (“Cymraeg 2050”) provides a vision for the growth and further development of the Welsh language.

Where the Purposes include or relate to the provision of services in Wales they must be provided in Welsh and English unless it would be unreasonable or disproportionate to do so. Where they are provided in both Welsh and English, they must be provided in such a way as to not treat the Welsh language less favourably than English, in accordance with the Welsh Language (Wales) Measure 2011.

Where the provision of services forms part of the Purposes, you must act in accordance with the Welsh Language (Wales) Measure 2011 and the aims of Cymraeg 2050. In practice, this will include the following:

i) Ensure that any written material produced, including digital material, is bilingual.

Ensure that any signage is bilingual.

Ensure that any training or public events are held bilingually.

Actively promote and facilitate the Welsh language (including providing services and increasing opportunities to use the Welsh language) within funded activities.

For general advice on providing services bilingually and for information on which organisations are able to support you, please contact the Welsh language advice service “Helo Blod” on 03000 258888 or e-mail [heloblod@gov.wales](mailto:heloblod@gov.wales) with your query.

## Sustainable development

Your use of the Funding must contribute to the achievement of the Welsh Government’s well-being objectives contained in the Welsh Government’s Programme for Government. You must work in a sustainable way (sustainable development principle) in delivering the Purposes so as to ensure you are working in a preventative, integrated, long-term and collaborative way that involves people that reflect the diversity of Wales.

## Welsh Ministers’ functions

You acknowledge that the Welsh Ministers have a range of functions which will continue to accrue and be amended and that decisions in relation to each such function are obliged to be taken in the light of all relevant and to the exclusion of all irrelevant considerations. You agree that nothing contained or implied in, or arising under or in connection with, the Conditions will in any way prejudice, fetter or affect the functions of the Welsh Ministers or any of them nor oblige the Welsh Ministers or any of them to exercise, or refrain from exercising, any of their functions in any particular way.

## General

If at any time any of the Conditions are deemed to be or become invalid, illegal or unenforceable in any respect under any law, the validity, legality and enforceability of the remaining provisions will not in any way be affected or impaired.

No failure or delay on our part to exercise any power, right or remedy under the Conditions will operate as a waiver of any such power, right or remedy or preclude its further exercise or the exercise of any other power, right or remedy. The powers, rights or remedies hereby provided are cumulative and not exclusive of any powers, rights or remedies provided by law.

Any amendment or variation to the Conditions must be in writing and signed by us and you in the same manner as this letter (or as otherwise agreed by us in writing from time to time).

You may not assign or otherwise dispose of in any way your rights, benefits, obligations or duties under the Conditions.

Conditions 7, 10, 11, 12, 14, and 21(e) and such other Conditions which by implication need to continue in force beyond the final payment of Funding will so continue in full force and effect.

The award of the Funding is to you alone and no one else is entitled to make any claim in respect of the Funding or seek to rely on or enforce any of the Conditions.

In circumstances where you comprise two or more persons or bodies, the liabilities of such persons or bodies shall be joint and several and the default of one of such persons or bodies shall be deemed to be the default of all.

The Conditions and any disputes or claims (including any non-contractual disputes or claims) arising out of or in connection with its formation or its subject matter are to be governed by and construed in accordance with the laws of Wales and England as applied in Wales and the parties hereto submit to the exclusive jurisdiction of the courts of Wales and England.

## How to accept this award of Funding

To accept this award of Funding two authorised signatories must sign and return a full copy of this letter to the RPB Support Team at [abb.PartnershipPMO@wales.nhs.uk](mailto:abb.PartnershipPMO@wales.nhs.uk).

None of the Funding will be paid to you until we have received your signed letter.

We must receive your signed letter within 28 days of the date of this letter or this award of Funding will automatically be withdrawn.

Yours faithfully



Amy Dolben

**On behalf of the Gwent RPB**

## SCHEDULE 1- Notification Events

The Notification Events referred to in Condition 7 are listed below:

- repayment of any part of the Funding is required in accordance with any relevant legislation;
- you fail to comply with any of the Conditions;
- the Funding, in full or in part, is not being used for the Purposes;
- you fail to achieve any or all of the Targets;
- there is unsatisfactory progress towards completing the Purposes, including meeting the Targets;
- you fail to provide information about the Purposes requested by us or any UK subsidy enforcement body or any of its auditors, agents or representatives;
- we have reason to believe that you and/or any of your Personnel are involved in fraudulent activity or have been involved in fraudulent activity whilst the Purposes are/were being carried out];
- we have made an overpayment of Funding to you;
- there is a duplication of funding in respect of any part of the Purposes. This includes but is not limited to any payments received by you in relation to the effects of the spread of the Coronavirus (COVID-19) from your insurance provider (cancellation/business disruption insurance), and/or any Welsh Government fund/scheme;
- any declaration made in Condition 7 is, or proves to be, incomplete untrue or misleading incorrect in any respect or, if repeated at any time with reference to the facts and circumstances then existing, would be incorrect;
- there has been a modification (qualification, adverse or disclaimer) to the auditor's opinion on your financial statements;
- an event or circumstance has occurred and is outstanding which constitutes (or, with the expiry of a grace period, the giving of notice, the making of any determination or any combination thereof, would constitute) a default or termination event (howsoever described) under any other agreement or instrument which is binding on you or to which any of your assets is subject;
- a moratorium in respect of all or any of your debts or a composition or an agreement with your creditors is agreed, applied for, ordered or declared;
- you stop or suspend payment of any debts or are unable, or admit in writing your inability, to pay your debts as they fall due;
- the value of your assets is less than your liabilities (taking into account contingent and prospective liabilities);

you commence negotiations, or enter into any composition, compromise, assignment or arrangement, with one or more of your creditors with a view to rescheduling any of your indebtedness (because of actual or anticipated financial difficulties);

any action, proceedings, procedure or step is taken in relation to you in relation to:

- i) the suspension of payments, a moratorium in respect of any indebtedness, winding up, dissolution, administration or reorganisation (using a voluntary arrangement, scheme of arrangement or otherwise); or
- ii) a composition, compromise, assignment or arrangement with any of your creditors; or
- iii) the appointment of a liquidator, receiver, administrative receiver, administrator, compulsory manager or other similar officer in respect of you or any of your assets.

a statutory demand is issued against you;

you cease, or threaten to suspend or cease, to carry on all or a material part of your business;

there is a change in your constitution, status, control or ownership and/or your external auditors resign;

you fail to comply with any statutory reporting obligations which are applicable to you (including, but not limited to, filing requirements at Companies House, the Charity Commission, the Financial Conduct Authority);

there is any change, whether permanent or temporary, in your shareholders, directors, trustees or partners and/or Personnel which may affect your ability to deliver the Purposes;

any event occurs or circumstances arise which in our opinion gives reasonable grounds for believing that providing the Funding and/or the continuation of the arrangements contemplated by this letter could bring us into disrepute;

any event occurs or circumstances arise which in our opinion gives reasonable grounds for believing that you may not, or may be unable, to perform or comply with any of your obligations under the Conditions.

## SCHEDULE 2- Payment Profile

Amount of Instalment	Last Date for Claim	Documents required to enable a claim to be made
Up to total expenditure incurred in the period 1 <sup>st</sup> April 2026 – 31 <sup>st</sup> March 2027 (end-date)	30 <sup>th</sup> April 2027	<ul style="list-style-type: none"> <li>• Signed Award Letter</li> <li>• Progress Reporting form</li> <li>• Monthly Finance Monitoring return</li> <li>• Notification of claim value from the PMO Finance Team</li> </ul>

## SCHEDULE 3- Reporting Schedule

In addition to a monthly Finance Monitoring Return, a reporting template will be provided for you to complete. The schedule below displays the dates and sections required for submission for projects supported via the RPB revenue funding.

Quarter	Projects	Report Content	Project Report Deadline
Quarter 1 - April to June 2026	Only projects informed of the requirement	Q1 Data and Case Studies	Wednesday 15 <sup>th</sup> July 2026
Quarter 2 - July to Sept 2026	All RPB-funded projects	6 Month Narrative (including Case Studies) and Q1/Q2 Data	Wednesday 14 <sup>th</sup> October 2026
Quarter 3 - Oct to Dec 2026	Only projects informed of the requirement	Q1/Q2/Q3 Data and Case Studies Only	Wednesday 13 <sup>th</sup> January 2027
Quarter 4 - Jan to Mar 2027	All RPB-funded projects	Yearly Narrative (including case studies) and full-year data (Q1/Q2/Q3/Q4)	Wednesday 17 <sup>th</sup> April 2027
Quarter 1 – 4 (April 2026 to Mar 2027)	All RPB-funded projects	Changes, updates, challenges or any notification of events (Schedule 1) to be requested through the RPB process (refer to the RPB Revenue Guidance)	As and when required

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## Confirmation of Acceptance for 2026-27 Funding Award

**Please refer to the project(s) listed on page 1.**

### Two Signatures Required

We declare that we are duly authorised to accept the award of funding, and the conditions included in this award letter.

<b>Signed</b>	
<b>Designation</b>	
<b>Organisation</b>	
<b>Date</b>	

<b>Signed</b>	
<b>Designation</b>	
<b>Organisation</b>	
<b>Date</b>	

***A full copy of the signed award letter with Wet/Electronic signatures (not typed) should be scanned and emailed to the Gwent RPB Support Team (PMO) to [abb.PartnershipPMO@wales.nhs.uk](mailto:abb.PartnershipPMO@wales.nhs.uk)***

<b>DYDDIAD Y CYFARFOD:</b> <b>DATE OF MEETING:</b>	12 February 2026
<b>CYFARFOD O:</b> <b>MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD:</b> <b>TITLE OF REPORT:</b>	Development of the Annual Report 2025/26
<b>CYFARWYDDWR</b> <b>ARWEINIOL:</b> <b>LEAD DIRECTOR:</b>	Rani Dash, Director of Corporate Governance
<b>SWYDDOG ADRODD:</b> <b>REPORTING OFFICER:</b>	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad**  
**Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA**  
**SBAR REPORT**

**Sefyllfa / Situation**

In line with Chapter 3 of the Manual for Accounts: Annual Report and Accounts, the Health Board is required to publish, as a single document, a three part Annual Report and Accounts.

This paper outlines the requirements of the Annual Report and Accounts 2025/26, and the key contributors in the development of these reports.

The Health Board received the DRAFT Manual for Accounts on the 18<sup>th</sup> December 2025, outlining the draft reporting deadlines.

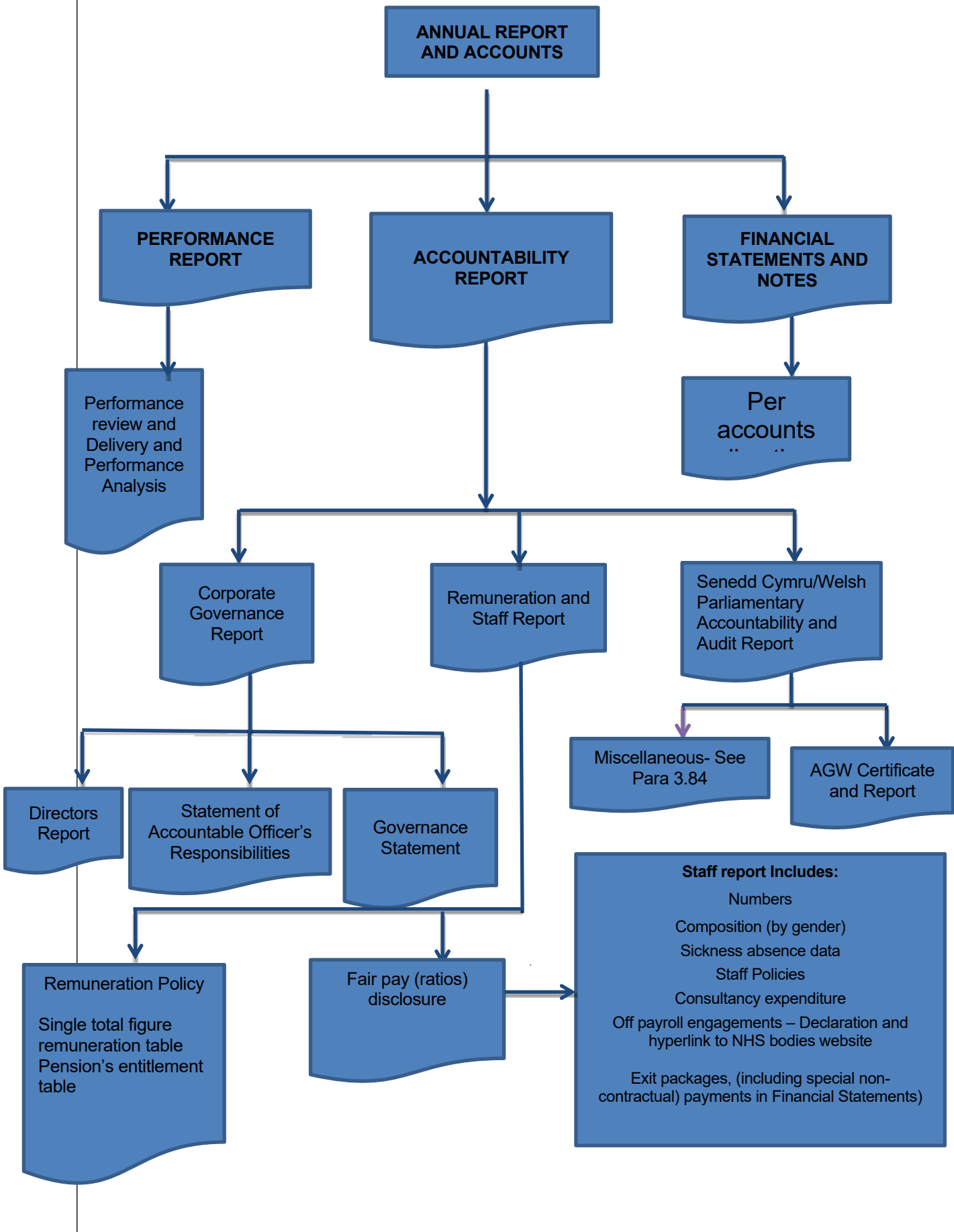
**Cefndir / Background**

NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

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

- The Financial Statements, including:
  - The Audited Annual Accounts 2025/26.

### Annual Report and Accounts Outline Structure



### Asesiad / Assessment

It is proposed that the development and submission of the different sections of the Annual Report are led as follows:

<b>Section</b>	<b>Lead</b>	<b>Submission</b>
Performance Report	Director of Strategy, Planning and Partnerships	Director of Corporate Governance
Accountability Report	Director of Corporate Governance	Director of Corporate Governance
Remuneration Report	Director of Corporate Governance	Director of Corporate Governance
Annual Accounts	Director of Finance	Director of Finance
Final combined document	Director of Corporate Governance	Director of Corporate Governance

As highlighted earlier in this report, the final Manual for Accounts is awaited. The timetable for submission is outlined below:

<b>Annual Reports 2025/26 - Key Dates</b>	<b>2026</b>	
<b>Draft Accounts to WG</b>	<b>Fri</b>	<b>1-May</b>
<b>Draft Performance Report Overview, Accountability Report and Remuneration Report to WG</b>	<b>Fri</b>	<b>8-May</b>
Draft Reports to ARA Committee Members	<b>Tues</b>	<b>12-May</b>
<b>ARA Committee meeting</b> to Consider Draft Accounts and Draft Accountability Report	<b>Tues</b>	<b>19-May</b>
Final Accounts & Accountability Report to Audit Committee Members	Fri	19 June
<b>ARA Committee meeting</b> to Consider Final Accounts, and Accountability Report	<b>Tues</b>	<b>23-June</b>
<b>Board meeting to approve Final Accounts and Accountability Report</b>	<b>Wed</b>	<b>24-June</b>
<b>Certification by Auditor General</b>		
<b>Final Annual Report Deadline for Submission to WG</b> – Annual Report and Accounts as a single unified document	<b>Tues</b>	<b>30 June</b>
<b>Annual General Meeting</b> – to receive the Annual Report and Accounts	Wed	

### Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- Note the requirement to prepare a 3 part Annual Report 2025/26;
- Note the timescales for submission;
- Note that the final Manual for Accounts is awaited

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

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
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:	

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment</b> (EIA) completed	<b>No does not meet requirements</b>

	<p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio</b>  <b>Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>Not Applicable  Choose an item.</p>

# Internal Audit Progress Report

## Audit, Risk and Assurance Committee

February 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services



GIG  
CYMRU  
NHS  
WALES

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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



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## 1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2025/26 Internal Audit Plans for Aneurin Bevan University Health Board (the 'Health Board') to the February 2026 Audit, Risk and Assurance Committee (the 'Committee');
- seek **approval** to defer two audits, Clinical Audit and Six Goals Programme, and delay the commencement of Directorate Review – Ophthalmology / ENT into 2026 / 27 to incorporate cataract testing;
- request **approval** for the Estates Assurance: Space Utilisation audit to be completed as an advisory review for the sharing of best practice; and
- provide details (with attached copies) of audit briefs for information purposes to the Committee.

## 2. Progress against 2025/26 Internal Audit Plan

The following final report has been issued since the meeting of the Audit, Risk and Assurance Committee on 16<sup>th</sup> December 2025:

<b>AUDIT ASSIGNMENT</b>	<b>ASSURANCE RATING</b>
Subject Access Requests	Limited

Further information over the assurance rating detailed above is included within Appendix B.

The current position of the 2025/26 Internal Audit Plan is summarised below, with further detail within Appendix A.

<b>Audit Status</b>	<b>Number</b>
Final reports	10
Draft reports	5
Work in progress	7
Planning	5
Requested deferral/ delay (see below)	3
Total number of audits planned	30

## 3. Summary of Findings for Recently Completed Work

Limited assurance reports are considered by the Audit, Risk and Assurance Committee in detail. The following summary provides the Committee with the main conclusions from the final report issued since 16<sup>th</sup> December 2025.

## Subject Access Requests (limited assurance)

The audit found that while the Health Board's Subject Access Request (SAR) performance has improved significantly - reaching 99.84% compliance after adopting a new administration system - some important control gaps remain. These gaps led to an overall **limited assurance** conclusion.

## 4. Request to Delay/ Defer

In planning the final audits for 2025/26, the following is noted:

- Clinical Audit – The extraordinary audit committee in January 2026 received an update on the proposed clinical audit approach. Noting that the new arrangements have yet to be fully implemented, an audit of the arrangements would offer limited assurance benefit/ value at this stage. It is therefore proposed, subject to the Committee's approval, that this audit is delayed until the revised arrangements are established.
- Six Goals Programme – Audit Wales concluded their review of *Urgent and Emergency Care: Arrangements for Managing Demand* covering issues considered as part of our planning for 2025/26. Noting that assurance has already been provided in this area, and to avoid duplication, it is suggested that this audit is deferred.
- Directorate Review - Ophthalmology/ ENT – during our planning for the 2026/27 Internal Audit Plan it was felt that this review should be expanded to cover recent significant increased investment for cataracts and regional working in this area. It is therefore proposed that the scope of this review is expanded to include the above, and whilst it will commence in Q4 2025/26, the conclusion of the review will extend into the 2026/27 cycle of work.

Therefore, we are seeking **approval** to defer the Clinical Audit into the later quarters of 2026/27 to provide time for the new arrangements to embed; **approval** to defer the Six Goals Programme audit; and **approval** to delay the start and conclusion of the Directorate Review – Ophthalmology / ENT audit into 2026/27.

## 5. Request to Amend Review to Advisory

The Estates Assurance – Space Utilisation is a national review that is being completed across other NHS Wales organisations. Following the completion of our NHS Wales-wide planning process, it was identified that an advisory approach would enable a wider review around the sharing of best practice and identifying opportunities for consideration across NHS Wales and ultimately, be more beneficial to the Health Board. This approach has been agreed with the other NHS Wales organisations being reviewed and would enable a consistent review across each client, to maximise the learning. Therefore, whilst the review scope would remain the same, we are seeking **approval** to change the focus to a consultancy report.

## 6. Summary of Audit Briefs Recently issued

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

## 7. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report and to **approve** the deferment/ delay of work as noted in section 4 and the change of Estates Assurance – Space Utilisation to an advisory review, as outlined in section 5.

## Appendix A: Progress against 2025/26 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Work in Progress
2. Standing Orders Compliance	Substantial	Final Report
3. Strategic Risk and Assurance		Planning
4. Subject Access Requests	Limited	Final Report
5. Benefits Realisation (excluding digital)		Planning
6. Business Continuity Plan	Reasonable	Final Report
7. Capital Projects: Service Readiness		Draft Report
8. Falls Management		Work in Progress
9. Directorate Review - CAMHS		Draft Report
10. Professional Staff Registration		Planning
11. Clinical Audit		Request for deferral
12. Directorate Review – Ophthalmology / ENT		Request for delay
13. Public Health	Advisory	Final Report
14. Six Goals Programme		Request for deferral
15. Discharge Planning		Work in Progress
16. Safeguarding	Reasonable	Final Report
17. Cancer Referral Rates		Planning
18. Occupational Health		Draft Report
19. Overseas Recruitment		Planning
20. Speaking up Safely		Draft Report
21. Follow-up of High Priority Recommendations		Work in Progress
22. Cyber Security (Including cyber incident response)	Reasonable	Final Report
23. Shadow IT		Work in Progress
24. Welsh Intensive Care Information System	Substantial	Final Report
25. RGH Central Decontamination Unit (capital systems from 2024/25)	Reasonable	Final Report
26. Estates Assurance – Space Utilisation		Work in Progress
27. Financial Sustainability (b/fwd from 2024/25)	Reasonable	Final Report
28. Waiting List Management (b/fwd from 2024/25)	Reasonable	Final Report
29. The Grange Emergency Department		Draft Report
30. NHH Regional Satellite Centre (deferred from 2024/25)		Work in Progress

## Appendix B: Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:



### **Substantial assurance**

Few matters require attention and are compliance or advisory in nature.

**Low impact** on residual risk exposure.



### **Reasonable assurance**

Some matters require management attention in control design or compliance.

**Low to moderate impact** on residual risk exposure until resolved.



### **Limited assurance**

More significant matters require management attention.

**Moderate impact** on residual risk exposure until resolved.



### **No assurance**

Action is required to address the whole control framework in this area.

**High impact** on residual risk exposure until resolved.



### **Assurance not applicable**

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

## Appendix C: Audit / Review Briefs Issued

Audit Title	Status	Outline Scope
<b>Divisional Budgetary Control</b>	Brief issued	The overall scope of the audit is to ensure the Budgetary Control Financial Control Procedure is adhered to within a sample of divisions, with the overall objective of determining if financial sustainability is being maintained.
<b>Falls Management</b>	Brief issued	To provide assurance that the Falls Policy for hospital adult inpatients is adequate and is being adhered to by management/ staff.
<b>Discharge Planning</b>	Brief issued	This review will focus on the arrangements and mechanisms within the Health Board to facilitate the safe and efficient discharge of patients.
<b>Benefits Realisation</b>	Draft brief issued	The audit will focus on the processes and procedures to establish and capture key benefits arising from initiatives/ investments (excluding digital projects/ programmes).
<b>Overseas Recruitment</b>	Draft brief issued	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.
<b>Professional Staff Registration</b>	Draft brief issued	To ensure appropriate arrangements are in place to demonstrate that all staff (medical, clinical, nursing and other groups) requiring professional registration are appropriately registered throughout their employment.

# Aneurin Bevan University Health Board – Audit Committee Update

Date issued: February 2026



# Contents

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For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email [info@audit.wales](mailto:info@audit.wales).

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

# Introduction

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This document provides the Audit Committee with an update on our current and planned accounts and performance audit work at Aneurin Bevan University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in March 2025.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

# Accounts audit update

## Audit of the 2024-25 Charitable Fund Accounts

- **Executive Lead:** Director of Finance and Procurement
- **Focus of the work:** To provide an audit opinion on the 2024-25 Charitable Fund Annual Report and Accounts
- **Status: Audit work complete** – audit opinion to be provided by end of January 2026
- **Expected Board date:** 28 January 2026

## Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Director of Finance and Procurement
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** Planning and early testing underway
- **Expected committee date:** 23 June 2026

# Performance audit update

## GP Managed Contact Arrangements (Local Work)

- **Executive Lead:** Chief Executive Officer
- **Focus of the work:** We are reviewing the Health Board's arrangements for awarding the contracts to GPs who are members of the eHarley Street Group, as well as the on-going contract management arrangements relating to these practices. We will draw upon work already undertaken by Internal Audit to inform our work as appropriate.
- **Status:** Report in clearance
- **Expected committee date:** April 2026

## Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Finance
- **Focus of the work:** This work will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Report drafting
- **Expected committee date:** April 2026

### **Structured assessment 2025 - deep dive review of the arrangements to manage estates**

- **Executive Lead:** Director of Finance
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork
- **Expected committee date:** April 2026

### **Review of cancer services**

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider:
  - The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services;
  - The efficacy of local plans and associated actions to recover cancer waiting lists; and
  - Use of the additional Welsh Government financial allocations to improve cancer services.
- **Status:** To commence in February.
- **Expected committee date:** June 2026

## Other relevant publications

Since the last committee update, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

<a href="#"><u>Checking the patients. Results from a pilot data matching exercise on GP patient lists</u></a>	January 2026
<a href="#"><u>Facing the Future – Auditor General for Wales Podcast – Episode 4</u></a>	November 2025
<a href="#"><u>Opportunities for Change – Auditor General for Wales Podcast – Episode 3</u></a>	November 2025
<a href="#"><u>Under Pressure – Auditor General for Wales Podcast – Episode 2</u></a>	November 2025
<a href="#"><u>A Unique Perspective – Auditor General for Wales Podcast – Episode 1</u></a>	November 2025

Since the last committee update, Audit Wales has also published the following corporate documents.

<a href="#"><u>Fee scheme 2026-27</u></a>	January 2026
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## Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



[Data tools](#) to help you better understand public spending trends.



Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.



Our [newsletter](#) which provides you with regular updates on our public service audit work, good practice, and events.



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We welcome correspondence and telephone calls in Welsh and English.

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



# Inpatient Hospital Falls Management

## Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG  
CYMRU  
NHS  
WALES

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



## Introduction

Aneurin Bevan University Health Board (the 'Health Board') recognises that the minimising of hospital falls, and effective management of patients following a fall, is an important patient safety challenge for the Health Board, in common with all Health Boards. The definition of a fall is "an event which results in a person coming to rest inadvertently on the ground or other lower level" (WHO:2018).

The National Institute of Health and Care Excellence (NICE) identifies that falls and fall related injuries are a common serious problem for older people and falls in hospital are the most reported patient safety incidents. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and in certain instances mortality, not only affecting patients but also relatives, carers and hospital staff. The prevention of falls and the effective management after a fall are key requirements to support people who are at risk.

## Scope, Risks & Approach

<p>Scope</p>	<p>To provide assurance that the Falls Policy for hospital adult inpatients is adequate and is being adhered to by staff.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> <li>1. Assess whether the Health Board's Falls Policy (and any other supporting policies) for hospital adult inpatients is up to date, evidence-based, and aligned with current national guidelines and best practice standards.</li> <li>2. The Health Board is proactive in reducing the risk of adult inpatient falls through the development of falls guidance and raising awareness.</li> <li>3. Falls incidents involving adult inpatients are investigated and scrutinised to identify any common themes and trends and appropriate corrective action is determined.</li> <li>4. There is regular monitoring and reporting of Falls for adult inpatients data at an appropriate forum to provide assurance to the Board as well as share learning and good practice.</li> </ol>
<p>Associated risks</p>	<ul style="list-style-type: none"> <li>• Failure to properly risk assess patients leading to increased falls and patient harm.</li> <li>• Lack of appropriate monitoring of falls leading to missed opportunities to identify weakness and implement improvements.</li> <li>• Reputational damage arising from increased or serious hospital falls.</li> <li>• Financial loss with regards prosecution notices and fines.</li> </ul>
<p>Approach</p>	<p>The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.</p> <p><a href="#">Assurance opinions and action plan risk ratings</a></p>

Link to Health & Care Quality Standards	<p>This review may contribute towards assurance over the following Health &amp; Care Quality Standards:</p> <p>Quality Domains: Person Centred, Safe, Timely and Effective</p> <p>Quality Enablers: Workforce and Whole System Approach</p>
---	---

## Contacts & Timings

Client contacts	<p>Peter Carr</p> <p>Karen Hatch</p>	<p>Executive Director of Allied Health Professions &amp; Health Science</p> <p>Assistant Director Allied Health Professions &amp; Health Science</p>
Audit Assurance contacts	<p>Stephen Chaney</p> <p>Eifion Jones</p> <p>Rhian Gard</p>	<p>Head of Internal Audit</p> <p>Deputy Head of Internal Audit</p> <p>Internal Audit Manager</p>
Indicative timings	<p>Fieldwork</p> <p>Debrief meeting</p> <p>Audit Committee</p>	<p>January 2026</p> <p>February 2026</p> <p>April 2026</p>
Brief agreement	<p>Peter Carr, Executive Director of Allied Health Professions &amp; Health Science</p> <p>08.01.2026</p>	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

### Disclaimer notice

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

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

# Divisional Budgetary Control

## Final Internal Audit Brief

Aneurin Bevan University Health Board

## Introduction

The review of Divisional Budgetary Control will be completed in line with Aneurin Bevan University Health Board's (the 'Health Board') 2025/26 Internal Audit Plan.

The Health Board is required to have approved Standing Financial Instructions (SFI) which govern the regularity of financial transactions.

*SFI Section 5 – Financial Management and Budgetary Control* includes sub-sections addressing Budgetary Delegation; Financial Management, Reporting and Budgetary Control; Capital Financial Management, Reporting and Budgetary Control; and Reporting to Welsh Government - Monitoring Returns.

All sub-sections outline expected actions/ responsibilities for all budget holders.

The audit is to focus on the principal expenditure control process of budgeting and the subsequent monitoring of spend and budget variance in a sample of divisions.

## Scope, Risks & Approach

Scope	<p>The overall scope of the audit is to ensure the Budgetary Control Financial Control Procedure is adhered to within a sample of divisions, with the overall objective of determining if financial sustainability is being maintained.</p> <p>Objectives of the audit are as follows:</p> <ol style="list-style-type: none"> <li>1. <b>Deliverable service plans (e.g. workforce / capacity plans)</b> are developed that are within delegated divisional budget allocations;</li> <li>2. <b>Policies and procedures</b> are available to budget holders, are up-to-date and reflect current working practices;</li> <li>3. <b>Budget holder responsibilities</b> are defined and observed;</li> <li>4. <b>Budget variances</b> that arise in the year are monitored and overspends are addressed; and</li> <li>5. <b>Virements</b> used to reallocate funds between divisions are controlled and monitored.</li> </ol>
Associated risks	<ul style="list-style-type: none"> <li>• Officers approve expenditure outside their delegated authority.</li> <li>• Insufficient control of the Health Board's Expenditure.</li> <li>• Breach of Standing Financial Instructions.</li> </ul>
Limitations to scope	<p>The audit opinion will be determined based on the adequacy of arrangements to establish and manage budgets, rather than the performance of the sampled divisions.</p>
Approach	<p>The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.</p> <p><a href="#">Assurance opinions and action plan risk ratings</a></p>
Link to Health & Care Quality Standards	<p>This review may contribute towards assurance over the following Health &amp; Care Quality Standards:</p>

---

	Quality Domains	Quality Enablers
	Safe Care	Leadership
	Timely Care	Workforce
	Effective Care	Culture and Valuing People
	Efficient Care	Information
	Equitable Care	Learning, Improvement and Research
	Person-centred Care	Whole Systems Approach

## Contacts & Timings

Client contacts	Robert Holcombe Robert Jones Lisa Ingleson Karen Archer Andrew George	Executive Director of Finance, Procurement & VBH Assistant Director of Finance Business Partner Accountant - Surgery Business Partner Accountant - Medicine Business Partner Accountant – Digital Directorate
Audit Assurance contacts &	Stephen Chaney Eifion Jones	Head of Internal Audit Deputy Head of Internal Audit
Indicative timings	Fieldwork Debrief meeting Audit Committee	December 2025 January 2026 February 2026
Brief agreement	Robert Holcombe, Executive Director of Finance, Procurement & VBH	



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# Discharge Planning

## Final Internal Audit Brief

Aneurin Bevan University Health Board



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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



## Introduction

Effective discharge planning is a critical component of the patient pathway, and minimising associated delays remains a priority. The Health Board is committed to ensuring the safe, effective and timely discharge of patients into an environment that meets their individual needs.

This review will assess the accuracy and completeness of a sample of patient discharge performance measures reported, including any relevant controls to support the process.

## Scope, Risks & Approach

Scope	<p>To assess the accuracy, completeness, and reliability of data recorded and reported within the discharge process and ensuring that information is incorporated into an established performance reporting framework.</p> <p>Objectives of the area under review:</p> <ol style="list-style-type: none"> <li>1. Systems and procedures in relation to discharge processes support the accurate recording of relevant data;</li> <li>2. A sample of records in relation to discharge processes are complete, accurate and subject to appropriate access controls; and</li> <li>3. A reporting framework which includes performance measures in relation to discharge planning is in place, with accurate and timely reports issued to appropriate stakeholders.</li> </ol>													
Associated risks	<ul style="list-style-type: none"> <li>• Inaccurate reporting impacting the decision-making process and / or subsequent management actions implemented.</li> <li>• Relevant information relating to discharge is not captured in patient notes, resulting in inaccurate performance data.</li> <li>• Performance relating to the discharge process is inaccurate and / or incomplete.</li> </ul>													
Approach	<p>The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues.</p> <p>Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review.</p> <p><a href="#">Assurance opinions and action plan risk ratings</a></p>													
Link to Health & Care Quality Standards	<p>This review may contribute towards assurance over the following Health &amp; Care Quality Standards:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #e6f2ff;">Quality Domains</th> <th style="background-color: #e6f2ff;">Quality Enablers</th> </tr> </thead> <tbody> <tr> <td>Effective</td> <td>Information</td> </tr> <tr> <td>Efficient</td> <td>Learning, improvement and research</td> </tr> <tr> <td>Person centred</td> <td>Whole systems approach</td> </tr> <tr> <td>Safe</td> <td>Workforce</td> </tr> <tr> <td>Timely</td> <td></td> </tr> </tbody> </table>		Quality Domains	Quality Enablers	Effective	Information	Efficient	Learning, improvement and research	Person centred	Whole systems approach	Safe	Workforce	Timely	
Quality Domains	Quality Enablers													
Effective	Information													
Efficient	Learning, improvement and research													
Person centred	Whole systems approach													
Safe	Workforce													
Timely														

## Contacts & Timings

Client contacts	Jennifer Winslade Kate Fitzgerald	Executive Director of Nursing Head of Transformation and Delivery Planning
Audit Assurance contacts	& Stephen Chaney Eifion Jones Warren Alexander	Head of Internal Audit Deputy Head of Internal Audit Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	January / February 2026 February 2026 TBC
Brief agreement	Executive Director of Nursing 13 <sup>th</sup> January 2026	



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<b>DYDDIAD Y CYFARFOD:</b> <b>DATE OF MEETING:</b>	12 February 2026
<b>CYFARFOD O:</b> <b>MEETING OF:</b>	Audit, Risk and Assurance Committee
<b>TEITL YR ADRODDIAD:</b> <b>TITLE OF REPORT:</b>	Audit, Risk and Assurance Committee Forward Work Plan 2025/26
<b>CYFARWYDDWR</b> <b>ARWEINIOL:</b> <b>LEAD DIRECTOR:</b>	Director of Corporate Governance
<b>SWYDDOG ADRODD:</b> <b>REPORTING OFFICER:</b>	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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	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)**

<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Not Applicable
• <b>Service Activity &amp; Performance</b>	Not Applicable
• <b>Financial</b>	Not Applicable
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	Not Applicable Choose an item.

## **ANNUAL PROGRAMME OF BUSINESS 2025/26**

### **AUDIT, RISK & ASSURANCE COMMITTEE**

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

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

**Area of Focus as per Standing Orders:**

The Audit, Risk and Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

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

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

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

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26						
			Quarter 1			Quarter 2	Quarter 3		Quarter 4
			22 <sup>nd</sup> April 2025	20 <sup>th</sup> May Draft Accounts	24 <sup>th</sup> June Final Accounts	18 <sup>th</sup> Sept 2025	21 <sup>st</sup> Oct 2025	16 <sup>th</sup> Dec 2025	12 <sup>th</sup> Feb 2026
<b>Preliminary Matters</b>									
Attendance and Apologies	SI	Chair	√	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√	√
<b>Committee Requirements as set out in Standing Orders</b>									
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	√						
<b>Corporate Governance, Risk &amp; Assurance</b>									
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	An	DofCG					√		
Receive full report of all offers of gifts and hospitality as declared	An	DofCG	√						√
Compliance with Ministerial Directions	BI	DofCG	√						√
Compliance with Welsh Health Circulars (WHCs)	BI	DofCG	√D	√D	√D	√			√
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	An	DofCG							√
Compliance with regulatory requirements	An	DofCG							√
Audit Recommendations Tracking Report	Qu	DofCG		√Q4		√Q1	D√Q2	√Q2	√Q3
Annual Review of Risk Management Framework	An	DofCG	√						
Report on Risk Management Maturity	BI	DofCG					√		√

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Committee Risk & Assurance Report	SI	DofCG	√		√	√	√	√	
<b>Financial Governance and Control</b>									
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	√	
Report of Losses and Special Payments ( <i>May report will be included in the Accounts</i> )	BI	DofF&P	√	√			√		
To Approve Reviewed and Updated Financial Control Procedures	Ad hoc	DofF&P	√		√	√	√	√	
<b>Annual Report and Accounts</b>									
To consider the approach and timelines for the Annual Report and Accounts	An	DofCG							√
Review the Health Board's Annual Report (Overview & Performance Section) ( <b>Part 1</b> )	An	DofCG		√	√				
Review Draft/Final Accountability Report, including Annual Governance Statement ( <b>Part 2</b> )	An	DofCG		√	√				
Review Draft/Final Annual Accounts and Financial Statements ( <b>Part 3</b> )	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			√				
<b>Counter-Fraud</b>									
Review of the Counter Fraud, Bribery and Corruption Policy ( <i>Feb 2026</i> )	3-Yearly	DofF&P	-	-	-	-	-	-	√
Receive the Counter Fraud Annual Report	An	HofCF		√					

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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√	√	
<b>Clinical Audit</b>									
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√	√	
<b>Internal Audit (Including Specialised Audit) – NWSSP Audit &amp; Assurance Services</b>									
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	√						
<b>External Audit – Audit Wales</b>									
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						√	

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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							
<b>Total Items Scheduled</b> (excluding preliminary items) -to be updated prior to each meeting			<b>13</b>	<b>16</b>	<b>17</b>	<b>14</b>	<b>16</b>	<b>14</b>	<b>8</b>
<b>Audit, Risk and Assurance Committee Members to meet Independently with:</b>									
External Audit Team	BI	Chair			√			√	
Internal Audit Team	BI	Chair		√			√		
Local Counter Fraud Team	BI	Chair	√			√			√

Lead Officer Key	
<b>DofCG</b>	Director of Corporate Governance
<b>DofF&amp;P</b>	Director of Finance and Procurement
<b>HofCF</b>	Head of Counter Fraud
<b>PPV</b>	Post Payment Verification
<b>HofIA</b>	Head of Internal Audit
<b>AW</b>	Audit Wales
<b>Chair</b>	Chair

Frequency of Inclusion Key	
<b>SI</b>	Standing Item
<b>AN</b>	Annually
<b>BI</b>	Biannually
<b>Quarterly</b>	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√R	Received at the Scheduled meeting
<b>D</b>	Deferred from this agenda

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

# **Structured Assessment**

## **2025**

Aneurin Bevan University Health Board

December 2025

# About us

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# Audit snapshot

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## What we looked at

- 1 We looked at how well Aneurin Bevan University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:
  - how well its board works;
  - how it keeps track of risks, performance, service quality, and recommendations;
  - how it produces key plans and strategies; and
  - how it manages its finances.
- 2 We also looked at the Health Board's progress in implementing recommendations from:
  - previous structured assessment reports; and
  - our 2024 report on cost savings.

## Why this is important

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

## What we have found

- 4 The Health Board has an effective Board supported by continued good governance arrangements. Clear and high-quality information helps the Board carry out its duties. Support from the Good Governance Institute has also improved how reports are written and presented. The Board listens well to patients and service users, but it could do more to hear from staff.
- 5 The Health Board is improving how it manages risks and is finalising its corporate risk register. This year, it approved a new long-term strategy and delivered a Welsh Government approved three-year Integrated Medium-Term plan. These plans give the organisation a clear direction, with set milestones and targets.
- 6 Although financial oversight is strong and the Health Board has a good track record of savings delivery, its financial position is getting worse. It submitted a balanced three-year plan but now expects a deficit of £19.9 million by the end of the year. To meet these financial challenges, the Health Board must focus on transforming services and delivering its strategy. This is an area we have previously recommended for improvement but is not yet well-progressed.

## What we recommend

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

# Key facts and figures

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

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

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

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

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

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

# Our findings

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## Board effectiveness and openness

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

### Public openness of board business

- 8 The Health Board continues to demonstrate that it is being open and transparent about Board and committee activities:
  - it continues to livestream and publish recordings of all public Board meetings;
  - the public can observe any public board meeting;
  - it publishes Board and committee papers a week before each meeting on its website;
  - uses private sessions only when needed to discuss sensitive topics; and
  - has open and transparent Board and committee discussions, especially when discussing challenges.
- 9 The Health Board could further enhance transparency by making documents available in Welsh and in formats that are easy to use.
- 10 The Health Board recognised that members of the public cannot attend committee meetings. To address this. they are producing short public summaries to increase transparency of committee business.

## Supporting effective board conduct

- 11 The Health Board has clear and up-to-date governance arrangements that help the Board and its committees run effectively. The Audit, Risk and Assurance Committee ensures key governance controls are in place. This includes routinely overseeing compliance with Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.
- 12 The absence of a Stakeholder Reference Group and a Healthcare Professionals Forum is a gap and represents a breach of Standing Orders. While it has a Clinical Advisory Forum, this group does not offer the same level of representation at Board meetings. In addition, meeting minutes of the forum are not shared with the Board or published on the Health Board's website.
- 13 In February 2025, Internal Audit gave substantial assurance on how the Health Board manages declarations of interest and gifts. The Health Board has widened the group of staff who must make declarations, but more assurance is needed to confirm compliance with these new rules.
- 14 About 40% of the Health Board's policies are still out of date, with little improvement since last year. The Health Board now reports progress in its performance report. We have previously recommended stronger review processes, and further action is needed - especially where outdated policies create unnecessary risk.

## Assurance on Joint Commissioning Committee effectiveness

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

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

### **Board and committee meeting effectiveness**

- 17 The Board and its committees work effectively. Their terms of reference, business cycles and work plans are all up to date. Board and committee chairs are actively involved in the meeting agenda setting process.
- 18 The Health Board appropriately considers how its committees operate and makes changes if needed. In April 2025, it established a Mental Health and Learning Disabilities Committee to provide greater oversight and scrutiny of this area following concerns around its performance. In addition, it has:
- appointed a new chair of the Partnerships, Population Health, and Planning Committee; and
  - increased the frequency of the Finance and Performance Committee which provides greater opportunity for scrutiny and depth of challenge.
- 19 Board and committee meetings continue to be well chaired, and most run to time. Independent Members participate fully in meetings, providing reasonable scrutiny on the information presented. However, on occasion we see some members focus too much on operational detail.
- 20 There is a reasonable process for committees to provide assurance to the Board and share information with each other. However, these assurance reports are placed in the consent agenda and are not usually discussed. As we recommended last year, the Board should make sure there is enough opportunity to not only raise but discuss escalated issues.

- 21 In September 2025, Internal Audit gave limited assurance on the Health Board's management of health and safety risks. They found insufficient escalation of risks and recommended the Health Board improve monitoring at committee and Board level by December 2025.
- 22 Board and committee papers are generally timely, well-structured, and highlight key risks and decisions. The Health Board has arranged training on report writing and presentation from an external provider. The Corporate Governance team now reviews all papers before they go to committees, which has improved their quality.

### **Hearing from staff and service users**

- 23 The Health Board continues to engage staff well, using methods including Chief Executive open meetings, Executive drop-ins, and newsletters. Board and committee sessions also include regular patient stories. However, the Health Board could make more use of staff stories at public Board meetings to give the Board valuable feedback on staff views.
- 24 The Health Board uses a range of approaches to hear from patients and service users from diverse backgrounds, including good community engagement with hard-to-reach groups and consideration of service user diversity. Board members also visit frontline services, and patient safety leadership walk rounds take place. The Patient, Quality, Safety Outcomes Committee receives high-level updates on these activities, but there is no reporting on actions taken in response to issues identified.

### **Board cohesion and continuous improvement**

- 25 The Health Board has a stable Executive, with all roles filled. Over the last year, the Health Board has appointed:
  - a new Medical Director; and
  - appointed the existing Director of Nursing as the Deputy Chief Executive.

- 26 The Health Board has good processes for inducting new Independent Members and has recently appointed two, representing Trade Unions and the Third Sector. As of October 2025, there are two vacancies: the Director of Social Services (local authority partner) and the Local Government Independent Member. These gaps are being managed but both the Chair and the Vice Chair will also come to the end of their terms in 2026. The Health Board will need to manage this overall position carefully.
- 27 The Health Board's arrangements for Board and committee self-assessments continue to be effective. These considered their composition and effectiveness of how they work. The outcomes informed the review of each committee's terms of reference, and the programme of board development. In 2024-25, these board development sessions covered topics including:
- estates strategy;
  - long-term strategy and plan development, prior to approval;
  - health pathways; and
  - cyber security.
- 28 There is a comprehensive Board development plan in place for 2025-26, with support from the Good Governance Institute. This included work to improve how the Board works, building effective relationships, scrutiny and governance, and strategic risk-based assurance.

## Providing board assurance

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

### Managing strategic and corporate risks

- 29 The Health Board has a comprehensive Strategic Risk Register reviewed at every Board meeting, forming part of its Board Assurance Framework. The Health Board aligned its key strategic risks to its Integrated Medium-Term plan and allocated Executive Director responsibility for individual strategic risks. It has completed assurance mapping for each strategic risk, building on work started last year and continues to score risks in line with its risk appetite. The Health Board assigns each risk to a committee for assurance who also use this to inform Board and committee agenda setting.
- 30 The Health Board's Corporate Risk Register was still in draft during our review, with the Executive Team working with operational teams to complete it. The Health Board plans to implement the register in November 2025. Once it is in place, the Health Board must ensure the Strategic Risk Register reflects any new risks identified on the Corporate Risk Register.

### Managing performance

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

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<sup>1</sup> There are five levels of monitoring in use, routine arrangements, area of concern, enhanced monitoring, targeted intervention, and special measures.

- 32 This revision has strengthened the framework with increased focus on leadership and corporate governance, in addition to routine performance and quality review. These additional aspects include for example, ensuring policies are up to date, staff training, compliance and response to audit recommendations.
- 33 The Health Board has continued to improve its organisational performance reporting. The report now has four sections, each presented by the relevant Executive Director. Following last year's Structured Assessment, the report includes details on key areas for improvement and actions to address underperformance, as well as targets and comparisons where available. The Health Board has also strengthened its focus on primary and community services by adding more measures.
- 34 Over the past two years, we have seen escalation and de-escalation where required and improving reporting to committee and Board. Nonetheless, there have remained significant performance and financial challenges. The Health Board now needs to fully implement and embed the new framework, ensure that it operates effectively and achieves the desired impact.

## Monitoring quality and safety

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

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

- 36 Since our review, the Health Board has set out clear and sound governance arrangements and accountability for clinical and quality governance within its Quality Management System Framework 2025-28. The framework is operating well with evidence of operational teams escalating quality issues effectively. The new Quality Management Group reports to the Executive Committee and provides assurance to the Patient Quality, Safety Outcomes Committee.
- 37 The Patient, Quality, Safety Outcomes Committee oversees quality and monitors performance. It receives a regular Quality Outcomes Framework report, which is comprehensive but very long<sup>3</sup>. In some areas, we found the presentation confusing, with significant opportunity to better identify areas of concern. The report needs to be drafted in a way that clearly highlights areas of concern to committee members. The report also does not identify learning effectively. In July 2025, the Health Board had four Duty of Candour events, but the report did not include lessons learned.
- 38 The Patient, Quality, Safety Outcomes Committee receives regular updates on the Health Board's 2025–26 Clinical Audit Plan, which is on track for delivery. However, the plan only covers the mandatory national clinical audit programme. There is no local clinical audit programme or oversight of audit activity within divisions, which could mean missed opportunities for learning and providing targeted assurance to the Committee.

## Tracking and monitoring recommendations

- 39 The Health Board has reasonable processes for monitoring and tracking audit recommendations. It keeps an audit tracker for both Audit Wales and Internal Audit recommendations, which Executive Directors update and review, especially for open actions.
- 40 The Health Board is now making good progress in addressing our previous recommendations:

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<sup>3</sup> In June 2025, the report was 113 pages

- 12 out of 18 recommendations from past structured assessment reports are now complete. Two are in progress, with three not started and one has been superseded; and
  - eight out of 11 of our [2024 Review of Cost Savings](#) recommendations have been completed. We discuss this more in **paragraph 64**.
- 41 The Health Board is continuing to strengthen its approach to following up and implementing outstanding audit recommendations. Recently the Health Board has included a regular focus on progress of audit actions in its Performance Management Framework to strengthen accountability for delivery.
- 42 The Health Board does not track quality focused recommendations, such as those made by Healthcare Inspectorate Wales and the Public Services Ombudsman for Wales.

## Preparing strategies and plans

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

#### **Producing key strategies and plans**

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

- 44 The Health Board is working on its clinical services plan. A number of services in the enhanced Local General Hospitals are now under consideration as part of the development of a Business Case for Nevill Hall Hospital. The Health Board is currently undertaking a gap analysis to inform its new clinical services plan. This work is vital to tackle current performance and financial pressures and to create sustainable services that meet people's needs.
- 45 The Partnerships, Population Health and Planning Committee oversees strategy and plan development prior to Board approval. The Health Board also shares draft strategies and plans with Independent Members during development sessions before they are formally approved at public Board meetings.
- 46 Following committee oversight, the Health Board submitted an approvable, financially balanced Integrated Medium-Term Plan (IMTP) for 2025-28. It developed the plan with input from its divisions and a wide range of internal and external stakeholders. The Health Board's IMTP aligns with the long-term strategy and sets out clear priorities. It translates these ambitions into operational priorities and measurable actions over three years. The plan clearly identifies key actions for the first year, with milestones and outcome measures, although the detail for years two and three is less clear.
- 47 Welsh Government approved the plan, but it came with 14 accountability conditions that the Health Board is tracking and reporting on throughout the year. The Health Board is making satisfactory progress against these conditions; however, its financial position has worsened, with a forecast deficit of £19.9 million at month five. As a result, the Health Board is unlikely to meet the requirement to deliver a financially balanced plan. We discuss this further later in the report.
- 48 The Committee also oversees the development of corporate plans. Recently, it reviewed work on the People Plan, Estates Plan, and Digital Strategy. The People Plan has now been approved, while the Digital Strategy is still being developed. In October 2025, the Committee also looked at lessons from the previous IMTP and discussed plans for developing the 2026–29 IMTP. This shows a positive approach to learning and reflection.

## Board assurance on partnership working

- 49 In April 2025, Welsh Government instructed the Chairs of Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to establish a South-East Wales Regional Joint Committee. In September 2025, the Board approved the establishment and terms of reference of the Committee.
- 50 The Partnerships, Population Health and Planning Committee provides assurance to the Board on partnership work. This includes regional partnership boards, public services boards, and collaboration with other Health Boards, including Cwm Taf Morgannwg University Health Board and Cardiff and Vale University Health Board. The Board also receives regular updates on wider partnership activity, including joint working across Wales.
- 51 There are several risks related to partnership working. Our recent work on eye care services highlighted concerns with the complexity of partnership decision making and reporting. While regional solutions are expected to support long-term service sustainability, the capacity to develop and deliver these programmes whilst also managing immediate operational pressures is challenging.

## Monitoring delivery of strategies / plans

- 52 The Health Board's arrangements for overseeing its corporate strategy and plans are effective, but plans are not yet delivering the scale of change needed. The Health Board's IMTP includes clear delivery milestones, outcomes, and performance measures. In September 2025, the Board received an update on quarter one delivery for 2025–26, which showed the Health Board was on track. To support delivery, the Health Board has developed a range of enabling plans and strategies, most of which include clear milestones.
- 53 The Health Board recognised the need to improve oversight of priority programmes. To address this, it has strengthened its reporting approach to provide specific oversight of the following areas:
- place-based care and population health;

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

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

## Managing finances

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

#### Meeting financial objectives and duties

- 55 The Health Board did not meet all its financial duties in 2024-25. Of the three duties, it met its capital resource limit, reporting a small underspend of £0.066 million. However, it did not:
- spend within its revenue resource limit for the three-year period 2022-23 to 2024-25; and
  - have an agreed three-year IMTP for 2024-27.
- 56 Because a balanced financial position was unlikely, Welsh Government set the Health Board a target deficit of £7.3 million. The Health Board met this, reporting a year-end deficit of £7.1 million. Welsh Government also gave extra support in 2024–25, including a recurring £9.5 million allocation in December 2024 and a conditional recurring £31 million.
- 57 The Health Board submitted a balanced financial plan for 2025–26, based on achieving £40.4 million in savings. At submission, this was split as £15.7 million confirmed savings, £10.3m opportunities, and £14.4 million yet to be identified.

- 58 In July 2025, Welsh Government reduced the Health Board's escalation status from Level 4 to Level 3. This reflected progress against its financial improvement plan, including meeting the agreed control total for 2024–25 and having an approved three-year plan for 2025–28.
- 59 By month five of 2025–26, the Health Board changed its forecast from breaking even to a £19.9 million deficit. This means it is unlikely to meet its financial duties for the year. It also raises doubts about whether the original balanced plan was sufficiently realistic.

### Financial planning arrangements

- 60 The Health Board identifies major financial risks, such as higher prescribing, Continuing Healthcare, delayed discharge, ward pressures and mental health service costs. It also has a strong record of making savings. In 2024–25, it saved £45.5 million against a target of £40.5 million, with £32 million being recurring savings. This strong planning and past success gave confidence that the 2025–26 financial plan, part of the IMTP approval process, could be delivered. However, as noted earlier, the plan is proving difficult to achieve, and the Health Board is now forecasting a deficit.
- 61 The Health Board is engaging its divisions and directorates to identify savings. This includes savings identified in its 'Opportunities Compendium', division plans and savings ideas from staff. The Health Board has continued to have a strong approach to value and sustainability, with several of its workstreams developing schemes to support this years required financial savings<sup>4</sup>.
- 62 The Board is appropriately informed of the required savings to achieve financial balance, the savings approach and the risk of non-delivery. Savings updates to the Board indicate schemes that are off-track (no plan in place and not expected to achieve). However, we have not seen any learning reported on failed or under-delivering schemes.

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

- 63 The Health Board's financial plan for 2025–26 was predicated on £40.4 million in savings, which it subsequently increased to £42.5 million. By month six, £15.1 million had been delivered, in line with the phasing and recognising the split between confirmed savings, opportunities, and areas yet to be identified.
- 64 In 2024, Audit Wales reviewed the Health Board's approach to Cost Savings. Of the 11 recommendations in that report, the Health Board has made good progress: nine are complete, one is in progress, and one has not yet started. Areas which require further progress are set out in **Appendix 2**.

## Financial management arrangements

- 65 The Health Board has a good approach to financial controls oversight. The Board reviews its Standing Orders and Standing Financial Instructions frequently, most recently in September 2025. It proactively assesses compliance with them. The Health Board completed a self-assessment against its Standing Financial Instructions this year, providing assurance to the Audit, Risk and Assurance Committee. This highlighted good compliance and some areas to improve, including meeting the break-even duty, clarity in workforce budgets for divisions, guidance on prepayments and policies on grant funding. Internal Audit will also undertake a compliance review of both Standing Orders and Standing Financial Instructions in 2025-26.
- 66 The Board delegates financial oversight to the Audit, Risk and Assurance Committee and the Finance and Performance Committee. These committees discharge their responsibilities appropriately. This includes overseeing reports on compliance with financial processes and controls, and assurances from internal audit and counter fraud work. The Health Board reports on high-value purchases and single tender actions, although there remains a lack of analysis of trends of single tender actions. This makes it hard to see if the Health Board is improving its approach to procurement.

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

## **Monitoring financial performance**

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

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

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

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

# Recommendations

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

## Recommendations

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

# Appendices

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# 1 About our work

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## Scope of the audit

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

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

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

## Audit questions and criteria

### Questions

Our audit addressed the following questions:

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

## Criteria

Our audit questions were shaped by:

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

## Methods

We reviewed a range of documents, including:

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

We interviewed the following key stakeholders:

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

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

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

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

## 2 Previous audit recommendations

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### Outstanding recommendations from previous structured assessment reports

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

#### 2022 Recommendation 2

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

#### 2022 Recommendation 7

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

#### 2023 Recommendation 1

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

### 2023 Recommendation 2

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

### 2023 Recommendation 3

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

### 2023 Recommendation 6

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

### 2024 Recommendation 1

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

- 1.1 Ensure the organisation's new long-term strategy and clinical services plan clearly defines the required sustainable service solutions and decisions for the medium to longer term. This should include a strong focus on population health and prevention **(Complete, paragraph 43)**;
- 1.2 Ensure there is comprehensive engagement with clinical and other staff across all domains of the organisations service provision to feed into the development of the clinical services plan **(Complete, paragraph 43)**;  
and
- 1.3 Publish well-being objectives either alongside or within its new long-term strategy and ensure Well-being of Future Generations (2015) Act requirements are an integral part of the strategy **(Complete, paragraph 43)**.

### 2024 Recommendation 2

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

### 2024 Recommendation 3

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

### 2024 Recommendation 4

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

- 4.1 introducing a self-assessment on Standing Financial Instruction compliance **(Complete, paragraph 65)**; and
- 4.2 ensuring Single Tender Action reports include total contract values, setting out whether Board or Welsh Government approval was needed, and provide trend analysis of numbers and total values of Single Tender Actions for comparative periods in previous years **(Not yet started, paragraph 66)**.

### 2024 Recommendation 5

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

### 2024 Recommendation 6

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

**2024 Recommendation 7**

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

**2024 Recommendation 8**

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

**2024 Recommendation 9**

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

## Recommendations from our 2024 Review of Cost Savings Arrangements

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

### Recommendation 1

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

### Recommendation 2

- 2.1 The Health Board should clearly demonstrate how the savings and efficiency ideas that it canvasses from its staff are then used to inform and shape deliverable savings schemes **(Complete, paragraph 61)**.
- 2.2 The Health board should put clear arrangements in place to canvass savings and efficiency ideas from service users and other stakeholders **(Complete, paragraph 61)**.

### Recommendation 3

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

### Recommendation 4

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

**Recommendation 5**

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

**Recommendation 6**

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

**Recommendation 7**

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

**Recommendation 8**

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

**Recommendation 9**

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

**Recommendation 10**

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

### 3 Management response

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	<p>The Health Board should report every six months to the Audit, Risk and Assurance Committee compliance with declarations of interest by staff cohort, identifying actions the Health Board are taking to address non-compliance (paragraph 13).</p>	<p>The Health Board has an established implementation plan for embedding the Standards of Business Conduct Policy. This plan includes monitoring compliance across staff cohorts and identifying areas of non-compliance.</p> <p>Findings from this monitoring will inform twice-yearly reports to the Audit, Risk and Assurance Committee, which will include details of actions being taken to address any non-compliance.</p>	April 2026	Director of Corporate Governance / Head of corporate Governance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	To ensure that the staff voice is heard at Board, the Health Board should ensure that staff stories are routinely used at both Board and committee meetings (paragraph 23).	The Board's Forward Workplan for 2026/27 will include a specific commitment to routinely incorporate staff stories at both Board and committee meetings to ensure the staff voice is heard. In addition, the Health Board is exploring informal mechanisms to further enhance staff engagement at Board level.	April 2026	Director of Corporate Governance / Board Business Manager
R3	The Health Board should ensure that reports to the Patient, Quality, Safety Outcomes Committee highlight issues raised through patient safety leadership walk rounds and the actions to address them (paragraph 24).	Reporting of issues identified during Patient Safety Leadership Walk Rounds, along with the actions taken to address them, is now embedded within the Health Board's governance framework. These issues and corresponding actions are captured in the Performance Report, which is formally submitted to the Quality	December 2025	Medical Director/ Assistant Director for Quality and Patient Safety

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>Management Group (QMG) and subsequently to the Patient, Quality, Safety Outcomes Committee (PQSOC).</p> <p>The first update was presented to QMG in November and will be reported to PQSOC on 2nd December, with ongoing updates provided every two months thereafter.</p> <p>Each report will include a summary of issues identified, actions taken, and progress against those actions to ensure transparency and assurance.</p> <p>In addition, the Performance Report will also be presented to the Executive Committee, providing comprehensive oversight. Responsibility for</p>		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>maintaining this reporting process rests with the Director of Nursing, ensuring that this approach remains a standard part of the Health Board's governance arrangements.</p>		
<b>R4</b>	<p>The Health Board should redevelop its Quality Outcomes Framework report to better highlight issues and provide assurance. This should include improving the report format, presentation of data, trends, targets and actions (paragraph 37).</p>	<p><b>Phase 1 – Report Redesign</b> Improvements to the Quality Outcomes Framework (QOF) report format will be evident in the Q2 report presented to PQSOC in December 2025. Key enhancements include:</p> <ul style="list-style-type: none"> <li>• A redesigned layout that is shorter, more concise, and standardised for consistency.</li> <li>• Enhanced visual presentation of data using run charts to show variation and trends over time.</li> </ul>	<p>Phase 1 31 December 2025</p>	<p>Executive Director of Nursing / Deputy Director of Nursing</p>

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<ul style="list-style-type: none"> <li>• Clear definitions accompanying each metric to explain what is being measured and why it matters.</li> <li>• Inclusion of performance against agreed targets alongside actual results to strengthen assurance.</li> <li>• A dedicated section outlining implications and associated improvement actions to address areas of concern and improve patient outcomes.</li> </ul> <p><b>Phase 2 – Enhanced Statistical Analysis</b> The QOF report will transition to Statistical Process Control Charts (SPCC), enabling statistically</p>	Phase 2 28 February 2026	Executive Director of Nursing / Deputy Director of Nursing

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

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		trends, targets, and improvement actions across the framework.		
R5	To provide targeted assurance on local quality issues, the Health Board should ensure its clinical audit plan includes local clinical audit activity, which is determined through a risk based assessment and appropriately resourced (paragraph 38)	<p>The Health Board has adopted a phased approach to strengthening local clinical audit arrangements.</p> <p>Phase one has focused on establishing the Corporate Local Audit Plan, which provides a structured method for developing audit activity aligned to Health Board level risks, national and local standards, and strategic priorities. This ensures our corporate audit activity is driven by a clear, risk based assessment of organisational need.</p> <p>Phase two will involve working closely with Directorates and</p>	31 March 2027	Medical Director/ Assistant Director for Quality and Patient Safety

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>Divisions to support them in developing their own local clinical audit plans. These plans will be grounded in:</p> <ul style="list-style-type: none"><li>• risks identified on directorate risk registers,</li><li>• themes and issues arising from quality and safety processes, and</li><li>• opportunities to use audit as a structured method for learning, assurance and improvement.</li></ul> <p>We recognise that the absence of fully established directorate level plans remains a current gap. However, the work underway demonstrates clear progress toward a sustainable model of audit governance.</p>		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>To ensure this activity is appropriately resourced, we are providing dedicated support through the Clinical Audit and Quality Improvement teams, who will work alongside Directorates to prioritise activity, build local audit capability, and ensure alignment with the Health Board's audit governance framework.</p> <p>This phased approach will ensure the development of embedded, risk based, directorate owned local audit programmes that provide targeted assurance on local quality issues and drive continuous improvement across services</p>		

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R6	<p>The Health Board should introduce a Patient, Quality, Safety Outcomes Committee audit tracker for recommendations from other review bodies, including Healthcare Inspectorate Wales and Public Services Ombudsman for Wales (paragraph 42).</p>	<p>The Health Board will record and monitor recommendations and actions from Healthcare Inspectorate Wales and the Public Services Ombudsman for Wales through the Audit Management and Tracking (AMaT) system.</p> <p>AMaT reporting will be integrated into the Patient, Quality, Safety Outcomes Committee's assurance process to ensure oversight of progress and completion.</p>	28 February 2026	Executive Director of Nursing / Deputy Director of Nursing

## 4 Key terms in this report

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

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

# About us

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

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

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



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