

Audit, Risk and Assurance Committee

- Main Meeting

Tue 28 April 2026, 09:30 - 11:30

Agenda

1. PRELIMINARY MATTERS

 ARAC 20260428 Agenda - Main Meeting Final.pdf (3 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absense

Oral *Chair*

1.3. Declarations of Intrest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 12 February 2026

Attached *Chair*

 ARAC 20260428 1.4 20260212 Main Meeting Minutes - Chair Approved.pdf (8 pages)

1.5. Committee Action Log and Matters Arising

Attached *Chair*

 ARAC 20260428 1.5 20260212 Action Log - Chair Approved.pdf (5 pages)

1.5.1. Revisit Records Management Internal Audit

Oral *Head of Internal Audit*

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

2.1. To Approve reviewed and updated Financial Control Procedures

Attached *Director of Finance and procurement*

-  ARAC 20260428 2.1 Finance Governance Report - 28.04.26.pdf (13 pages)
-  ARAC 220260428 2.1a Appendix 1 ABUHB_Finance_0245 FMS General Ledger_Final.pdf (13 pages)
-  ARAC 20260428 2.1b Appendix 2 ABUHB_Commissioning_0891 Commissioning Additional Non NHS Clinical Services_Final.pdf (11 pages)

2.2. To Agree the Counter Fraud Annual Work Plan 2026/27

-  ARAC 20260428 2.2 Annual Plan 26-27 Cover Sheet.pdf (4 pages)
-  ARAC 20260428 2.2a ABUHB Counter Fraud Work Plan 2026-2027 Final .pdf (13 pages)

2.3. To Approve Audit Recommendation Tracking report

Attached *Director of Corporate Governance*

 ARAC 20260428 2.3 Internal_External Audit Recommendations Cover Report.pdf (8 pages)

-  ARAC 20260428 2.3a Appendix A Completed Audit Recommendations.pdf (5 pages)
-  ARAC 20260428 2.3b Appendix B Revised Deadline Requests.pdf (6 pages)
-  ARAC 20260428 2.3c Appendix C Exceeding Extension Threshold.pdf (3 pages)

3. ITEMS FOR DISCUSSION

3.1. To Receive Report of Losses and Special Payment

Attached *Director of Finance and Procurement*

-  ARAC 20260428 3.1 Losses Report Feb 26.pdf (9 pages)

3.2. To Receive Report on the use of Single Tender Action

Attached *Director of Finance and Procurement*

-  ARAC 20260428 3.2 Single Tender Action Report - 01.11.2025 - 31.03.2026 (003).pdf (4 pages)

3.3. To Receive the Internal Audit Progress Report

Attached *Head of Internal Audit*

-  ARAC 20260428 3.3 ABUHB April 2026 Internal Audit Progress Report .pdf (9 pages)

3.4. To Receive Internal Audit Reports

Attached *Head of Internal Audit*

- Strategic Risk and Assurance Report (reasonable)
- Capital Projects: Service Readiness Report (reasonable)
- Directorate Review – CAMHS (reasonable)
- Occupational Health (reasonable)

-  ARAC 20260428 3.4a ABU-2526-03 Strategic Risk & Assurance Final Report for Client.pdf (9 pages)
-  ARAC20260428 3.4b ABUHB 2526 07 Capital Projects Service Readiness Final IA Report.pdf (13 pages)
-  ARAC20260428 3.4c ABU-2526 09 Final Directorate review CAMHS IA Report.pdf (10 pages)
-  ARAC20260428 3.4d ABU 2526 18 Occupational Health Final Internal Audit Report for Client.pdf (14 pages)

3.5. To Agree the Internal Audit Annual Workplan 2026/27

Attached *Head of Internal Audit*

-  ARAC20260428 3.5 ABUHB DRAFT Internal Audit Plan 2026-27 v2.1 for ARAC.pdf (29 pages)

3.6. To Review the Draft Internal Audit Opinion and Annual Report

Attached *Head of Internal Audit*

-  ARAC20260428 3.6 ABU DRAFT HIA Opinion and Annual Report 2025-26 v2.pdf (27 pages)

3.7. To Receive the External Audit Progress Report 2025/26

Attached *Audit Wales*

-  ARAC20260428 3.7 ABUHB Audit Committee Update April 2026.pdf (10 pages)

3.8. To Agree the External Audit Annual Plan 2026/27

Attached *Audit Wales*

-  ARAC20260428 3.8 ABUHB Audit Plan 2026.pdf (23 pages)

3.9. To Receive the Audit Wales Digital Transformation Report

Attached *Audit Wales*

4. ITEMS FOR INFORMATION

4.1. To receive the Committee Programme of Business 2026/27

Attached *Chair*

- ARAC 20260428 4.1 Audit, Risk and Assurance Committee Forward Work Plan Cover Report.pdf (3 pages)
- ARAC 20260428 4.1a ARA Committee Work Programme 2026-27.pdf (7 pages)

4.2. To receive the Regional Integration Fund Audit Wales Report

Attached *Audit Wales*

- ARAC 20260428 4.2 Managing-the-Regional-Integration-Fund.pdf (51 pages)

4.3. Internal Audit Briefs

Attached *Head of Internal Audit*

- Benefits Realisation Audit Brief
- Overseas Recruitment Audit Brief
- Professional Staff Registration
- Cancer Referral Rates Audit Brie

- ARAC 20260428 4.3a Final Internal Audit Brief - ABU-2526-05 Benefits Realisation v1.1.pdf (3 pages)
- ARAC 20260428 4.3b ABUHB Overseas Recruitment Final Audit Brief.pdf (4 pages)
- ARAC 20260428 4.3c ABUHB 2526 10 Professional Registration Final Internal Audit Brief.pdf (3 pages)
- ARAC 20260428 4.3d ABU-2526-17 Cancer Referral Rates Final Audit Brief Client Issue.pdf (3 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 Next Meeting: Tuesday 19th May 2026

AUDIT, RISK & ASSURANCE COMMITTEE MAIN MEETING AGENDA

Date and Time

Tuesday 28th April 09:30

Venue

Microsoft Teams

Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 12 February 2026	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
1.5.1	Revisit Records Management Internal Audit	Oral	Head of Internal Audit
2	ITEMS FOR APPROVAL/RATIFICATION/DECISION		
2.1	To Approve reviewed and updated Financial Control Procedures	Attached	Director of Finance and Procurement
2.2	To Agree the Counter Fraud Annual Work Plan 2026/27	Attached	Head of Counter Fraud
2.3	To Approve Audit Recommendation Tracking report.	Attached	Director of Corporate Governance
3	ITEMS FOR DISCUSSION		
3.1	To Receive Report of Losses and Special Payment	Attached	Director of Finance and Procurement
3.2	To Receive Report on the use of Single Tender Action.	Attached	
3.3	To Receive Internal Audit Progress Report	Attached	



3.4	To Receive Internal Audit Reports • Strategic Risk and Assurance Report (reasonable) • Capital Projects: Service Readiness Report (reasonable) • Directorate Review – CAMHS (reasonable) • Occupational Health (reasonable)	Attached	Head of Internal Audit
3.5	To Agree the Internal Audit Annual Workplan 2026/27	Attached	
3.6	To Review the Draft Internal Audit Opinion and Annual report 2025/26	Attached	
3.7	To Receive the External Audit Progress Report 2025/26	Attached	Audit Wales
3.8	To Agree the External Audit Annual Plan 2026/27	Attached	
3.9	To Receive the Audit Wales Digital Transformation Report	Attached	
4	ITEMS FOR INFORMATION		
4.1	To receive the Committee Programme of Business 2026/27	Attached	Chair
4.2	To receive the Regional Integration Fund Audit Wales Report	Attached	Audit Wales
4.3	Internal Audit Briefs • Benefits Realisation Audit Brief • Overseas Recruitment Audit Brief • Professional Staff Registration • Cancer Referral Rates Audit Brief	Attached	Head of Internal Audit
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 19 th May 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



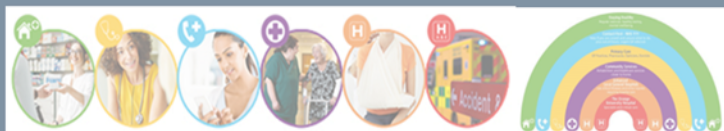
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DATE OF MEETING	Thursday 12 th February 2026
VENUE	Microsoft Teams

PRESENT	Iwan Jones - Committee Chair – Independent Member Dafydd Vaughan - Independent Member Neil Patrick - Independent Member Helen Sweetland – Independent Member
IN ATTENDANCE	Rani Dash - Director of Corporate Governance Rob Holcombe - Director of Finance and Procurement Rob Jones - Assistant Finance Director Stephen Chaney - Head of Internal Audit Eifion Jones – Deputy Head of Internal Audit Sara Utleby - Performance Audit Lead, Audit Wales Julie Rees - Audit Wales Finance Audit Lead, Audit Wales Paul Solloway – Director of Digital Danielle Jackson - Secretariat
OBSERVING	None to note
APOLOGIES	Lucy Windsor – Head of Corporate Assurance



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Minute Reference	Preliminary Matters
ARAC 0212/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
ARAC 0212/02	Apologies for Absence Apologies were noted.
ARAC 0212/03	Declarations of Interest There were no declarations of interest raised to record.
ARAC 0212/04	Minutes of the previous meeting The minutes of the meeting held on the 22 January 2026 were agreed as a true and accurate record.
ARAC 0212/05	Committee Action Log The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due. Rani Dash (RD), Director of Corporate Governance, highlighted the action relating to alignment of job planning reporting (2110/05), noting it had been routed to the People & Culture Committee and would return to ARAC via ongoing audit recommendation tracking. Iwan Jones (IJ), Committee Chair, confirmed the item could now be Completed on the ARAC action log. ACTION: Secretariat The Committee AGREED that completed actions could be removed from the Action Log.
ARAC 0212/06	Update on Records Management Audit Following Review of Management Responses Paul Solloway (PS), Director of Digital, presented a comprehensive update on progress since the December 2024 Internal Audit that had concluded limited assurance for records management, and the subsequent Board Development session in June 2025. It was reported that: Standards & awareness: The Records Management Team had completed 63 ward visits; records management content had been submitted to the Core Learning Committee for potential mandatory status; standards were included in Ward Accreditation; content had been introduced at Corporate Induction; a Health Record Support Network (100+ members) had been launched; and a staff survey was in progress.



Storage: Security at Nevill Hall Hospital had been improved (locks, secure doors) and live records were being moved to Online House. At St Cadoc's Hospital, the Mental Health archive store had been emptied, records transferred to Online House, and keys returned to Estates; removal of records from Langstone and Goldcliffe areas was targeted by end-March; other St Cadoc's locations had been reviewed and deemed fit for purpose.

Tracking & systems: Training improvements were underway; a WPAS Product Team had been established to drive lifecycle improvement and usage; all ward clerks had access to WNCR; and progress continued with digitisation.

Stephen Chaney (SC), Internal Audit, observed that estates constraints had historically amplified storage/security risks, but confirmed the steps reported by PS were positive. SC proposed that Internal Audit would refresh the 2024 findings through its annual follow-up, with a more detailed review considered in 2026/27.

Neil Patrick (NP), Independent Member, sought assurance on disaster recovery/back-ups for digitised records. PS confirmed fault-tolerant systems with tested backup procedures were in place, noted a required C-Cube system upgrade was on the risk register, and advised mitigating controls were operating pending upgrade completion.

Dafydd Vaughan (DV), Independent Member, asked about the Online House lease and possible alternative storage. PS confirmed work with Estates to extend the lease given limited regional alternatives, alongside a longer-term plan to accelerate scanning and reduce creation of new paper (e-forms), ultimately reducing need for a scanning bureau. Alternative third-party storage would be explored, noting prior closure of a Llanelli facility following space gains at Online House.

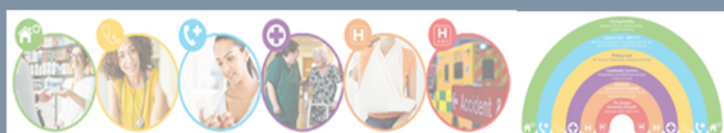
It was requested that the Records Management Internal Audit report be reviewed and updated, with the revised version presented to the Committee.



	ACTION: Director of Digital and Internal Audit The Committee NOTED the significant progress and governance routes for the below requests. • Mandatory training to be progressed via the Core Learning Committee/People & Culture governance route. • Corporate induction changes to be considered via People & Culture. • Lease extension to progress via the Executive Committee. ACTION: Secretariat
	ITEMS FOR APPROVAL / RATIFICATION / DECISION
ARAC 0212/07	To Approve the Committee Annual Programme of Business 2026/27 Rani Dash (RD), Director of Corporate Governance, introduced the 2026/27 programme for approval, noting prior circulation for comment. The Committee APPROVED the 2026/27 Audit, Risk and Assurance Forward Work Programme.
ARAC 0212/08	To Approve the Audit Recommendations Tracking Report Rani Dash (RD), Director of Corporate Governance, presented the tracker, drawing attention to 31 recommendations marked as completed and 31 requests for revised implementation deadlines that required Committee Approval. Dafydd Vaughn (DV), Independent Member, and Iwan Jones (IJ), Committee Chair, queried several older, persistent items (notably digital/technology actions and records-related items) and proposed a targeted review of all actions pre-2023 to confirm ongoing relevance, closure potential, and whether some actions sat outside the Health Board's direct control. Stephen Chaney (SC), Head of Internal Audit, supported this, noting significant areas often received subsequent follow-up work which could affect the status/relevance of earlier recommendations. Paul Solloway (PS), Director of Digital, added context on inherited digital actions (e.g., Digital Strategy refresh due end-March; Shadow IT audit in progress; WRIS actions expected to fall away



	on system replacement) and therefore agreed that it would be a good time for a deep dive. ACTION: Head of Corporate Risk and Assurance
ARAC 0212/09	To Approve Reviewed and Updated Financial Control Procedures. Robert Holcombe (RH), Director of Finance and Procurement, introduced, and Robert Jones (RJ), Deputy Finance Director presented, the four Financial Control Procedures requiring review and one new policy for Grant Funding arising from the SFI self-assessment. The Committee queried timing risks for year-end accounts; RJ and Julie Rees (JR), Audit Wales Finance Manager, confirmed there were no issues anticipated. The Committee APPROVED the four updated Financial Control Procedures: Purchasing Cards, Engaging Off Payroll Workers, Patients Property, Procurement Policy and the new Grant Funding Policy.
	ITEMS FOR DISCUSSION
ARAC 0212/10	To Consider the Approach and Timelines for the Annual Report and Account Rani Dash (RD), Director of Corporate Governance, outlined the proposed structure and timetable aligned to the draft Manual for Accounts, noting the AGM date would be confirmed with the incoming Chair. Iwan Jones (IJ), Committee Chair, acknowledged the scale of work; RD confirmed the approach largely represented updates within an unchanged structure. The Committee NOTED the Approach and timetable.
ARAC 0212/11	To Receive the Internal Audit Progress Report



Stephen Chaney (SC), Head of Internal Audit, presented the progress report. and highlighted suggested planning amendments:

- Clinical Audit (Local Plans) work be deferred to Q3/Q4 2026/27 to allow the end-to-end process (local plans, actions, monitoring) to embed.
- Six Goals Programme review be deferred given overlap with a recent Audit Wales review and replaced with coverage of Primary & Community Care in 2026/27 instead.
- Ophthalmology & ENT (Directorate Review) work to commence this year and continue into 2026/27 to include cataract funding (regional arrangements and value for money). Rob Holcombe (RH), Director of Finance and Procurement, noted most expenditure had been through tendered external capacity, suggesting a straightforward Value for Money assessment; SC agreed to liaise off-line.
- Proposed reframing the Space Utilisation Capital Audit from Assurance to Advisory to enable wider comparative, transformational insights across organisations. Neil Patrick (NP), Independent Member, asked about implications; SC clarified the advisory scope would be more strategic, albeit without a rating.

It was confirmed that the draft annual opinion and the 2026/27 plan would be brought to the April meeting.

The Committee **NOTED** the report and **APPROVED** all deferrals and scoping changes were approved as set out above.



ARAC 0212/12	To Receive the External Audit Progress Report 2025–26 Julie Rees (JR), Finance Lead Audit Wales, reported that the 2024/25 Charitable Funds audit had completed by 28 January with no issues to report, and that planning and early testing for the 2025/26 Annual Report & Accounts audit were underway and an Audit Plan for April ARAC would set out identified audit risks and responses. Sara Utley (SU), Performance Audit Lead Audit Wales, summarised the Performance Audit pipeline (GP managed contracts; Structured Assessment deep-dives - digital systems, Estates and Cancer services), noting linking points with Internal Audit and that deep-dive branding reflected 2024/25 programme funding despite contemporary fieldwork. The Committee NOTED the report.
ITEMS FOR INFORMATION	
ARAC 0212/13	To Receive Internal Audit Briefs of Audits Underway The Committee received three briefs from Audits Underway: • Falls Management • Divisional Budgetary Control • Discharge Planning The Committee NOTED for information.
ARAC 0212/14	Committee Programme of Business 2025/26 The Committee received the Programme of Business The Committee NOTED the report for information.
ARAC 0212/15	Structured Assessment 2025 – Final Sara Utley (SU), Performance Audit Lead, confirmed the final Structured Assessment 2025 report and management response had been included for information and that the report had previously been presented to ARAC and Board. The Committee NOTED the report.
OTHER MATTERS	

ARAC 1209/22	Items to be Brought to the Attention of the Board and Other Committees Records Management support requests: • Mandatory Training Proposal – To be considered by the Core Learning Committee / People & Culture Committee. • Corporate Induction Content – To be progressed through the People & Culture Committee. • Lease Extension for Online House – Requires development of a business case and escalation to the Executive Team and potentially the Finance & Performance Committee.
ARAC 1209/23	Any Other Urgent Business • Nothing reported.
ARAC 1209/24	Date of the next meeting Tuesday 28 th April 2026 09:30

DRAFT

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
September 2025	1809/06 Checklist for future projects	Provide a follow up report to assess the impact of the checklist.	Director of strategy, planning and partnerships	April 2026	Completed Evidence to be shown in future audit reports
October 2025	ARAC 2110/05 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	Completed Job Planning routed to the People & Culture Committee and would return to ARAC via ongoing audit recommendation tracking.
October 2025	To Receive the National Fraud Initiative (NFI) 2024 - 25	Report back to the Committee on the outcomes of the NFI review once completed.	Head of Counter Fraud	May 2026	Not Due Included within the Counter Fraud Annual report



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
December 2025	ARAC 1216/08 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	In Progress This will be presented at the May meeting, which sits between Q4 and Q1, to ensure that a more comprehensive review can be completed.
January 2026	ARAC 0122/09 To Receive an Assurance Report on Systems and Processes to Improve Discharge Performance, linked to Audit Recommendations.	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	In Progress This will be presented at the May meeting, which sits between Q4 and Q1, to ensure that a more comprehensive review can be completed.



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	ARAC 0212/06 Update on Records Management Audit Following Review of Management Responses	Revisit Records Management Audit report and return to Committee	Director of Digital and Internal Audit	April 2026	Completed Interim follow-up type review scheduled for Q2 of the 2026/27 Internal Audit Plan.
February 2026	ARAC 0212/06 Update on Records Management Audit Following Review of Management Responses	Mandatory training to be progressed via the Core Learning Committee/People & Culture governance route.	Director of Digital	To be confirmed by relevant Committee Secretariat and Director of Digital	Completed Core Learning Committee will feed into People and Culture Committee



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	ARAC 0212/06 Update on Records Management Audit Following Review of Management Responses	Corporate induction changes to be considered via People & Culture.	Director of Digital	To be confirmed by relevant Committee Secretariat and Director of Digital	Completed Induction changes have been enacted.
February 2026	ARAC 0212/08 To Approve the Audit Recommendations Tracking Report	Complete a targeted review of all actions pre-2023 to confirm ongoing relevance, closure potential, and whether some actions sat outside the Health Board's direct control.	Head of Risk and Assurance	May 2026	Not Due



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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial governance, reporting & control
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Finance Director – Financial Systems & Services

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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

The Audit, Risk and Assurance Committee is requested to:

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



- Financial Management System General Ledger (Appendix 1)
- Commissioning Non-NHS Clinical Services (Appendix 2)

The Financial Control Procedures presented were considered and approved by the Executive Committee at their meeting on the 09th April 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:

- Financial Management System General Ledger (Appendix 1)
- Commissioning Non-NHS Clinical Services (Appendix 2)

Together with a summary of all FCP review dates.

1.1. Financial Management System General Ledger

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

The Financial Management System (FMS) is the Health Board's primary financial platform, providing a structured and reliable framework for managing and reporting all financial activity.



As a core component of this system, the General Ledger (GL) plays a critical role by recording every financial transaction for Aneurin Bevan University Health Board (ABUHB) using a computerised double-entry bookkeeping method. The GL acts as the central repository of financial data within the FMS, ensuring the integrity, accuracy and completeness of information that underpins both financial accounting and management reporting.

The document has been circulated for comment as follows:

- Finance Manager – Central Management Accounts
- Head of Financial Services & Accounting
- Head of Business Systems and Governance
- Assistant Finance Director – Financial Systems and Services
- NWSSP – Audit and Assurance Services

Section	Name	Main Changes
1	Introduction	References to 'Oracle' amended to 'Financial Management System' Clarification of the Financial Management System and General Ledger as a core component for holding financial data
6	Roles & Responsibilities	6.4 Financial Planning and Performance – Responsibility added to confirm that the General Ledger is consistent with the Monthly Monitoring Return and rollover of budgets
7	General Ledger	7.1.4 Password Protection System – Amended password complexity rules to reflect a password is required to be 12 characters in length; contain at least one letter and one number; not contain consecutive characters. A Welsh Government recommendation, enforced by NWSSP Central Team eBusiness Services across NHS Wales 7.2.3 Maintenance of Account Codes and Hierarchy – Segment Descriptions and format - Section expanded to explain the five segment coding structure with examples of how to use 7.2.8 Maintenance of Account Codes and Hierarchy – Expenditure Financial Code Combinations – Clarification that expenditure code combinations not previously used, but where all five elements have been created, will automatically be created by the system 7.2.10 Maintenance of Account Codes and Hierarchy – Budget Financial Code Combinations – Clarification that where requested budget code combinations have not previously been used for expenditure, but have all five elements created, Finance users will be required to manually link 7.3.4 Manual Journal Entries – Clarification that only Finance staff are authorised to input journals into the General Ledger added 7.3.6 Control Checks on Journals – Financial Planning and Performance team process to review budget on a monthly basis added. Central Management Accounts Team and Business Partner Accountants quarterly review of accruals posted added



7.5 Reporting Timetables – Paragraph expanded to highlight responsibility, collaboration and communication

7.6 Monthly and Annual Reporting – Section added to reflect the Financial Planning and Performance team’s process to review and confirm the reported monthly financial position and roll over of annual budget.

1.2. Commissioning Non-NHS Clinical Services

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

The procedure provides a framework and guidance for use when considering commissioning additional services to support patient care improvements.

It is specifically applicable when engaging non NHS providers and suppliers of health services.

The scope applies to both externally commissioned and insourced services, where external providers operate within Health Board premises.

The document has been circulated for comment as follows:

- Finance Business Partner - Contracting
- Assistant Finance Director – Financial Strategy, Planning and Capital
- NWSSP – Audit and Assurance Services

Section	Name	Main Changes
3	Commissioning Non NHS Clinical Services	D What are the Operational Management Factors to Consider? Project Group - Addition that an Independent Member of the project group may be appropriate to sit on the supplier interview panel - Change of name from 'The Aneurin Bevan Community Health Council' to 'Llias'
4	Related Procedures	Section added to sign post relevant procedures
5	Further Information	Finance Business Partner – Contracting added as a point of enquiry



Summary Position on Financial Control Procedures

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

FCP	Year Due	Approved	Committee Approved	Review Date	Notes
General Ledger	26/27	Due for review	Apr-23	18-Apr-26	Presented in Apr 26
Commissioning Non NHS Clinical Services	26/27	Due for review	Apr-23	18-Apr-26	Presented in 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	
Engaging Off Payroll Workers	28/29	Y	Feb-26	12-Feb-29	
Patients' Property	28/29	Y	Feb-26	12-Feb-29	
Purchasing Cards	28/29	Y	Feb-26	12-Feb-29	
Procurement Policy	28/29	Y	Feb-26	12-Feb-29	
Grant Funding	28/29	Y	Feb-26	12-Feb-29	

2. Technical Accounting Issues

Technical updates

Since the last committee meeting in February 2026, there have been three technical accounting updates issued by Welsh Government.

Update Note 6 covered the following area:

- 2025/26 Losses**

Confirmation that organisations needed to submit approval requests for novel/contentious losses for 2025/26 to Welsh Government by 12 March 2026.

The Health Board did not have any novel or contentious losses to report for 2025/26 prior to the 12 March 2026 deadline. The Health Board has subsequently been requested to report the loss relating to the Band 2-3 settlement in order to support funding allocations in the closing 2025/26 allocation round which is agreed outside this deadline.



- **2025/26 NHS Charities Accounts – Materiality**

Template required to be submitted by organisations with confirmation that the 2025/26 Charitable Accounts did not exceed the materiality threshold of £30m for any of the following:

- Gross Assets,
- Gross Liabilities,
- Gross Income, or
- Gross Liabilities.

The Aneurin Bevan Health Charity does not exceed the materiality threshold. Gross Assets at the 31st December 2025 were £4.5m, as reported to the Charitable Committee on the 18th April. There was little movement to this figure to 31st March 2026.

The Corporate Finance Team submitted the confirmation on behalf of the Health Board by the deadline of 26th March.

- **2025/26 NHS Charities Accounts - Leases**

Confirmation required to Welsh Government whether the Charitable Accounts held any operating or finance leases which would fall within the scope of IFRS 16.

Confirmation that the Aneurin Bevan Health Charity held no such leases was submitted to Welsh Government by the Corporate Finance team by the deadline on the 18th February 2026.

- **Transfers**

For organisations where an asset transfer was processed in 2025/26, final transfer values (by 6th March) and signed S1/ S2 forms (by 26th March) were required to be submitted to Welsh Government.

The Health Board had one transfer of asset in 2025/26, where we received equipment from Powys Teaching Health Board in August 2025. The final asset values and signed S1/ S2 forms were submitted to Welsh Government in January.

- **Last Day for Cash Payments between NHS Organisations and Welsh NHS Charitable Funds**

Confirmation from Welsh Government that the final date for receipt of payments between NHS Wales organisations, including Welsh Government, was to be 24th March 2026.

This is to enable clean ledgers, from a receipting and baking perspective, for all organisations towards the 31st March and year-end ledger closure.

- **Non-Cash Requests**

Confirmation from Welsh Government that the final date for organisations to make changes to the 2025/26 AME Non-Cash Returns is the 17th April.



- **Arbitration Deadlines**

Welsh Government issued a reminder that the final date to submit an arbitration case for transactions in 2025/26 is 16th April 2026.

It also noted that all invoices agreed as part of the Year-End Agreement of Balances should be paid by organisation within 4 weeks of year-end.

- **Year-End Arrangements for Notional Pensions**

Confirmation that the arrangements for Notional Pensions Returns will follow the same as previous years, and returns should be submitted to Welsh Government by noon on the 10th April.

The Notional Pensions returns relate to 9.4% pension element that is covered by Welsh Government. The Health Board are required to confirm the total pensions paid in the year to employees to identify the total notional element which is funded by Welsh Government.

- **Cash Arrangements**

Confirmation that Strategic Cash and Working Balances Cash Support, (including IFRS 16), would be available to be drawn down on the 17th of March.

The Health Board received the following Cash Support in March:

- Revenue Strategic Cash of £18.314m,
- Revenue Working Balances Cash of £1.471m, and
- Capital IFRS 16 Working Balances Cash of £3.868m.

- **Return of LHB/ SHA Bank Interest**

Bank Interest Forms were required to be submitted by the 6th March. Interest net of bank charges, as reported in the Annual Accounts, is payable to Welsh Government in 2025/26 before 31st March. Subsequently, any monies received are returned by Welsh Government to HM Treasury.

The Health Board had a nil return for 2025/26, as it did not receive any interest from its' bank account, as it is a non-interest-bearing Government banking account.

Update Note 7 covered the following areas:

- **Pension Annual Allowance Compensation Scheme (PAACS) Provision Details**

Confirmation that the information for the PAACS Provision will be provided by Welsh Government, following their meeting with the Government Actuary Department in March.

It was confirmed that the information would be issued by Welsh Government on the 9th April.

The PAACS Provision is a notional payment, which is funded by Welsh Government.



- **Welsh Risk Pools**

Confirmed template and timetable for submissions of the Welsh Risk Pool quarterly AME return provided by Welsh Government.

The Welsh Risk Pool AME return confirms the total Welsh Risk Pool debtor and provisions in relation to Clinical Negligence and Personal Injury that are included in the 2025/26 Annual Accounts for the Health Board.

It is important that both the Health Board and NWSSP (as hosts of the Welsh Risk Pool) report the same balances to ensure consolidation within the Welsh Government accounts.

Update Note 8 covered the following areas:

- **Non-Cash DEL**

It has been confirmed that as of 1st April 2026, the non-cash DEL budgets will be replaced by non-cash AME budgets. As a result, all non-cash will now be treated as AME.

All information previously provided in relation to non-cash DEL will be transferred into the appropriate AME budgets.

There is no impact on the Health Board, except for classification of non-cash funding, as reported through the Monitoring Returns and in-year non-cash returns.

- **Additional Radiology Information System Programme (RISP) Guidance**

Additional clarification and guidance issued by Welsh Government regarding the accounting entries organisations should use to recognise RISP in their ledgers for 2025/26 and beyond.

This confirmed guidance follows discussions in the Capital Technical Accounting Group on how organisations should recognise the Right of Use asset and associated Depreciation charges.

The guidance is based on the principles drafted by the Health Boards Capital Finance Manager.

- **Notional Pension**

Issuing of the Notional Pension information, which organisations are to use to calculate the Notional 9.4% contribution.

Organisations are required to ensure all information from April 2025 to February 2026 is correct, and update with March 2025 confirmed values. Organisations will subsequently receive the Single Lead Employer information from NWSSP, due by the 9th April, which need to be verified, prior to completing and submitting the notional pension return to Welsh Government by the deadline on the 10th April.



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

The 2025/26 Manual for Accounts was issued by Welsh Government on the 4th of March. There have been no changes to the Manual between draft and Final.

The key changes to the Manual from the 2024/25 accounts, as identified in February, are highlighted below.

Area of Change	What Has Changed	Impact on the Accounts
Annual Report – Remuneration Report	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.
Remuneration Relationship Note	Must report in £ not £000; nil rows hidden not deleted.	Numerical disclosure values appear 1,000× larger, though underlying costs unchanged
Financial Statement Templates	Capital note sections moved; revenue headings removed unless reinstated by WG.	Presentation in the note ordering and structure.
Asset Valuation Framework	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.
Land & Building Indices	Updated indices to 2030.	Indexation adjustments impact revaluation reserve and closing PPE carrying values.
Capital Provisions	Requirement to separately disclose capital provisions.	Provisions note expands to include new capital headings; presentation changes but totals unchanged.
IFRS 17 – Contract Assessment	Annual review required.	Expected nil impact, continuing prior assessment. <i>Would be changes to timing and method of revenue recognition.</i>
Interparty Leases (IFRS 16 Template)	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.
FR14 Lease Liability Return	Removed several data fields (funding split, cash/non-cash, agent role).	Supplementary disclosure reduced; no change to primary statements or IFRS 16 figures.
Losses & Tribunal Settlements	‘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>
Capital Scheme Derecognition Method	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>



Intangible Asset Valuation	Revaluation model withdrawn; historic cost basis adopted prospectively.	Revaluation reserve movements cease for intangibles; future values remain stable apart from amortisation.

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.

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



3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of March 2026 and on a cumulative basis for the 2025/26 Financial Year.

Category	Invoices	In Mth %	YTD %
NHS	Value	97.7	98.6
	Number	95.3	93.3
Non-NHS	Value	96.2	96.9
	Number	97.4	97.1

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditor invoices within 30 days of delivery of goods/services in March 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 March, as it has done every month since August. However, the Health Board has not achieved 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.

Whilst disappointing to have not achieved the target cumulatively in 2025/26, this has been the Health Boards best performance with regard to NHS PSPP figure over the last 5 years, and indicates that the target will be achieved in 2026/27.

Category	No. Invoices	YTD %
NHS	2021/22	87.0
	2022/23	88.6
	2023/24	88.5
	2024/25	91.9
	2025/26	93.3

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

There is no further updated with regard to the SFI's.



Argymhelliad / Recommendation

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

- Financial Management System General Ledger (Appendix 1)
- Commissioning Non-NHS Clinical Services (Appendix 2)

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	FCP – Financial Control Procedure PSPP – Public Sector Payment Policy NWSSP – NHS Wales Shared Services Partnership KPI – Key Performance Indicators SFI – Standing Financial Instructions



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

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





Aneurin Bevan University Health Board

Financial Control Procedure Financial Management System General Ledger

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

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

Issue date: DRAFT
Review by date: DRAFT
Policy Number: ABUHB/Finance/0245

Contents:	Page
1. Introduction	4
2. Policy Statement	4
3. Aims	4
4. Objectives	4
5. Scope	4
6. Roles and Responsibilities	5
6.1 Director of Finance, Procurement and Value	5
6.2 Business Systems Analyst	5
6.3 Accounts Receivable Manager	5
6.4 Financial Planning and Performance	5
6.5 NWSSP	6
7. FMS General Ledger	6
7.1 General Ledger System Access	6
7.2 Maintenance of Account Codes and Hierarchy	7
7.3 Information Input and Processing	9
7.4 Reconciliation of Control Accounts	11
7.5 Reporting Timetables	12
7.6 Monthly & Annual Reporting	12
8. Related Procedures	13
9. Further Information	13
10. Audit	13
11. Review	

FMS General Ledger – Do's and Don'ts

Do's

- ✓ Ensure adequate segregation of duties is maintained.
- ✓ Maintain physical security of all financial systems and records.
- ✓ Ensure access is restricted to authorised personnel only.
- ✓ Use individual usernames and strong passwords as required (minimum 12 characters, mix of letters and numbers, no repeating characters).
- ✓ Complete the required new user form and obtain delegated Budget Holder approval before system access is granted.
- ✓ Ensure all feeder system files (Payroll, Stock, Pharmacy) are processed in line with the monthly timetable.
- ✓ Reconcile feeder files to import data to confirm accuracy and completeness.
- ✓ Ensure all manual journals are balanced, correctly coded and include adequate narrative.
- ✓ Run month-end close routines and ensure all integrated system feeds are posted.
- ✓ Prepare and review balance sheet control account reconciliations monthly.
- ✓ Maintain documentation for any creation, amendment or deletion of account codes for audit purposes.

Don'ts

- ✗ Do not use generic usernames unless absolutely essential and approved by the Head of Business Systems and Governance.
- ✗ Do not share usernames or passwords with any other individual.
- ✗ Do not allow weak passwords or override password complexity requirements.
- ✗ Do not process journals without adequate justification, coding, balance, or narrative.
- ✗ Do not ignore missing or failed feeder system files – all must be investigated and resolved.
- ✗ Do not link capital subjectives to revenue codes or vice versa when creating financial codes.

1. Introduction

The Financial Management System (FMS) is the Health Board's primary financial platform, providing a structured and reliable framework for managing and reporting all financial activity.

As a core component of this system, the General Ledger (GL) plays a critical role by recording every financial transaction for Aneurin Bevan University Health Board (ABUHB) using a computerised double-entry bookkeeping method. The GL acts as the central repository of financial data within the FMS, ensuring the integrity, accuracy and completeness of information that underpins both financial accounting and management reporting.

2. Policy Statement

This procedure will highlight the responsibilities and appropriate processes of General Ledger (GL) users.

3. Aims

To ensure all General Ledger users are aware of appropriate procedures and controls.

4. Objectives

- Sufficient controls in place to ensure adequate segregation of duties
- Adequate physical security
- A clearly defined audit trail from source input documentation
- Access restricted to authorised personnel only
- Feeder systems are appropriate and operated in a controlled environment

5. Scope

This procedure details the controls underlying the ABUHB's General Ledger. It should be read in conjunction with the Health Board's [Standing Orders](#) and [Standing Financial Instructions](#).

6. Roles and Responsibilities

6.1 The Director of Finance, Procurement and Value

The Director of Finance, Procurement and Value is ultimately responsible for the security, integrity and accuracy of the General Ledger.

This responsibility is delegated to the Assistant Director of Finance (Financial Systems and Services) who in turn delegates to the Head of Business Systems and Governance with the operational management delegated to the Principal Finance Manager – Business Systems.

6.2 Business Systems Analyst

The Business Systems Analyst is responsible for the integrity of the hierarchical coding structure and ensuring that the General Ledger is in balance.

They are responsible for ensuring all daily, weekly and monthly feeds from sub ledgers and feeder systems are received and processed in accordance with the monthly timetable.

They will run month end close routines as per their standard operating procedures and adhere to month end close deadlines.

They are also responsible for user maintenance.

6.3 Accounts Receivable Manager

The Accounts Receivable Manager will run month end close routines, as per their standard operating procedures, and adherence to the month end close deadlines.

6.4 Financial Planning and Performance (FP&P)

The Financial Planning and Performance team (FP&P) will run reports at both month-end and year-end to ensure and confirm that the reported position is consistent with the Monthly Monitoring Return, which is submitted to Welsh Government.

FP&P are also responsible for confirming that budgets can be rolled-forward to future financial years.

6.5 NHS Wales Shared Services Partnership (NWSSP)

NHS Wales Shared Services Partnership (NWSSP) Accounts Payable will run month end close routines, as per the Accounts Payable standard operating procedure, and adherence to month end close deadlines.

7. FMS General Ledger

7.1 General Ledger Access

7.1.1 Access to the General Ledger is controlled via access levels. Access levels will be determined, for each individual user, or groups of users, dependent on their position and level of responsibility.

7.1.2 Access to the system will be by way of a username for each individual user. A [new user form](#) must be completed, signed by the appropriate delegated Budget Holder and emailed to abb.financebusinesssystems@wales.nhs.uk. Upon receipt of the form, the Business Systems Analyst will process and inform the user.

7.1.3 Generic usernames / accounts are sometimes used to enable system processes where there is no human interface. Such generic usernames and/or accounts will only be set up if absolutely necessary and only after approval by the Head of Business Systems and Governance.

The Head of Business Systems and Governance will ensure that where such generic accounts exist, they will be configured, or other controls will be in place to minimise the risk from damage of misuse.

7.1.4 In addition to the username, the General Ledger will also be protected by a password protection system.

- **Password expiry is not enforced.** Once set, passwords do not expire and only require changing if manually updated by the user, in line with current security guidance.
- **User accounts are locked after a defined number of failed login attempts.** Users are permitted a maximum of **three** unsuccessful login attempts before the account is automatically disabled.
- **Password complexity rules are enforced by the system to prevent the use of weak passwords**

- Passwords must:
 - be a **minimum of 12 characters** in length
 - contain **at least one letter and one number**
 - **not contain consecutive repeating characters**

7.1.5 A review of the General Ledger System access is completed by the Business Systems Analyst on a monthly basis.

7.2 Maintenance of Account Codes and Hierarchy

7.2.1 The General Ledger uses a five segment coding structure. Each segment has a defined purpose and format. When combined, all five segments form a Fully Qualified Account (FQA) that must be used for all financial transactions.

The structure is consistent across the organisation and ensures accurate financial reporting, budgetary control and statutory compliance.

The ABUHB's coding structure consists of five elements:

- Entity
- Cost Centre
- Subjective
- Analysis
- Other

When linked, all five elements form a valid financial code.

7.2.2 Segment descriptions and format as below:

Segment	Segment Name	What it Represents	How it is Used	Format / Length	Example
1	Entity	Identifies the legal entity within ABUHB	Distinguishes the statutory reporting entity	3 digits (numeric)	040
2	Cost Centre	Identifies the department, ward, service, or team	Used for budget ownership and management reporting	4 digits (alphanumeric)	8001 P001
3	Subjective	Identifies the type of income or expenditure	Determines the nature of the transaction (e.g. pay, supplies, income)	5 characters (alphanumeric)	33010 2K141

4	Analysis	Provides additional detail for reporting and analysis	Used for more granular financial analysis where required	4 characters (alphanumeric)	2250
5	Other	Reserved for future or specific reporting requirements	Typically defaults to a standard value unless otherwise instructed	6 digits (numeric)	000000

7.2.3 All requests for the creation, amendment or deletion of one of these five elements must be emailed to abb.financebusinesssystems@wales.nhs.uk . If requesting a new element, the requestor must specify where the new element fits into the segment hierarchy. Before creation, amendment or deletion, the Business Systems Analyst will check the validity of the request. Appropriate documentation relating to these requests should be maintained for audit purposes.

7.2.4 A common Subjective chart of accounts is maintained across all Health Boards and Trusts in Wales. Therefore, any creation or amendment to codes will be actioned by Central Team eBusiness Services (CTeS).

7.2.5 The Business Systems Analyst is responsible for maintaining the hierarchical coding structure and, prior to month and financial year ends, runs control reports to ensure the integrity of the hierarchical coding structure.

7.2.6 The Business Systems Analyst will annually perform a review of cost centres to ascertain the following:

- Zero actuals during the financial year
- Zero budget during the financial year

The results will be shared with the appropriate Business Partner Accountant and unless otherwise informed, will be closed.

Closed cost centres will only be removed from the hierarchy structure after 26 months, from point of closure, to ensure it is still visible for retrospective reporting purposes.

- 7.2.7** When a financial code combination is proposed for an expenditure transaction and has not previously been used, as long as all five elements of the code have been created, the General Ledger will automatically create it using its dynamic insert functionality. This means users do not need to manually set up new valid combinations in advance.
- 7.2.8** When a new code combination has been used for expenditure, the Business Systems Team will run a scheduled job in the FMS to add it to the budget area.
- 7.2.9** Where code combinations have not previously been used for expenditure and where all five segments have been created in the system, Finance users will be required to manually link.
- 7.2.10** Controls are applied through cross validation rules, which prevent invalid or inappropriate combinations from being created or used. These rules ensure that only compatible elements can be combined, for example preventing revenue cost centres from being used with capital subjective codes, or preventing Charitable Funds entities from being used with non charitable cost centres. Where a combination breaches these rules, the system will stop the transaction from being posted. Financial codes will be automatically validated, i.e., linking all five elements detailed in paragraph 7.2.1, when they are used in combination for the first time. Where possible, validation rules will be set in the system to help check the validity of the financial code e.g. that revenue codes are not being linked to capital subjective codes and vice versa.

7.3 Information Input & Processing

- 7.3.1** There are four methods of inputting financial information into the General Ledger:
- The processing of interface files from feeder systems.
 - The processing of feeds as part of an integrated system (e.g. AP/AR, Procurement)
 - Manual Journal Entry
 - File upload from a PC or linked system tool(e.g. RPA)
- 7.3.2** The processing of interface files from feeder systems forms part of the monthly timetable. The following feeder system financial information is fed into the General Ledger through interface files:

- Payroll – Weekly and Monthly
- Stock – Monthly
- Pharmacy - Monthly

The Business Systems Team will be notified electronically when a feeder file is ready for processing.

It is the responsibility of the Losses and Litigation Officer, in the Financial Accounting Team, to completely ensure that the payroll files transferred to the GL accurately reconcile to the Payroll System (ESR).

Reconciliation from the feeder file to the import data will be conducted by the Business Systems Team to ensure that no data has been lost or corrupted during the import process.

7.3.3 The General ledger is part of an integrated Financial Management System, which includes modules such as Accounts Payable and Accounts Receivable. The system will be set up to generate feeds either on a daily basis, weekly basis or at month end. The Business Systems Analyst will check at each month and year end that all the relevant system generated feeds have been imported and posted in the General Ledger.

The Head of Financial Services and Accounting is responsible for reconciling each module to the General Ledger Control Account Balances

7.3.4 Manual accounting entries (journals) can be input into the General Ledger by Finance staff only. Access to manual journal entry will be controlled via access security levels, as detailed in Section 7.1.1. Every manual journal input into the General Ledger should be uniquely identifiable, either by a unique header name for the journal or by a sequential number. Each journal should be balanced, include valid financial codes and adequate narrative.

7.3.5 Journals can be entered via a file upload (spreadsheet), either directly from the PC or using a software application tool linked to the General Ledger. Access to spreadsheet journal entry will be controlled via access security levels, as detailed in Section 7.1.1. Each journal should be uniquely identifiable, either by using a unique header name for the journal or by a sequential number. Each journal should be balanced, include valid financial codes and adequate narrative.

7.3.6 Control checks on journals include:

- All budget reports are reviewed monthly in detail by the Business Partner Accountants, Financial Planning and Performance and Corporate Finance Teams.
- The organisation's balance sheet is subject to monthly review to understand significant movements.
- Quarterly review of accruals posted by the Central Management Accounts Team and Business Partner Accountants

7.3.7 The Head of Business Systems and Governance is responsible for ensuring a month end checklist of controls is available and completed. . The checklist contains all tasks, as per the monthly timetable, that are required to be completed, by date and by responsible officer. The checklist is reviewed at the Corporate Finance Senior Management Team meeting on a monthly basis.

7.4 Reconciliation of Control Accounts

A reconciliation of Balance Sheet control accounts will be carried out on a monthly basis by the appropriate officer. Reconciliations are reviewed and authorised by a senior officer as set out in the table below:

Reconciliation	Prepared by	Authorised by
Bank account statements to cash books	Treasury Officer	Treasury Manager
Cash books to the general ledger	Treasury Officer	Treasury Manager
Accounts receivable (debtors) to general ledger	Accountancy Manager	Assistant Head of Financial Accounting
Accounts payable (creditors) to general ledger	Losses & Litigation officer	Head of Financial Services & Accounting
PAYE, NI, pension to the general ledger	Treasury Manager	Assistant Head of Financial Services
VAT return to general ledger	Financial Services Manager - VAT	Head of Financial Services & Accounting

Payroll feeds	Losses & Litigation officer	Head of Financial Services & Accounting
Primary care control accounts for dentists, doctors, pharmacists and opticians	Accountancy Manager	Assistant Head of Financial Accounting

7.5 Reporting timetables

General Ledger input and closure dates will be included in the Monthly Reporting Timetable.

The timetable is reviewed annually by the Head of Management Accounts and Costing and Assistant Finance Director (Financial Strategy, Planning and Capital) with input from appropriate finance teams. The timetable is communicated via the Finance Hub SharePoint site under 'Tools and Useful Documents.'

7.6 Monthly and Annual Reporting

The Financial Planning and Performance team (FP&P) will ensure that the final month-end reported position, on the General Ledger, reflects the agreed position, as reported to Welsh Government.

Following the financial position meeting on working day 5, the FP&P team will arrange for any required journals to be forwarded to the Business Systems team for posting in the current period. This requires a controlled temporary re-opening of the current period.

Once final journals are posted, the FP&P team will confirm when the month-end ledger position is final.

In relation to the rollover of annual budgets, the FP&P team review and confirm that budgets have been rolled-over correctly between financial years.

The Business Systems team will action the rollover of budgets following confirmation from the FP&P team that budgets are balanced and reflect the correct level of income.

When budgets have been rolled forward, the FP&P team will check rolled-forward budgets and confirm to the Systems team prior to notifying other users.

8. Related Procedures

- [Standing Orders](#)
- [Standing Financial Instructions \(SFIs\)](#)

9. Further Information

Enquiries regarding this procedure should be directed to the Assistant Finance Director (Services and Systems); Head of Business Systems and Governance or the Principal Finance Manager – Business Systems.

10. Audit

The procedure will be subject to internal audit review.

11. Review

The procedure will be reviewed every three years, unless significant changes require a review earlier.



Aneurin Bevan University Health Board

Commissioning Non NHS Clinical 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.

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

Issue date: DRAFT
Review by date: DRAFT

Contents:

1. Introduction	3
2. Policy Statement	3
3. Commissioning Non NHS Clinical Services	3
A. Why do we need to externally commission?	4
B. What are they key clinical governance issues?	4
C. How do we comply with the corporate governance framework	5
D. What are the operational management factors to consider?	8
4. Related Procedures	9
5. Further Information	10
6. Audit	10
7. Review	10

Do's and Don'ts – Commissioning Non-NHS Clinical Services

Do's

- ✓ Assess internal service capacity first (waiting times, demand trends, resources, pathway constraints).
- ✓ Document clinical governance requirements including registration, accreditation and performance history.
- ✓ Confirm financial affordability and budget delegation before commissioning.
- ✓ Follow Corporate Governance Framework expectations and Welsh Government requirements.
- ✓ Ensure procurement rules are applied when required based on contract value.
- ✓ Consult the Board on significant service or financial impact decisions.
- ✓ Implement appropriate monitoring: activity, outcomes, risks, patient pathway compliance.
- ✓ Establish a multidisciplinary Project Group including clinical, commissioning, workforce and IM representation.
- ✓ Check for related-party or conflict-of-interest issues in potential providers.

Don'ts

- X Commission externally without fully reviewing internal options and improvement plans.
- X Progress without documenting clinical governance standards and expected pathways.
- X Assume procurement exemptions apply—validate per contract value and rules.
- X Award contracts exceeding thresholds without required Ministerial notification or approval.
- X Overlook patient communication, continuity-of-care, emergency arrangements or IT/data-sharing requirements.
- X Allow providers with undeclared conflicts of interest or unverified registrations.

1 Introduction

The procedure provides a framework and guidance for use within Aneurin Bevan University Health Board (ABUHB) when considering commissioning additional services, to support patient care improvements. It is specifically applicable when engaging non NHS providers and suppliers of health services.

2 Policy Statement

The procedure is to be used for commissioning additional service capacity outside of the usual NHS agreements.

The scope applies to both externally commissioned and insourced services, where external providers operate within ABUHB premises.

3 Commissioning Non NHS Clinical Services

There are several elements to consider before a service proposal is commissioned.

The main areas to consider when commissioning external or “insourced” services can be summarised over 4 key questions:

	Key Question	Responsibility	Comments
A	Why do we need to externally commission?	Division	
B	What are the key Clinical Governance issues?	Medical Director with input from service lead Clinician	
C	How do we comply with the Corporate Governance Framework?	Commissioning	Financial affordability confirmed by the Budget Holder
D	What are the Operational Management factors to consider?	Division and Commissioning	Including involvement of the Community Health Council (if appropriate)

A. Why Do We Need to Externally Commission?

The position of the internal service requires review, to establish the need to commission. The assessment will be used to gain executive approval to consider external commissioning. The assessment should include:

- Waiting times & lists,
- Demand profile & trends on the service,
- Delivery against planned resourced activity – can this be improved,
- Resource limitations (workforce, facilities, equipment),
- Which elements of the patient pathway are struggling to deliver,
- Target delivery position,
- Future internal development/improvement plans,
- A recurrent or non-recurrent issue to resolve,
- Have financial resources been delegated,
- Is additional funding available internally,
- Is Welsh Government funding available,
- Are there national trends and factors affecting ABUHB,
- Does the proposal reflect value based commissioning,
- Are there regional solutions now or in the future to be considered,
- Proposed outcomes and measures,
- Impact on the Integrated Medium Term Plan (IMTP) and strategic approach.

B. What are the Key Clinical Governance Issues?

Documentation of the clinical governance issues, in relation to minimum standards and clinical patient pathways should be completed.

The assessment should include:

- Provider registration accreditation (eg HIW, CQC),
- Workforce accreditation appropriate to service (eg Royal College Surgeons). Registration checks to be undertaken for all named individuals,
- Quality & Safety Standards expected,
- History of past performance against clinical performance indicators (eg. national joint registry),

- Service access criteria – what types of patients we want to be seen and treated (eg. simple, complex),
- Best Practice clinical patient pathway expected (Agreed and approved by the Medical Director and relevant lead specialty clinician),
- How to deal with unforeseen events, continuity of care, complaints and redress, and
- Productivity and outcomes expected from provider.

C. How Do We Comply With the Corporate Governance Framework?

This is relatively straight forward for NHS providers, where Long Term Agreements (LTAs) or ad hoc activity, can be agreed through the Commissioning Team and/or Executive Team.

Approval is subject to budget delegation, financial resources and operational arrangements being clarified.

The usual commercial Procurement rules do not apply by special dispensation.

However, ABUHB adopts an 'informal policy' which considers the following commissioning elements :

1. Can we deliver internally?
2. Can we commission extra through existing LTAs?
3. Can we commission through new NHS LTAs in Wales?
4. Can we commission through new NHS LTAs in England?
5. Using the [Procurement Manual](#), can we commission through NHS Treatment Centres? (requires Procurement where privately owned), and
6. Using the [Procurement Manual](#), can we commission privately? (requires Procurement).
7. If 1 to 6 are not achievable, then the contract should be re-tendered through the UK national framework or on an open market basis.

This approach has been influenced by Welsh Government expectations, that Health Boards optimise local service delivery, before exploring externally. This information is explicitly requested in ministerial briefings, along with the clarification of long term local development delivery plans.

When commissioning external services where Procurement is required, the approach varies depending on the estimated value of the contract. Commissioning will lead on the plan, with support from Procurement, to ensure compliance with appropriate guidance and legislation.

Adequate budget and [Scheme of Delegation](#) limits apply:

General Delegated Financial Approval Limits

Body/Committee/Post	Financial Limit £'s
Delegated Budget Holders	£25K and below
Divisional Directors/General Managers/ Assistant Directors	£50K
Executive or Board level Director	£125K
Chief Executive/Deputy Chief Executive	£250K
Chief Executive and Chairman/(Deputy Chief Executive/Vice Chairman in their absence)	£500K
Board*	£1M
Welsh Government	>£1M

** Urgent issues between scheduled Board meetings should be referred to the Director of Corporate Governance to seek approval via Chair's action.*

The Board should be consulted on issues of significant service and financial impact.

Prior to commencement of the financial year, the IMTP consultation and approval process will act as the mechanism to undertake external & insourced commissioning activities. Following this approach, the Board is aware of the implications and financial resource required and provides approval.

During the financial year, if external or insourced commissioning is required to deliver an improved level of performance, or for other reasons, the Executive Team should consider the proposal and the Board be informed.

The Board has the ability to authorise contracts up to £1m, thereafter Ministerial approval is required, in addition there are monitoring arrangements to be complied with:

The expected value of a contract guides the Ministerial monitoring requirement:

- For individual contracts with a value exceeding £250k and up to £500k, the Minister needs to be 'Informed'.
- For individual contracts with a value exceeding £500k and up to £1m, the Minister needs to be 'briefed' and adequate time allowed for the Minister to review the contract particulars before awarding the contract.
- For individual contracts with a value exceeding £1m the Minister/Welsh Government must give written approval to enter into the agreement.

Once a Procurement process is agreed, the contract will be reviewed in terms of tender type (open market, framework agreement, etc), action points, documentation, timescales to receive bids, award of contract and implementation dates.

The process should ensure that tender details submitted have been robustly scrutinised, including relevant references and interviews have been undertaken with potential providers.

An example of a timeline for a contract value between £500k and £1m is included below:

Contracting Stage	Anticipated Date/Timescales
Briefing paper to Minister	Usually 1 week
Receive Minister comments and 'Note'	Day 0
Issue PIN via OJEU mechanism	Day 1
Formal responses received	Day 20
Evaluation/Assessment to ensure award criteria being met – Pre Qualification	Day 28
Evaluation/Assessment to ensure award criteria being met – Final Evaluation and Selection	Day 36

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

Issue date: DRAFT
Review by date: DRAFT

Prepare ABUHB Board Report	Day 38
Update Minister of outcome and intention to award	Day 39
Execute Agreement	Day 40
Contract Start	Day 45

The above demonstrates the steps and potential timescales required to comply with regulations.

D. What are the Operational Management Factors to Consider?

There are significant management factors to consider as part of external or insourced commissioning.

These include a range of patient related, directorate operational and commissioning monitoring aspects.

Potential Conflicts of Interest

Consideration also needs to be given to any related party issues with potential providers.

As part of any procurement process, potential providers will be asked to document the following:

- Whether the organisation employs or engages any current Health Boards employees and whether these individuals have personal financial interests in the organisation,
- Whether the organisation intends to use any current Health Board employees to deliver the contract,
- Whether the organisation employs Board members or others holding positions of influence,
- Whether there are any other influential interests or relationships or connected parties.

This information will be reviewed by the Executive Team before a decision is made whether to proceed with that potential provider.

Project Group

A Project Group should be established with membership, as a minimum, to include a Specialty Clinician, Commissioning Lead, Directorate Manager, Workforce and Informatics representative.

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

Issue date: DRAFT
Review by date: DRAFT

It may also be appropriate to invite an Independent Member (IM) of the Board to sit on the group, or to attend the supplier interview panel.

Llais (formerly The Aneurin Bevan Community Health Council) may need to be informed or involved in any clinical pathway changes

The group will be expected to support the delivery of the actions below:

- Internal and external implementation issues,
- Contract Management resources,
- Patient Communication mechanisms and messages,
- Identification of the relevant patient cohort to offer the service to (eg. long waiters or everyone),
- Divisional and Commissioning Team resources to deliver the project aims,
- Workforce, facilities, diagnostics and equipment requirements if delivered within ABUHB venues,
- Registration checks for all named individuals,
- Provider Responsible Officer for provider medical staff to be confirmed,
- Ensure the patient pathway is monitored to meet the specification,
- Distance to travel and patient transport arrangements,
- Project monitoring – activity, outcomes, performance (including Clinical lead),
- IT and information sharing interfaces and document control,
- Adverse incidents and emergency patient event management arrangements, escalation & patient continuity of care processes,
- Risk register & decision record,
- Potential for joint working and learning and
- Financial management arrangements.

4 Related Procedures

- [Standing Orders](#)
- [Standing Financial Instructions \(SFIs\)](#)
- [Scheme of Delegation](#)
- [Procurement](#)
- [Contract Management](#)

5 Further Information

Enquiries regarding this procedure should be directed to either the Finance Business Partner – Commissioning or Finance Business Partner – Contracting.

6 Audit

The procedure will be subject to internal audit.

7 Review

The procedure will be reviewed every three years, unless significant changes require a review earlier.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Annual Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Gareth Lavington- Head CF

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

To appraise the Audit Risk and Assurance Committee of plan of work for the upcoming financial year for the Counter Fraud Team and seek Approval.

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

ABUHB is legally bound to provide a Counter Fraud service. As a result, they employ a Counter Fraud team who maintain the provision. The team must comply with the NHS requirements of the Government Functional Standards S013 and the Welsh Government Directions. One of the NHS requirements is that ABUHB completes a plan for the proposed Counter Fraud work for each financial year. The head of Counter Fraud completes the plan and gains agreement from the Director of Finance, Procurement and Value.

Cefndir / Background

This document has been prepared by the Head of Counter Fraud to address the inherent and emerging Fraud Risks faced by the organisation, to plan for any required investigation work, and to prepare an educational and promotion strategy for the upcoming year.

Asesiad / Assessment

Please see separate report

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee are asked to review and if appropriate approve the work plan for the upcoming year.

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

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

Gwybodaeth Ychwanegol:**Further Information:**

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

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

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



Counter Fraud Annual Plan 2026/27

Gareth Lavington
Head of Counter Fraud

01/03/2026

COUNTER FRAUD ANNUAL PLAN 2026/2027

Mission

To safeguard Aneurin Bevan University Health Board (ABUHB) by preventing, detecting, and deterring fraud through proactive education, intelligence-led investigation, and a culture of awareness and integrity—ensuring every pound is protected for patient care.

Strategic Framework

This plan reflects Counter Fraud expectations set for all NHS bodies, incorporating:

- Government Functional Standard GovS 013: Counter Fraud, adopted across NHS-funded services.
- NHSCFA Counter Fraud Requirements, with annual reporting through the Counter Fraud Functional Standards Return (CFFSR) due 31 May 2027.
- NHSCFA Strategic Pillars (Understand, Prevent, Respond, Assure), emphasised in NHSCFA's Business Plan 2025–2026.
- Welsh Government Directions on Countering Fraud, Bribery and Corruption, requiring each NHS body to maintain accredited LCFS provision.
- NHS Wales Counter Fraud Strategy 2026-2030 Strategic Objectives (Prevent, Detect, Respond, Build Capability, Collaborate)
- Economic Crime and Corporate Transparency Act 2023

This work plan covers the period 1 April 2026 – 31 March 2027.

COUNTER FRAUD ANNUAL PLAN 2026/2027

Resources

The Aneurin Bevan University Health Board (ABUHB) Counter Fraud Team is an in-house service comprising the Head of Counter Fraud and three Local Counter Fraud Specialists (LCFS). All members of the team are accredited and experienced investigators, responsible for delivering the organisation’s statutory and mandatory obligations to prevent, detect, and respond to fraud, bribery, and corruption. The total number of resource days for the team is **701**.

The team are accountable to the Executive Director of Finance and Procurement, and report to the Fraud Champion (Assistant Director of Finance). Regular reporting is provided to the Audit & Risk Assurance Committee on all matters relating to fraud, bribery, and corruption. The Executive Director of Finance and Procurement holds overall accountability for Counter Fraud activity as the designated executive lead within the organisation.

As required by the NHS CFA Annual Counter Fraud Functional Standard Return (CFFSSR) the days allocated to the Counter Fraud provision are split between Reactive and Proactive activity. They are as follows.

SUMMARY TOTALS			
	STRATEGIC AREA OF ACTIVITY	RESOURCE Proposed 2025/26 (days)	RESOURCE Proposed 2026/27 (days)
A	PROACTIVE	436	436
B	REACTIVE	265	265
	TOTAL	701	701

COUNTER FRAUD ANNUAL PLAN 2026/2027

Compliance

The work plan below is directly aligned with the pillars set out in the new NHS Wales Counter Fraud Strategy 2026–2030.



It has been designed to remain flexible, enabling the Counter Fraud Team to respond effectively to emerging threats and issues as they arise throughout the year. The plan outlines defined tasks and objectives mapped to each of the Strategy's pillars, includes a proposed delivery schedule.

All NHS Requirements are fully addressed within this plan and successful delivery will result in a satisfactory (Green) rating in all areas of the Counter Fraud Functional Standard Return (CFFSR) to be reported in May 2027. This plan also provides assurance that ABUHB is doing all that it can to counter fraud in line with the Economic Crime and Corporate Transparency Act 2023.

The Government Functional Standards and NHS Requirements to meet those standards are available in full at the link below.

<https://cfa.nhs.uk/government-functional-standard/NHS-requirements>.

All proposed actions will be carried out Throughout the Year (TTY) unless otherwise stated and regular progress updates against the listed tasks will be provided to the Director of Finance, Fraud Champion and Audit Risk and Assurance Committee.

COUNTER FRAUD ANNUAL PLAN 2026/2027

Work Plan

Prevent – “Assess the risk, strengthen systems and controls and promote awareness to stop fraud before it occurs.”

Detect – “Use data, intelligence and advanced analytics to help prioritise resources and link fraud risks early.”

PREVENT & DETECT		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	Design and deliver a programme of targeted counter fraud awareness/education presentations to staff at all levels within the Health Board in line with the Counter Fraud education strategy *	TTY
2	Ensure that Counter Fraud awareness and signposting remains up to date and relevant within the organisational Corporate Induction offering. This will be achieved through ongoing engagement with the Organisational Development team.	Q1
3	Attend Primary Care Management Forums and provide updates to Primary Care partners concerning emerging trends and risks. Produce a quarterly bulletin to be disseminated to Primary Care Partners.	Quarterly
4	Produce a digital Counter Fraud newsletter communicating the work and results of the team that is disseminated organisation wide. This will provide statistics and case studies that are relevant and aim to act as a deterrent.	Quarterly
5	Produce and disseminate Counter Fraud bulletins and messaging to reinforce a counter fraud culture. Utilise all digital resources (MO365 suite) available in delivering this messaging.	Weekly

COUNTER FRAUD ANNUAL PLAN 2026/2027

PREVENT & DETECT		
	TASK/OBJECTIVE	PROPOSED DELIVERY
6	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan. Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality and Bribery Act.	Q2
7	Review key organisational policies, procedures, and documents, to ensure that fraud risk is adequately considered. Attend Policy Group Meetings and review agenda items.	Monthly
8	Action relevant Fraud Prevention Notices and IBURN Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	Reactive
9	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Reactive
10	Maintain a Fraud Risk Profile dedicated to managing the dissemination and recording of Fraud Risk and allocation of risk owners	TTY
11	Carry out fraud risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Carry out formal risk assessment into all inherent areas of fraud risk as identified locally, nationally or by the NHS CFA. Carry out risk assessment into areas that are identified as a result of detection work that are identified as emerging and or thematic risks **	TTY
12	Carry out risk reviews relating to Risks already known and reported and recorded on the fraud risk profile	TTY
13	Maintain a register of referrals made to the team for the purposes of analysis in order to identify trends suitable for proactive action	TTY

COUNTER FRAUD ANNUAL PLAN 2026/2027

PREVENT & DETECT		
	TASK/OBJECTIVE	PROPOSED DELIVERY
14	Undertake Local Proactive exercises*** that are intelligence led using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption. Results of this work will be evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption. Any losses, recoveries or savings achieved as a result of disruption activity are to be identified and recorded	TTY
15	Maintain an outcome register relating to Local Proactive exercises	TTY
16	Issue of fraud alerts to all appropriate staff/contractors.	Reactive

**Education and awareness activity will be specifically targeted towards Facilities and Estates Division and Medical Division within the timescale of this plan as they are underrepresented historically in uptake of awareness sessions*

*** See Appendix 1*

****See Appendix 2*

COUNTER FRAUD ANNUAL PLAN 2026/2027

Respond – “Investigate thoroughly, recover losses, and apply appropriate sanctions swiftly.”

RESPOND		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	Conduct criminal investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	Reactive
2	Use of the prescribed case management system Clue 3, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements to fully record investigative actions taken.	Reactive
3	Assist NHS Counter Fraud Authority and/or NHS CFS Wales as required in respect of any regional or national investigations.	Reactive
4	Ensure the application of sanctions in line with legislation and the policy document ‘Applying Appropriate Sanctions Consistently’.	Reactive
5	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the particular circumstances of each case.	Reactive
6	Conduct initial review of the matches identified on the National Fraud Initiative (NFI). Where required instigate formal investigation into matches that require it.	Q4
7	Liaise with Human Resources team where appropriate in conducting criminal investigation into staff members ensuring compliance with relevant policies and procedures and information sharing.	Reactive
9	Attend all necessary meetings with HR team when dealing with staff members suspected of committing fraud.	Reactive

COUNTER FRAUD ANNUAL PLAN 2026/2027

Build Capability – “Invest in our people by providing specialist training and equipping counter fraud teams with latest tools and technology.”

BUILD CAPABILITY		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	Maintain access to NHS CFA learning resources including NGAGE and the Fraud Hub.	TTY
2	Attend Fraud Forum and take part in the training that is provided.	Q2/Q4
3	All team members to gain memberships of the Government Counter Fraud Profession (GCFP)*.	Q4
4	Undertake ALL mandatory learning.	TTY
5	Explore opportunities for further learning/training within Data and Digital resources.	TTY
6	Undertake CLUE 3 training as it is released.	TTY
7	Participate in the quality assurance and engagement process conducted by the NHS CFA.	TTY
8	Undertake all additional training as required by the Health Board or NHS CFA.	TTY
9	Maintain knowledge of relevant legislation via online learning updates	TTY

**If appropriate – consultation ongoing with NHSCFA. Likely to be a mandatory requirement by March 2027.*

COUNTER FRAUD ANNUAL PLAN 2026/2027

Collaborate – “Foster strong partnerships across NHS Wales, other Welsh public bodies, Welsh Government, and UK agencies such as HMRC and DWP to share intelligence and best practice.”

COLLABORATE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
1	Completion and agreement of the Annual Work Plan (2026/2027) with Director of Finance.	Q1
2	Completion of the Annual Report (2025-2026) for review by Director of Finance and Audit Committee.	Q1
3	Engage in regular meetings/liaison with Director of Finance (Senior Responsible Officer for Fraud).	TTY
4	Engage in regular meetings/liaison with Fraud Champion.	TTY
5	Attend Corporate Finance Senior Management Team and Heads of Financial Services meetings.	TTY
6	Attend Audit Risk and Assurance Committee meetings to provide regular progress updates.	TTY
7	Ensure attendance at all Lead LCFS meetings & Fraud Liaison Group to share best practice and emerging trends.	TTY
8	Attend Primary Care Forums to foster relationships with relevant stakeholders and disseminate emerging trends and risks.	Quarterly
9	Attend Policy Group Meetings and review agenda items in relation to Fraud Proofing.	Monthly
10	Liaise with Corporate Governance colleagues in measuring the effectiveness of the conflicts of interest policy and registers that include gifts and hospitality with reference to fraud, bribery and corruption, and the requirements of the Bribery Act 2010.	TTY
11	Engage in regular meetings with the Head of Internal Audit (NWSSP Audit & Assurance).	TTY
12	Engage in regular meetings with representatives from Audit Wales.	TTY
13	Meet with Independent Members of the ARAC.	TTY

COUNTER FRAUD ANNUAL PLAN 2026/2027

COLLABORATE		
	TASK/OBJECTIVE	PROPOSED DELIVERY
14	Ensure regular liaison with the Post Payment Verification Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS. To attend all PPV joint Fraud meetings.	Quarterly
15	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g. NFI).	Reactive
16	Maintain membership of Controlled Drugs Local Intelligence Network (CD LIN) and attend at quarterly meetings. (This is an intelligence sharing exercise involving Primary Care Pharmacy teams, Police and Counter Fraud.)	Quarterly
17	Collaborate with Cyber Security Team in designing and developing targeted exercises.	TTY
18	Provide Quarterly statistic reports to Counter Fraud Service Wales for onward reporting to Welsh Government for the purposes of benchmarking.	Quarterly

COUNTER FRAUD ANNUAL PLAN 2026/2027

Appendix 1

Known Risk	Rationale
Salary Overpayments (OP's)	Known risk to the organisation in relation to financial loss. Salary OP's still taking place. Salary OP's provide an opportunity for criminal offences to occur.
Agency Worker Pre-employment checks	National issue identified concerning the use of imposters by Organised Criminal Gangs (OCG') in order to defraud the NHS. A Local Proactive Exercise (LPE) is ongoing into this area as below and part of that LPE involves a comprehensive risk assessment into the control measures in place and the effectiveness of PEC's involving Agency workers
Recruitment Pre-employment checks	Fraudulent information being provided in order to gain employment with the NHS e.g Fake qualifications has been identified as an inherent risk to the NHS. Comprehensive risk assessment to be carried out to assess the effectiveness of current PEC processes. This will involve liaison with NWSSP partners.
Petty Cash Procedures	Fraud carried out by abusing petty cash procedures has been identified by the NHS Counter Fraud Authority as an inherent risk to NHS organisations. This risk is a low financial value but a comprehensive risk assessment will be carried out into the control measures currently in place and their effectiveness.
Patient Travel Re-imbursement	Fraud carried out by abusing patient travel cost re-imbursement procedures has been identified by the NHS Counter Fraud Authority as an inherent risk to NHS organisations. This risk is a low financial value but a comprehensive risk assessment will be carried out into the control measures currently in place and their effectiveness.
Overseas Patients	Fraud carried out by has been identified by the NHS Counter Fraud Authority as an inherent risk to NHS organisations. In addition- a number of referrals have been made to the Counter Fraud Team relating to Overseas Patients. As a result, a comprehensive risk assessment will be carried out in order to assess the current opportunity for fraud to occur in this area.
Job Planning/Medical Rostering	As a result of referrals to the Counter Fraud team concerning the allocation and uptake of extra duties by medical staff this area has been identified for formal risk assessment. The purpose of the risk assessment will be to identify weaknesses within current procedures and processes that allow the opportunity for fraud to occur.

COUNTER FRAUD ANNUAL PLAN 2026/2027

Appendix 2

LPE Area	Rationale
Medical Staff – Extra Duties/Rostering	Intelligence led exercise following issues identified as a result of investigations carried out by the Counter Fraud team in respect of medical staff and extra duty payments.
Agency Nursing Staff – Impersonation	Informed as a national risk to all NHS organisations. A number of prosecutions have taken place in relation to imposters attending and impersonating agency nursing and health care support staff.
Agency/Locum Medical Staff - Impersonation	Identified as a possible risk associated with Agency Nursing staff above.
Primary Care – Targeted Education	Informed as result of a number of issues raised with the Counter Fraud team by GP Practice managers. This LPE will be dedicated to addressing weaknesses in relation to Counter Fraud awareness and education within the Primary Care sector.
Payment Diversion Fraud	An ongoing and prevalent risk with high impact factors. This LPE will involve various targeted actions aimed at improving staff knowledge and resilience to this type of fraud.
Declarations of Interest	Following on from the success of the identification of poor uptake of DOI's by staff members as a result of last year's NFI exercise, further work will be carried out with the aim of raising awareness of the DOI register ensuring that relevant members of staff comply.
Targeted Surveys	Targeted surveys will take place throughout the year with the aim of gaining a better understanding of awareness levels of different Counter Fraud and Governance issues. This in turn will lead to the identification of areas of need for further education actions.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Internal and External Audit Recommendation Tracker Q4 Position
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Risk and Assurance Committee with an overview of the status of all internal and external audit recommendations as at the end of Quarter 4 2025/26 (01 January 2026 - 31 March 2026).

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 (February 2026) covered the position to the end of Quarter 3 2025/26. At that meeting:

- **31** recommendations were confirmed as completed
- **31** recommendations were granted a deadline extension.



Asesiad / Assessment

Internal and External Audit Recommendation Tracking

Since the previous report to the Committee, which recorded **102** live recommendations on the Tracker, a further **six** recommendations have been added.

As at the end of Quarter 4 2025/26, the Tracker contained a total of **108** live recommendations. Updates were requested for **56** recommendations that had reached their implementation date by 31 March 2026.

Table 1 below sets out the position following receipt and review of updates for these **56** recommendations. Based on this information, the Committee is asked to:

- **Approve** the completion of **29** recommendations; and
- **Approve 27** revised implementation deadlines.

Table 1

Lead Director	Completed	Revised Deadline	Total Updates
Chief Operating Officer	0	3	3
Director of Digital	2	13	15
Director of Finance & Procurement	0	2	2
Director of Nursing	15	1	16
Medical Director	2	0	2
Director of Allied Health Professions & Health Science	6	1	7
Director of Corporate Governance	0	2	2
Director of Planning, Strategy and Partnerships	3	4	7
Director of Public Health	1	1	2
Total updates this period	29	27	56

Table 3: Provides a summary of the **29** recommendations that have been confirmed as complete. Full details are set out in Appendix A.

Table 3

Completed Recommendations		
Audit Title	Assurance Rating	Number by Priority Rating
2023 IT Infrastructure	Reasonable	1
2024 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	2



2024/25 Health and Safety	Limited	1	3
2024/25 Medical Equipment and Devices	Reasonable	2	
2024/25 Job Planning	Limited	1	
2024/25 Newport East Health and Wellbeing Centre	Reasonable	1	
2025/26 Safeguarding	Reasonable	3	
2025/26 Discharge Planning Progress Update	Not Rated	1	
2025/26 Urgent and Emergency Care: Flow out of Hospital Gwent Region	Not Rated	8	
2025/26 Structured Assessment	Not Rated	2	
2025/26 Welsh Intensive Care Information System	Substantial	1	
2025/26 Eye Care Review	Not Rated	1	
2025/26 RGH Central Decontamination Unit	Reasonable	1	1
TOTAL		5	9
		1	14
		29	

Table 4: Provides a summary of the **27** recommendations with revised deadlines. Full details are set out in to Appendix B.

Table 4

Recommendations with Revised Deadlines		
Audit Year and Title	Assurance Rating	Number by Priority Rating
2020/21 IM&T Control & Risk Assessment - Advisory	Not Rated	2
2022/23 Integrated Wellbeing Networks	Reasonable	1
2023/24 IT Infrastructure	Reasonable	2
2023/24 Waiting List Management	Reasonable	1
2024 Structured Assessment	Not Rated	2
2024/25 Declarations of Interests	Substantial	2
2024/25 Medical Equipment and Devices	Reasonable	1
2024/25 Records Management	Limited	2
2024/25 Intelligence Led Organisation	Reasonable	1
2024/25 Technical Continuity	Reasonable	1
2025/26 Business Continuity Planning	Reasonable	2
2025/26 Eye Care Review	Not Rated	1

2025/26 Safeguarding	Reasonable	1			
2025/26 Cyber Security	Reasonable	1	2		
TOTAL		8	12	0	7
		27			

Following the agreed removal of the **29** completed actions and the approval of **27** extension requests, **80** recommendations will remain live on the tracker.

Of the **80** recommendations, **60** remain within the agreed extension threshold of no more than two deadline revisions. The remaining **20** recommendations exceed this threshold.

Table 5 provides a summary of the implementation status of the **80** recommendations.

Table 6 provides additional detail on the **20** recommendations that fall outside the extension threshold. Full details are set out in Appendix C.

Table 5

Implementation Status	Total number of Recommendations
Within Original Deadline	40
1 st Extension	14
2 nd Extension	6
Total Number within the Threshold	60
3 rd Extension	8
4 th Extension	3
5 th Extension	7
6 th Extension	0
7 th Extension	2
Total Number Outside the Threshold	20
Overall Total	80

Table 6

Recommendations Outside of Agreed Deadline Extension Threshold			
Audit Year and Title	Assurance Rating	Number by Priority Rating	Number of Extensions Requested
2020/21 IT System Controls (WRIS)	Reasonable	5	5 x 5 th Extension



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

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

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



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

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

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





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	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
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Low	R4.1	Alert thresholds should be configured to identify relevant issues promptly	ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time.	Head of Ict	31/07/2025	31/03/2026	Completed	Completed	0	March 26 - We have now completed the Solarwinds upgrade and have since held additional workshops with our support partner Prosperon to realise benefits of the upgraded platform and the licenced modules we currently have entitlement for. We have also deputised and aligned training to two Solarwinds SME's across Networks & Business System that will now developing the platform further and internal train team members to be able to use the platform more effective for operational troubleshooting and reporting. We are currently reviewing the new licence changes proposed by Solarwinds and will seek additional funding for any required enhanced functionality.		New supported hardware platform with the latest software application. This will allow us to develop the platform further to enhance our monitoring and reporting capabilities	31/03/2026
4001EA2024	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Director of Nursing	N/A	1.1	Risk Management within plans - The Health Board should ensure that in future Six Goals for Urgent and Emergency Care Plans, all identified risks have clear risk owners and that mitigating actions have clear target dates (Exhibit 2).	The Six Goals Programme maintains a centralised risk register and action log; to strengthen our assurance process the register will be reviewed and updated regularly, with escalation routes clearly defined for significant risks. In addition, risk management will be strengthened across the Six Goals for Urgent and Emergency Care Programme, in the following ways: • all identified risks within the Programme will have named owners accountable for ongoing oversight, escalation, and resolution. This will be reflected consistently in the risk register and programme documentation. • each mitigating action will have clear target dates and associated leads. This will ensure timely intervention and provide a basis for tracking progress at Programme Board level. These improvements will be in place ahead of the September 2025 Programme Board meeting. Progress will be monitored by the Programme Team and reported to the Board quarterly to ensure sustained compliance.	Executive Director of Nursing	30/09/2025	31/03/2026	Completed	Completed	0	Risk management will be strengthened across the Six Goals for Urgent and Emergency Care Programme, in the following ways: • all identified risks within the Programme will have named owners accountable for ongoing oversight, escalation, and resolution. This will be reflected consistently in the risk register and programme documentation. • each mitigating action will have clear target dates and associated leads. This will ensure timely intervention and provide a basis for tracking progress at Programme Board level. These improvements will be in place ahead of the September 2025 Programme Board meeting. Progress will be monitored by the Programme Team and reported to the Board quarterly to ensure sustained compliance.		The Six Goals programme board is currently under review and will be reconfigured to bring other and interdependent programmes together into a refocused Urgent and Emergency Care Board. The new UEC programme board will ensure recommendations are complied with, building on the existing programme documentation reviewed as part of this audit. It is anticipated that the new UEC programme board will take effect from April 2026	31/03/2026
4001EA2024	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: • national programme funding has been secured and allocated to support the ABUHB Six Goals Programme through to March 2026. • a structured evaluation process will be undertaken for all projects funded up to March 2026. This will assess impact, outcomes, and alignment with strategic priorities to inform future funding decisions. • internal planning is underway to identify ongoing funding requirements for services expected to continue beyond 2025-26. This will include engaging with operational leads, finance colleagues, and strategic planning teams to ensure sustainability and alignment with health board priorities. • funding needs for continuing schemes will be incorporated into the Health Board's medium term financial plan and business planning processes, ensuring early visibility of any investment gaps or reallocation needs.	Executive Director of Nursing	31/12/2025		Completed	Completed	0			From 2026/27, we can confirm that £2.7M will be made available to support UEC activity annually until such time that annual priorities change.	31/03/2026
4005EA2025	External Audit	Discharge Planning Progress Update	Not Rated	Director of Nursing	N/A	3.1	The Health Board should work with its local authority partners to identify ways of providing staff with up-to date information on waiting times for needs assessments for community-based services and the lead in time for those services to commence	Further work to improve the flow of information will be addressed through the "Perfect Ward" project which will create the optimal environment for clinical teams working with social care colleagues to optimise discharge.	Executive Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	2	****• Optimal Ward Model piloted at three wards at RGH • Roll out of optimal ward model across all sites and wards to start 4th August and complete by end of March 2026*** "		Optimal Hospital Flow Framework has been rolled out across all site during 2025/2026	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	1.1	The Health Board and local authorities should embed processes to communicate discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis, supported by an ongoing programme of refresher training and induction training for new staff. Where possible, this should be done on a joint basis.	Current hospital discharge models are being reviewed and once finalised will be communicated clearly to all hospital and community staff. The current system is over complex and must be simplified for the benefit of people. Significant investment across the region on Balancing Rights and Responsibilities (BRR) training, focussing on front door pathways to support staff to take proportionate rights and risk-based decisions that put the person at the heart of decision making and whether an admission is necessary and appropriate. This is multi professional and multi-agency training across the five Local Authorities and Health Board. All staff operating in the hospital discharge space will have access to the range of policies and procedures as part of their induction and ongoing CPD/	Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	0	"September 2025: Head of Discharge currently reviewing Health Board discharge policy working with the five local authorities. Revised policy to be ratified by the Clinical Standards and Policy Group ahead of implementation. Roll out of the WG Out of Hos		A revised discharge policy has been submitted for ratification internally. The guidance sets out the core principles, processes, and roles essential for delivering safe, effective, and timely discharge within Aneurin Bevan University Health Board. It is aligned with recognised best practice in patient flow improvement, involving the Optimal Hospital Flow Framework incorporating the D2RA, SAFER (Seen, Aim, Flow, Early Discharge, Recovery) patient flow bundle, and Red to Green principles Balancing Rights and Responsibilities (BRR) training has been completed for initial cohorts with plans to continue. These sessions focus on front door pathways to support staff to take proportionate rights and risk-based decisions that put the person at the heart of decision making and whether an admission is necessary and appropriate. This is multi professional and multi-agency training across the five Local Authorities and Health Board.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	2.1	The Health Board should update its discharge policy to ensure that it reflects the national guidance issued by the Welsh Government in December 2023.	Update discharge policies including – complex and reluctant discharges and choice policy to reflect the national guidance	Director of Nursing	28/02/2025	31/03/2026	Completed	Completed	0			A revised discharge policy has been submitted for ratification internally. The guidance sets out the core principles, processes, and roles essential for delivering safe, effective, and timely discharge within Aneurin Bevan University Health Board. It is aligned with recognised best practice in patient flow improvement, involving the Optimal Hospital Flow Framework incorporating the D2RA, SAFER (Seen, Aim, Flow, Early Discharge, Recovery) patient flow bundle, and Red to Green principles	31/03/2026

4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	3.1	The Health Board and local authorities should review capacity to embed and deliver 7-day discharge. Despite discharges needing to happen daily, current ways of working do not support this, and a lack of weekend discharge means patients have a prolonged stay in hospital which increases risk of deconditioning and acquiring infection.	The Local Authorities and Health Board have discharge support in place to via Home First and Hospital to Home 7 days per week. Care packages can be reinstated and restarted on weekends, continue to embed a 7-day approach to discharge across the system. Temporary care can also be commissioned. Continue to embed 7-day discharge planning via the Home First and Hospital to Home, there is often reluctance to support discharges at weekends (risk averse) even where the Local Authorities/Health Boards' assessments indicate the person can be safely discharged home. Trusted Assessor model via Home First, workforce is a challenge. Progression of nurse led discharge as part of the optimal hospital ward model at RGH across three wards. Community Resource Team – medical staff to work 7-day end of January. Senior Nurse for Discharge appointed at RGH, in post from 6 Discharge Community Hospitals out to divert, focus on embedding the delivery of 7-day discharge.	Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	0	"September: Review of criteria led discharge to support weekend discharges, engagement with the interim Medical Director and Executive Director of Nursing. Local Authorities and Health Board have discharge support in place via Home First 7 days a week.		Optimal Hospital Flow Framework rolled out across all sites, acute and community. Evaluation to be undertaken post one year of implementation. The objective of the Criteria Led Discharge protocol is to provide a framework to enable criteria led discharge 7 days a week. The protocol is to ensure an effective process for the safe and timely discharge of adult patients by competent Registrants following a consultant identified plan.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	4.1	The Health Board should clarify roles and responsibilities regarding care package prescribing to ensure patients are not given unrealistic and unnecessary expectations in relation to care provision. This is particularly the case with older patients who may be seen as frail. This can disempower patients from being independent and may lead to future readmissions.	Review of roles and responsibilities regarding care package prescribing through the optimal ward model at RGH across three wards to include education/training and review of board rounds. Develop roll out plan for the optimal ward framework across all Hospital sites.	Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	0	"September 2025: Review of roles and responsibilities regarding over prescribing of care packages via the roll out of the Optimal Hospital Flow Framework and discharge resource review. Joint discharge review commissioned by the RPB to ensure optimal use		Optimal Hospital Flow Framework is an embedded initiative in line with national policy. This framework will be embedded through the use of short-term dedicated champions and divisional leadership in driving the framework principles into daily standard work.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	5.1	The Health Board should review its cultural appetite and approach to risk in relation to patient discharge. This should ensure risk is assessed across the whole patient pathway, so beds are not unnecessarily occupied	Updated discharge policies will be shared and form part of the education and communication framework to help prioritise the discharge agenda across the MDT, supported by the Strategic lead for discharge and the senior nurse. The risk in relation to non compliance with the discharge framework is evaluated and discussed at divisional and corporate level via local meetings and integrated boards and will feed into the discharge work streams	Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	0	"September 2025: Update discharge policy, review of risk in relation to patient discharge aligned to round out of OHFF. "		Criteria Led Discharge is a key protocol that will support discharge across 7 days a week releasing bed capacity for those who need it most. The protocol is to ensure an effective process for the safe and timely discharge of adult patients by competent Registrants following a consultant identified plan.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	6.1	The Health Board should embed its approach to the Trusted Assessor model and communicate this approach to all partners. Whilst there is recognition this may not help secure care packages or placements more quickly; it will ensure there is capacity to assess patients when required.	The Local Authorities and Health Board have undertaken a review of opportunities to embed a Trusted Assessor model against national best practice and local datasets for Pathway of Care Delays linked to assessment codes. Three areas of recommendation have been presented to Integrated Discharge Board to progress. Integrated front door • Embedding of quality conversations that promote positive risk management through the Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces. Review undertaken of assessment code delays from POCD datasets, ~~see page identified~~	Director of Nursing	31/03/2025	31/03/2026	Completed	Completed	1	The health board continues working with national and local partners to further develop the trusted assessor model. Currently the most established trusted assessor model is the Home first model. The Home First team works on behalf of all five Gwent local authorities at the front door of the Grange Hospital. The staff in the team work across Gwent using a trusted assessor model. This is facilitated by a single point of access, where health and social care professionals can refer individuals using one contact number, streamlining the process and enabling timely intervention. Within this framework, trusted assessors from social care are empowered to make decisions about care packages, equipment, or onward referrals without the need for further approval, which helps to minimise delays and ensure equitable delivery across the region. Home First have strong relationships with each individual local authority and are empowered to act on their behalf empowering early decision making"September 2025: "The Local Authorities and Health Board have undertaken a review of opportunities to		Currently the most established trusted assessor model is the Home first model. The Home First team works on behalf of all five Gwent local authorities at the front door of the Grange Hospital. The staff in the team work across Gwent using a trusted assessor model.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	7.1	The Health Board should monitor compliance with its discharge policy to assess the effectiveness and consistency of the application, and whether the intended outcomes are being achieved. This includes adhering to its own policy that an annual programme of learning will be reported to the Patient Quality, Safety and Outcomes Committee.	Data collected via POCD, CWS2 length of stay and discharge work streams will form the cornerstone of improving guidance, shaping the educational programme and focusing resources to improve and evaluate outcomes. Further development of CWS2 to replace the Complex List. Formal dashboard in development and reported to the Integrated Discharge Board. Learning and feedback to be presented at local forums and integrated boards and the patient Quality outcomes committee	Director of Nursing and Director of Digital	31/03/2025	31/03/2026	Completed	Completed	0	the Health Board Discharge policy has been recently simplified as part of the wider review and discharge improvement programme. Key Elements have been identified for increased awareness and education particularly in relation to best interest decisions and patient choice. POCD monthly meetings and scrutiny panels on-going as part of the wider discharge programme under the Integrated Discharge board governance structure.		Discharge performance and patient outcomes are monitored through through the Integrated Discharge Board and Quality and patient safety groups. Discharge performance is assessed through key metrics such as the number of discharges before midday on weekdays and weekends. Patient outcomes are monitored through CIVICA feedback mechanisms as well as re-admission rates following a recent discharge. Furthermore, compliance to expectations laid out in the policy are monitored through discharge fundamentals including compliance to estimated discharge dates set in the system and reasons for delay each day.	31/03/2026
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	9.1	The Health Board should improve record keeping by: 9.1. ensuring all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes to support effective discharge planning.	Monthly audits: ward staff conduct monthly audits of nursing documentation to assess the standard and detail of information recorded in patient records. This includes Admission documents, Risk Assessments, Care Records, and Discharge documents. Ward Accreditation Programme: The completion and detail of information recorded on these documents are included in the Ward Accreditation programme, which ensures that staff are aware of the importance of comprehensive documentation. Electronic WNCR Programme: Discharge Planning documentation is available on the electronic ~~WNCR programme, which facilitates the process and~~	Director of Nursing	30/04/2025	31/03/2026	Completed	Completed	1	The Health Board has implemented a ward accreditation programme with bronze, silver and gold levels that can be achieved. This is a recognised process through which wards and teams are assessed and recognised for their quality care and safety standards. The accreditation process aims to improve patient care by ensuring areas meet certain benchmarks such as cleanliness, staff performance, safety protocols, improvement projects and overall patient experience. ABUHB are currently rolling out accreditation across the health board with new teams joining the process every month. Most areas are at the beginning of their accreditation development - we would like to recognise their journey from bronze through to platinum. In addition, roll-out of CWS2 continues aiming to standardize processes around discharge planning pathways as part of the optimal hospital flow framework programme."September 2025: "BRR training focus on embedding training particularly at front door at GUH and COTE wards. Ongoing audits will include evidence that this appropriate is adopted, focus on patient outcomes. Ongoing ward audits aligned to the roll out of		The Health Board has implemented a ward accreditation programme with bronze, silver and gold levels that can be achieved. This is a recognised process through which wards and teams are assessed and recognised for their quality care and safety standards. The accreditation process aims to improve patient care by ensuring areas meet certain benchmarks such as cleanliness, staff performance, safety protocols, improvement projects and overall patient experience. ABUHB are currently rolling out accreditation across the health board with new teams joining the process every month. Most areas are at the beginning of their accreditation development - we would like to recognise their journey from bronze through to platinum.	31/03/2026

4008EA2025	External Audit	Structured Assessment 2025	Not Rated	Medical Director	N/A	3.1	The Health Board should ensure that reports to the Patient, Quality, Safety Outcomes Committee highlight issues raised through patient safety leadership walk rounds and the actions to address them (paragraph 24).	Reporting of issues identified during Patient Safety Leadership Walk Rounds, along with the actions taken to address them, is now embedded within the Health Board's governance framework. These issues and corresponding actions are captured in the Performance Report, which is formally submitted to the Quality Management Group (QMG) and subsequently to the Patient, Quality, Safety Outcomes Committee (PQSOC). The first update was presented to QMG in November and will be reported to PQSOC on 2nd December, with ongoing updates provided every two months thereafter. Each report will include a summary of issues identified, actions taken, and progress against those actions to ensure transparency and assurance. In addition, the Performance Report will also be presented to the Executive Committee, providing comprehensive oversight. Responsibility for maintaining this reporting process rests with the Director of Nursing, ensuring that this approach remains a standard part of the Health Board's governance arrangements.	Assistant Director for Quality and Patient Safety	01/01/2026		Completed	Completed	0			PSV actions have oversight from the Executive and Independent Member but are delivered through Divisions/Directorates. PSV reports are now a standing item on agendas for QMG/PQSOC. The Executive report will be received shortly.	31/03/2026	
4008EA2025	External Audit	Structured Assessment 2025	Not Rated	Director of Nursing	N/A	5.1	The Health Board should introduce a Patient, Quality, Safety Outcomes Committee audit tracker for recommendations from other review bodies, including Healthcare Inspectorate Wales and Public Services Ombudsman for Wales (paragraph 42).	The Health Board will record and monitor recommendations and actions from Healthcare Inspectorate Wales and the Public Services Ombudsman for Wales through the Audit Management and Tracking (AMaT) system. AMaT reporting will be integrated into the Patient, Quality, Safety Outcomes Committee's assurance process to ensure oversight of progress and completion.	Deputy Director of Nursing	28/01/2026		Completed	Completed	0	All PSOW recommendations are included on the monthly reporting to IQPD and included in the quarterly Quality Outcomes Framework report to give organisational awareness of the recommendations provided.		Those recommendations are recorded in the Actions section of the requisite Datix record to monitor progress and completion along with an independent database for completeness. This is held and overseen centrally by the Putting Things Right team.	31/03/2026	
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	4.1	Risk Assessments Of the 1,878 reported risks, the areas where the highest risks were overdue were: 142 in Corporate Services. 123 in Estates. A sample of 15 risks (relating to COSHH - 9, Sharps - 4 and Health & Safety – 2) was taken from the Datix Report from the Risk Register and the following was observed: 13 risks were not completed fully (e.g. target risk scores and target risk levels were not completed). - Seven risks were outstanding and past their "Next review date" and two risks were close to their "Next review date" (end of May 2025) and outstanding. - One high risk was identified in July 2023 and now passed its "Next review date" of April 2025 and is still outstanding. - Two low risks were given the status of "new risk" but were raised in March 2024, so should have the status of "current risk" and both have passed their "Next review date" of September 2024 and are outstanding. Eight risks raised between 2010 and 2023 were still classed as "current risks". These should have been closed or more detail added to explain the current position, including mitigating actions that have taken place in the meantime.	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. Expected Evidence of Implementation: - Review of Health and Safety Risks Report - Health and Safety Committee Notes of September 2025 meeting - Health and Safety Operational Group Notes of September 2025 meeting - Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings	Head of Health, Safety and Fire	31/10/2025	31/03/2026	Completed	Completed	1		The organisation has effective arrangements in place to actively monitor health and safety risks.	Routine inspections, audits, incident reviews, and statutory compliance checks are carried out, with actions recorded and tracked to completion.	Key performance information is reported through established health and safety / QPS groups, providing assurance to senior leadership that risks are being identified, controlled, and continually reviewed.	31/03/2026
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	5.1	Workplace Inspections A sample of 15 inspections conducted in 2024/25 were reviewed from the Health and Safety Dashboard. From the 213 actions raised: 70 were fully complete. 19 partially complete (overdue). 124 overdue actions (57 RAG rated amber and two RAG rated red). Of the 15 inspections, eight were completed between October and December 2024 and included 76 of the actions highlighted above. Whilst three of the inspections tested detailed compliance below 90%, AMaT did not include corresponding actions (for example, one of the inspections included an action that was RAG rated red). Discrepancies on the Dashboard could result in actions being missed resulting in significant patient or staff harm. Having been informed of this issue, management advised they were in the process of reviewing and actively addressing this matter. Further consideration should be given to reporting to an appropriate forum those areas that are not planned to be routinely covered by inspections – and the associated rationale/risks.	Agreed Action: To ensure divisional accountability, all divisions are responsible for ensuring that actions arising from workplace health and safety inspections are managed appropriately, including timely review and closure. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. Expected Evidence of Implementation: - Health and Safety Operational Group Notes of September 2025 meeting - Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings	Head of Health, Safety and Fire	31/10/2025	31/03/2026	Completed	Completed	1		Corrective actions from workplace health and safety inspections are recorded, assigned, and tracked to completion through established governance processes. Outcomes are shared with relevant teams, ensuring risks are addressed promptly and learning is communicated across the organisation.			31/03/2026
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	High	6.1	RIDDOR Reporting From the RIDDOR report for 2024/25 there were 73 incidents reported, of which 32 were categorised as 'slip, trip or fall'. The status of these was summarised as: 70 were closed. - Two were under management review / 'make it safe plus'. - One was awaiting closure. From the 11 incidents sample tested, seven were categorised as a 'slip, trip or fall' and the status of these were summarised as: - seven of the incidents were reported to the HSE within the RIDDOR timescale; but - four of the incidents were not reported to the HSE within the RIDDOR timescale. The main reason for non-adherence to the timeframe was because of late notification to the Corporate Health and Safety department.	Agreed Action: To ensure divisional accountability, all divisions will be held accountable for ensuring that all workplace incidents are reported and investigated promptly in line with legal requirements under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Timely reporting and investigation are critical to maintaining compliance and protecting staff and service users. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. Expected Evidence of Implementation: - Health and Safety Operational Group Notes of September 2025 meeting - Health and Safety Committee Notes of the September 2025 meeting - Health and Safety Performance Reports presented to Divisional Quality & Patient Safety meetings	Head of Health, Safety and Fire	30/11/2025	31/03/2026	Completed	Completed	0		RIDDOR-reportable incidents are identified promptly and notified to the Health and Safety Executive within required statutory timeframes.	Clear reporting procedures, timely incident reviews, and management oversight ensure that all qualifying incidents are escalated and submitted without delay, providing assurance of compliance with RIDDOR obligations.		31/03/2026
ABUHB-2425-12b	Internal Audit	Health and Safety	Limited	Director of Allied Health Professionals	Medium	7.1	Monitoring Health and Safety Risks at Committee and Board level Regular reporting was observed at many different forums including Board, Committees and operational forums in the form of QPS groups and divisional assurance meetings. Discussion was observed regarding outstanding risks and their levels in operational forums but limited escalation of risks which have been outstanding for an extended period. In addition, the Strategic Risk SRR010 has been reduced from a risk score of 16 to 12. Whilst the current risk score exceeds the appetite level, the overall risk should be reviewed in light of the internal audit outcomes reported. In addition, a deep-dive analysis would help provide greater insights on overdue risks and underlying issues.	A full review of all health and safety risks recorded in the DatixWeb system will be undertaken by the Corporate Health and Safety Department in Quarter 2 of 2025/26. The outcomes of this review will be presented to the Health and Safety Committee in September 2025 to inform assurance and improvement activity. To ensure divisional accountability, all divisions are responsible for actively managing their health and safety risks — including ensuring timely review, accurate risk grading, and appropriate mitigation. The Health and Safety Team is developing a Health and Safety Governance Framework, which will set out the accountability arrangements for poor compliance/performance with health and safety standards. This will be supported by the overarching Performance Management and Accountability Framework in place, should performance need to be escalated. The following mechanisms will be utilised to ensure health and safety compliance remains a key objective and focus: Health and safety risk management forms part of Divisional Directors' annual appraisals; 15 - It is discussed during regular 1:1 meetings' with Executive Directors; - Relevant expectations are reflected in divisional performance objectives and monitored through existing governance mechanisms. Expected Evidence of Implementation: - Review of Health and Safety Risks Report	Head of Health, Safety and Fire	31/12/2025	31/03/2026	Completed	Completed	0		The organisation has effective arrangements in place to actively monitor health and safety risks.	Routine inspections, audits, incident reviews, and statutory compliance checks are carried out, with actions recorded and tracked to completion.	Key performance information is reported through established health and safety / QPS groups, providing assurance to senior leadership that risks are being identified, controlled, and continually reviewed.	31/03/2026

ABUHB-2425-15	Internal Audit	Medical Equipment and Devices	Reasonable	Director of Allied Health Professionals	Medium	1.1	From a sample of 20 equipment items, four patient monitoring units which move around with patients could not be located and physically verified.	Agreed Action: A time limited working group will be established under the medical devices group to identify a solution for effective chain of custody monitoring. It must be recognised that there is no real time tracking solution established within the organisation and that RFID inert tracking system is currently utilised. An audit will be undertaken to establish baseline current state, including number of units within divisions, age of equipment and whether all units are RFID tagged and included on Medusa. This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation: - Written process for portable monitoring equipment chain of custody management - Audit outcomes - Documented monitoring and sign off within Medical Devices Group	Health Science Chair of Medical Devices Group	31/03/2026		Completed	Completed	0	The original management response has been superceded by a better solution... A protocol has been written for locating this equipment. There are two key developments that make tracing the equipment straightforward now that are described within the protocol: 1) The monitors that move with the patients to which they are connected communicate through the hospital computer network to a central Mindray system server, this can be interrogated to establish which WiFi access point or wired network point the respective monitor is communicating through and thus that location. 2) The monitors have passive RFID tags, which can now be logged with the location they are in when they are scanned during walk-throughs of ward areas by EBME and Equipment Library staff. The information is automatically uploaded into Medusa as the last seen location. In addition, Medusa can be interrogated for work orders relating to the equipment which will show if the respective monitor is undergoing work in in the EBME workshops or off-site. The protocol gives a step-by-step approach encompassing these for physically locating the equipment when this is required.	A new protocol has been adopted in the EMBE Department for locating items of medical equipment for which it is responsible for Medical Equipment Management (MEM) activities. The protocol specifies a stepwise process for determining the current location of a given item of equipment. There are new tools in place to aid this: 1) live update of the last seen location field in the Medusa MEM database on manual RFID scanning walkarounds and EBMEprocess touchpoints with the equipment, and 2) real-time visibility of current computer network connection point, and hence physical location, for Mindray patient monitors, both roving and static.	31/03/2026
ABUHB-2425-15	Internal Audit	Medical Equipment and Devices	Reasonable	Director of Allied Health Professionals	Medium	2.1	MEDUSA system modules (Work Orders, Planned Maintenance) were used to record the service/ maintenance where arrangements were managed by EBME. However, where a clinical service user managed this aspect themselves, no records of service events appear in the MEDUSA database and therefore no oversight is operated by the centre.	Agreed Action: Medusa maintenance tracking module or similar digital solution procurement will be explored by EBME and the estate & facilities division, to facilitate reconciliation of local electronic patient connected medical device management, with central oversight. Executive Director of Allied Health Professions and Health Science to communicate with divisions, highlighting divisional roles and responsibilities with respect to medical equipment management and adherence to organisational policies. Divisions should provide a mechanism for sharing access to this information to EBME for reconciliation audits to take place. Divisions will be expected to monitor progress through their divisional QPS meetings and provide assurance to the Medical Devices Group that inventory management processes are in place (this is also applicable to finding 3) This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation: - Implementation of digital solution that facilitates links between local and centrally held records - Divisions have mechanism in place to monitor asset management whether centrally held or through directorates	Health Science Chair of Medical Devices Group	31/03/2026		Completed	Completed	0	The Medusa Contracts Management module has been acquired and installed. This will centralise data on service contracts including those managed by the clinical departments and services. An ongoing rolling configuring and data population programme has been started to give full comprehensive oversight of contact information and status.	The Health Board has put in place a centralised system of recording external service contract management information about the equipment that is supported by these. The Medusa contracts management module has been acquired and installed into the Medusa Medical Equipment Management (MEM) database. Central oversight is now in place through an ongoing programme that has been started, to collate service contract information from clinical departments, configure the contracts management module and upload the data.	31/03/2026
ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	1.2	Job Planning compliance As of February 25, the compliance rate for the Health Board is 38.4% which means there is work to be done to ensure the Health Board reaches the 90% target set by the Welsh Government for the end of September 2025. Consultants are provided with time within their allocated SPA allocation time for the annual completion of job plans. From February 25 Dashboard out of 552 consultants: (including one consultant added post-fieldwork): • 212 job plans are complete • 245 job plans are in progress (including 141 >12 months overdue) – 44.40% • 26 job plans not started – 4.70% • 141 job plans in progress but are greater than 12 months overdue – 25.54% This highlights the need for immediate attention to ensure that all consultants meet their obligations and contribute to the overall goal of improved compliance.	Agreed Action: The Deputy Medical Director will hold deep dives in targeted areas where compliance is poor, starting with Medicine. Expected Evidence of Implementation: The actions identified will facilitate 90% compliance with job planning however given the change in approach and the requirement to put processes in place to support this 90% is unlikely to be achieved until the end of quarter two.	Medical Director	30/07/2025	28/02/2026	Completed	Completed	1		The Welsh Govt target of could not be completed - this could be classed as closed. The Health Board recognises that achieving 90% by Sept 2025 was extremely challenging and unlikely to have been met due to staff dispute and absence (e.g. parental leave, sickness absence etc). Believed a pragmatic target of 80% is achievable.	31/03/2026
ABUHB-24-25-28	Internal Audit	Newport East Health and Wellbeing Centre	Reasonable	Director of Public Health	Medium	4.1	Post project evaluation - communications A post project review should include the effectiveness of engagement of planned inclusions not provided (see Finding 2). Additionally, in the event that Park Surgery does move, certain support services for Park Surgery patients may nevertheless be provided from the new centre, potentially necessitating greater travel for certain services. An additional key matter raised in feedback was access to GPs, which in turn impacted referral to secondary services (see Finding 2).Review of communication, approvals and mitigations relating to such matters could also usefully form part of the planned post project review.	Agreed Action: During the Communication and engagement period a risk was flagged, at which point the communications and engagement strategy and working group was refreshed. Governance of the group was re-established with it reporting directly into the project board to ensure flow of communication, messaging and activities happened correctly. A series of engagement activities was carried out which can be found the engagement flow chart, and communication activity is captured in the embedded word document along with analytics of the 19 Hills ABUHB web page which hosted all communication throughout. In addition to this, the patients who will have been affected by moves, etc will have been appropriately communicated to in relation to appointments, etc and the dates from which they will be moved across to the new facility. As part of the wider Prost Project Evaluation and Lessons Learnt, communications will be subject area that will be assessed in order for us to take learning from. Expected Evidence of Implementation: • Lessons learnt findings 16	Assistant Director of Strategic Capital Planning & Head of Strategic Communications, Public Health.	31/03/2026		Completed	Completed	0		While a formal post-project evaluation focusing specifically on communications was not undertaken, we have gathered informal feedback from staff and patients using 19 Hills Health & Wellbeing Centre. This feedback was collected through day-to-day engagement with teams based in the building and attendees of the services delivered there. Key themes from the comments received include: •Improved service delivery: 'The space at 19 Hills means that we are able to provide this additional face to face class, which we feel is much more beneficial to antenatal families than the virtual group we would usually have offered.' •Positive experience and timely support: 'Many of the women signed up for antenatal education classes and found them really helpful... I've only had positive feedback and the service they offer is great!' •A welcoming environment that supports future service development: 'The space is welcoming and a hub of activity, providing us with a great atmosphere for our antenatal group...'	31/03/2026
ABUHB-2526-17	Internal Audit	Safeguarding	Reasonable	Director of Nursing	Medium	1.1	Safeguarding Policies and SOPs Ten policies and SOPs were reviewed (five key policies and five safeguarding SOPs). The main issues identified were: • Four of five key policies tested required review: two ABUHB policies are under active review and approval, one of which is the overarching Safeguarding & Public Protection Policy, while two all Wales policies are being reviewed within the Health Board to localise them; and • Four of five SOPs tested required review and update: it was not clear if they were up to date as there was no review date or information on the documents. Strengthening and reviewing policies and SOPs will ensure all stakeholders understand their specific duties and consistently follow established protocols, promoting a more co-ordinated and compliant approach to Safeguarding.	We acknowledge the need to ensure safeguarding policies and SOPs are current, clearly dated, and aligned with statutory requirements. While safeguarding operates within a multi agency framework via the Gwent Safeguarding Board, the Health Board has agreed through the Safeguarding Strategic Group to develop a localised suite of policies and SOPs. Actions will include: • Development and implementation of updated safeguarding policies and SOPs, incorporating statutory requirements and organisational needs. • Clear version control and review dates on all documents. Interim communication to staff highlighting which policies and SOPs are under review and where to access the most current guidance. Planned Policy Updates: • ABUHB Safeguarding Supervision Policy – renewed April 2025 • ABUHB Chaperone Policy – launched September 2025 • ABUHB Domestic Abuse Policy – scheduled for Clinical Standards & Policy Group November 2025 • ABUHB MAPPA Policy – scheduled for Clinical Standards & Policy Group November 2025 • ABUHB Safeguarding Policy – scheduled for Clinical Standards & Policy Group February 2026 • ABUHB People in Positions of Trust Policy – to be scheduled for Workforce Policy Group November 2025	Head of Safeguarding	28/02/2026		Completed	Completed	0		All the required policies have now been formally approved and are located on the Health Board Intranet. These went live in February 2026.	31/03/2026
ABUHB-2526-17	Internal Audit	Safeguarding	Reasonable	Director of Nursing	Medium	2.1	Training and awareness Level 1 and 2 adult and child training compliance as of Q1 2025/26 were close to meeting the Welsh Government target of 85%, however level 3 compliance was considerably below target: As of July 2025, 1,264 of 6,225 staff completed adult Level 3, and 860 of 2,457 completed child Level 3. A review should be conducted to identify opportunities to improve compliance, otherwise concerns of compliance should be escalated.	We recognise the need to improve compliance with Level 3 safeguarding training, which is currently significantly below the Welsh Government target of 85%. Actions will include: • Continued monitoring of compliance through the Safeguarding Strategic Group, with escalation to the Executive Committee Group, where progress is insufficient. • Implementation of a three-year delivery plan for Level 3 training, launched in April 2025, with clear milestones and capacity planning. • Short-term measures to increase training availability, supported by temporary funding, and review of sustainable long-term delivery options (SBAR to Executive Committee October 2025). • Measures to reduce non-attendance, including overbooking strategies and targeted reminders. • Communication to Divisional Leadership Teams to reinforce accountability for compliance.	Head of Safeguarding	31/01/2026		Completed	Completed	0		A training plan is implemented and adherence will be monitored via Safeguarding Strategic Group, which reports to QMG	31/03/2026

ABUHB-2526-17	Internal Audit	Safeguarding	Reasonable	Director of Nursing	Medium	4.1	Workforce representation Four Practitioner Concerns were reviewed and one did not have Workforce involvement even though it met the threshold.	Agreed Action: We acknowledge the importance of Workforce involvement in Practitioner Concerns processes to ensure consistency and timely resolution. Actions will include: • Ratification and implementation of the People in Positions of Trust Policy, which explicitly requires Workforce involvement in all relevant cases. • Completion of a documentation audit to confirm whether the identified case was an isolated incident or indicative of a wider issue. • Reporting of audit findings to the Safeguarding Strategic Group on 18 November 2025, with escalation of any systemic issues and implementation of corrective actions if required. • Publication of the approved policy on AB Pulse and communication to relevant stakeholders. Expected Evidence of Implementation: • Minutes from the Workforce Policy Group confirming policy implementation.	Head of Safeguarding	28/02/2026		Completed	Completed	0			Formal processes implemented. Compliance will be monitored through internal assurance processes.	31/03/2026
ABUHB-2526-24	Internal Audit	Welsh Intensive Care Information System	Substantial	Director of Digital	Medium	1.1	There is no structured process for monitoring and ensuring lessons are embedded in procedures and other programmes, with the current process mainly relying on staff reviewing the register.	Agreed Action: As part of the Digital Project Management Framework, the Project Initiation Document (PID) template will be updated to include a dedicated "Lessons Learnt" section. Each lesson will explicitly reference the originating project. Additionally, regular reviews of lessons learnt will be incorporated into project health checks. This process will ensure that lessons are consistently captured and embedded into future project PIDs. Expected Evidence of Implementation: Updated PID template. Internal approval and publication of the revised template. Delivery of targeted communications and training sessions to all project teams. Regular project health checks evidencing the embedding of lessons into new projects.	Assistant Director of Digital Transformation	31/03/2026		Completed	Completed	0			PID template updates completed. Internal approval and publication of the revised template completed. Delivery of targeted communications and training sessions to all project teams is completed. Regular project health checks scheduled to evidence the embedding of lessons into new projects.	31/03/2026
ABUHB-2526-25	Internal Audit	RGH Central Decontamination Unit	Reasonable	Director of Planning, Strategy and Partnerships	High	2.1	Derogation Schedule A derogation schedule records and approves deviations from standards, policies, or contract terms. The latest schedule (August 2025) was reviewed and identified several weaknesses e.g. some derogations lacked sufficient justification, and evidence of formal sign-off was not documented. In addition, the September 2025 risk register highlighted an amber-rated risk (score 12) relating to derogation approval and design variations. With project completion expected in February 2026, unresolved derogations may result in delays or challenges at handover and commissioning. Action was required to provide full justification and secure timely approvals for all derogations. Progress and resolution of these matters should be formally reported through the Project Board. Agreed Action: Urgent review of derogation schedule ensuring agreement and sign-off to the latest derogations. Derogation schedule reviewed by Head of Works & Estates. Derogation schedule will be presented to relevant subgroups for review and sign off. Expected Evidence of Implementation: Agreed and signed-off derogation schedule	Divisional Director Estates and Facilities	01/01/2026		Completed	Completed	0			Derogation scheduled signed off and completed. Further projects will ensure Derogation Schedule is completed prior to signing of contract	31/03/2026	
ABUHB-2526-25	Internal Audit	RGH Central Decontamination Unit	Reasonable	Director of Planning, Strategy and Partnerships	Medium	5.1	Project Bank Account Welsh Procurement Policy Note (WPPN) 04/21 requires that all Welsh Government construction and infrastructure contracts, and other appropriate contracts valued at £2m or more, utilise a Project Bank Account (PBA) unless compelling reasons for exemption are documented and approved. Similarly, Health Board SFIs require the Director of Finance to ensure PBA policy compliance for capital projects over £2m or formally seek exemption from Welsh Government. For this project, no PBA was established, and management had not confirmed whether an exemption application had been submitted. It was noted, however, that the main contract was an extension of the previous Endoscopy Redevelopment arrangement, and therefore a PBA was not considered, as the previous project had not applied a PBA, an issue highlighted in the last audit report. Project payments are currently managed through monthly valuations/invoices, with defined purchase orders in place. Internal processes should be reviewed to ensure PBA considerations (and exemptions, where relevant) are explicitly documented at the initiation of all capital projects over £2m. Agreed Action: Review internal process to ensure all necessary documentation is considered and completed prior to contract start date ensuring the governance process is followed and correctly implemented. Expected Evidence of Implementation: Signed documentation showing the correct process being followed.	Project Director	01/01/2026		Completed	Completed	0			Process reviewed and has/will be applied to future projects	31/03/2026	
4007EA2025	External Audit	Eye Care Review	Not Rated	Director of Planning, Strategy and Partnerships	N/A	3.1	Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities.	Chair of Regional Ophthalmology Programme Board	31/03/2026		Completed	Completed	0			Revised ambitious yet realistic priorities agreed by Programme Board in September 25 for the programme	31/03/2026

Appendix B: Revised Deadline Requests

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	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
2022.25	Internal	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects, allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	IWN Programme Manager	01/10/2023	31/12/2026	Overdue	Overdue	3	March 2026: The new community model is being implemented, as part of the health board's commitment to place based working. The IWN programme has four distinct functions within the PBC programme: 1. Community engagement and capacity building; 2. Community asset mapping and organising; 3. Bridging, linking and co-ordinating well-being assets; and 4. Individual and group behaviour change. The IWN programme is central to delivery of these four functions and engagement has continued over the last year with RPB development sessions, workshops with ISPBs, GAVO and TVA to ensure a universal model of well-being, proportionate to need. To address the four functions, the IWN team continue to work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individuals within them, to be able to thrive; identify, connect and mobilise existing strengths within a community that can be leveraged to enable communities to thrive; and create stronger, integrated support networks that enhance health, wellbeing and resilience of individuals and communities. The IWN programme evidences its impact through regular reporting to RIF, with progress captured against the RIF national dataset and any project and system-level measures to demonstrate project impact; details of inputs, outputs, outcomes and enablers which capture the intended and unintended impacts of the programme; and the provision of case studies to demonstrate impact of the IWN programme in a real-world context. Notable progress has been made with the alignment of behaviour change practitioners (BCPs) to locality areas over the last 6 months. BCPs provide specialist behaviour support and advice to people who want to quit smoking, as well as being equipped with the ability to support people to make changes to their diet, physical activity and alcohol use where appropriate. BCPs will be a core part of a place-based neighbourhood teams and will support building the capability of behaviour change amongst professionals and across neighbourhood teams.			31/03/2026
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R3	Infrastructure assets should be detailed within a single register / CMDB.	ABUHB partially accepts this recommendation. ITIL Best practice suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	Head of Informatics Service	30/11/2024	31/07/2026	Overdue	Overdue	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			31/03/2026
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	Chief Technology Officer	31/07/2024	31/07/2026	Overdue	Overdue	3	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			31/03/2026
2023.34	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 on WPAS. Refresher training will be provided to existing staff and competency assessed.	Head of Health Records/Referral & Booking Centres.	30/09/2024	31/01/2027	Overdue	Overdue	2	Mar 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse, including the expansion of RTT guidance are now in place. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials, including updated pathway content, are nearing completion. Planning is progressing for the next phase of refresher and review activity, alongside the commencement of inpatient training, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. Additionally, a Training Hub has been developed within the RBC ABPulse page, providing a central repository for SOPs covering outpatient booking, reception and validation processes. A Validation strategy is also in development to ensure a more consistent and structured approach to validation activity across services Apr 2025: The OCP process is currently underway and a recruitment exercise will be conducted to establish a new WPAS Product team responsible for delivering training. In the interim, the Information Development Manager and WPAS Service Manager are collaborating to identify solutions for bridging the gap in training support. The booking app is in place and will be available as part of the soft launch in mid November. Training materials and lesson plans will be reviewed and updated following the anticipated release of revised RTT rules 16/04/25 to ensure alignment.			31/03/2026
2020.00	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 to ensure informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	30/06/2026	Overdue	Overdue	7	All engagement has now completed with a board briefing in April before Public Board approval in May			31/03/2026

2020.00	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	Director of Digital	31/12/2021	31/07/2026	Overdue	Overdue	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			31/03/2026
4002EA2024	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	30/06/2026	Overdue	Overdue	2	April 2026: Date in line with the IMPT Strategy. August 2025: This will be developed as part of the detailed plans aligned with the long term strategy			31/03/2026
4002EA2024	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	30/06/2026	Overdue	Overdue	2	April 2026: Date in line with the IMPT Strategy. August 2025: Refer to above, Also the route map to recovery will need to be refreshed during 2025/26 to ensure financial savings are identified for the major thematic areas within the V&SB categories by the lead executives and delegated budge			31/03/2026
4916A2025	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	30/06/2026	Overdue		0	April 2026: Primary & Community Care are currently piloting an 'in house' Directory of Services for their Divisional use only. Discussions are ongoing about how to implement this on a wider basis. This doesn't form part of the Single Point of Access/Navigation Hub work programme as yet. Further internal discussions need to take place in order to ascertain centralised ownership & resource allocation (people & funding) to progress during Q1 of 2026/27: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.			31/03/2026
4916A2025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Chief Operating Officer	N/A	6.1	Referral pathways R6 To improve access and utilisation of referrals for appropriate alternative urgent and emergency care services, the Health Board should work with key staff, including WAST, to develop referral mechanisms that are clear, well-communicated and easily accessible (Paragraph 39).	To improve access to appropriate urgent and emergency care services, and to support more efficient use of alternative referral options, the Health Board is taking the following steps: ABUHB was the first Health Board in Wales to implement a 24/7 SPOA for referrals and advice between primary care, WAST, and secondary care. While this system is functioning well for direct secondary care access, we recognise the need to further strengthen pathways to alternative services. We have established a Navigation Hub Project Group specifically to improve the clarity and accessibility of referral routes to services such as Frailty, Ambulatory Emergency Care, and Urgent Primary Care. This group is reviewing existing referral mechanisms and identifying opportunities to streamline processes for front-line staff.	Chief Operating Officer	31/03/2026	30/06/2026	Overdue		0	April 2026: Referral routes via the Flow Centre are managed by each Department & Division. Current Flow Centre leads are working through the known pathways to ensure they are up to date, accurate, owned and published for access to all Divisions that do require use of them. This is being monitored via an improvement plan owned by Urgent Care Division & supported by the Associate Director of Operations (Patient Transportation Services) for transparency. Reporting via the Our Next Patient programme during Q1 2026/27.			31/03/2026

ABUHB-2425-07	Internal Audit	Declaration of Interests	Substantial	Director of Corporate Governance	Medium	1.1	Monetary Value Gifts We found two exceptions from 20 sampled where declarations were made after the benefit was approved; one was concerning a trolley for a ward and the other one was a £30 voucher for an individual which was received in the person's absence but was over the £25 threshold and in the form of a gift voucher. Whilst the policy allows, in some instances, gifts to be received (e.g. where it may cause offence to the donor), the declarations should be made (and approved) prior to the acceptance of the gifts. Furthermore, any cash, vouchers etc. should be donated to a charitable fund instead.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 14), awareness sessions will be held with managers to set out the requirements of the Policy and ensure these are further cascaded to staff. The Policy also sets out that the importance of continued compliance will be referenced in induction programmes. Expected Evidence of Implementation: Evidence of awareness sessions and inclusion of Standards of Business Conduct in the corporate induction programme.	Director of Corporate Governance	31/03/2026	30/06/2026	Overdue		1	Working with workforce and OD colleagues to include in corporate induction information. Policy and supporting guidance published on the Corporate Governance site on AB Pulse.			31/03/2026
ABUHB-2425-07	Internal Audit	Declaration of Interests	Substantial	Director of Corporate Governance	Medium	2.1	Mandatory Declarations Whilst it is the responsibility of individuals to declare interests, there is a requirement for some staff groups (e.g. Band 8A and above) to complete a mandatory declaration (either nil or otherwise). Currently, there is no central process (including reminders) for ensuring all staff required to do this complete the declaration process in a timely manner.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 6), Line Managers are responsible for ensuring employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy is to be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate. In addition, the Corporate Governance Directorate will establish a centralised process to monitor and track the submission of declarations by all those staff required to submit a return in-line with the policy.	Director of Corporate Governance	31/03/2026	30/09/2026	Overdue		1	Working with Workforce and OD colleagues to include list of 'high risk' groups in PADR documentation. Joint letter sent from DoCG and MD to all consultants reminding them of the requirement to declare interests. List of band 8a and above staff requested to target this cohort of 'high risk' staff. Meetings held with other Health Boards on the use of ESR to record DoIs in order to facilitate monitoring of compliance levels.			31/03/2026
ABUHB-2425-15	Internal Audit	Medical Equipment and Devices	Reasonable	Director of Allied Health Professionals	High	3.1	From the sample, six cases identified that the equipment user was responsible for the service/ maintenance cover of the item, but we were unable to obtain any records to evidence this was currently active in any of these cases.	Agreed Action: Executive Director of Allied Health Professions and Health Science to communicate with divisions, highlighting divisional roles and responsibilities with respect to medical equipment management and adherence to organisational policies. Risk assessment to be undertaken with respect to equipment maintenance. This will be held on the medical devices group risk register with progress being monitored by the group through risk agenda item. Time limited multi-divisional working group to undertake work to establish: - Develop divisions of responsibility document – this will support understanding of who is responsible for what aspects of medical equipment management - Definitive list of patient-connected electronic medical devices that are in-scope - Current state baseline audit of in-scope equipment where equipment maintenance is service responsibility - Seek divisional assurance that identified equipment has adequate maintenance arrangements This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required.	Health Science Chair of Medical Devices Group	31/03/2026	30/06/2027	Overdue		1	A tabular document has been created for cross-referencing key categories of medical equipment types and the different aspects of lifecycle management for medical equipment. Lead operational managers of services and departments for the top-level of medical equipment categories have been identified and a programme of work established with them to fully populate the table. There has been a delay to completing this information gathering exercise due to service pressures, however a clear path to green is now in place for completion within the next Month.			31/03/2026
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	4.1	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit. Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.	Head of IG & DPO	31/03/2026	30/11/2026	Overdue		0	The proposal has been developed but funding not yet identified			31/03/2026
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	31/01/2027	Overdue	Overdue	4	March 2026: March 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials are nearing completion. Planning is progressing for the next phase of refresher and review activity, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. A Training Hub has been developed within the RBC ABPulse page, providing a central repository for standard operating procedures. Functionality within WPAS to prompt users to check keynotes is being explored, with ongoing engagement across other Health Boards already using this feature.			31/03/2026

ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: Ref Description of the issue Number of patients 1 The alive / deceased patient file was not sent for scanning. - 47 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 3 The Patient was transferred without physical patient record within the HB. - 4 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 5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10 6 Various supplementary paper records left behind after the patient's DHR file was sent for scanning. - 8 We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: • no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months or	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. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: • A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings • The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit	Head of Health Records – DHR	31/12/2025	31/07/2026	Overdue	Overdue	4	March 2026 Update: Completed ward engagement visits, providing hands on support and advice to ward clerks with issues that were reported in the Audit. Following feedback from ward clerks, who reported uncertainty with role expectations and records management standards, The Health Records Support Network was established. This network enables real time advice, best practice sharing and access to Standard Operating Procedures. The Network has introduced a Monthly "Spotlight on" feature where a topic, issue or process is selected to share tips and best practice. Supplementary health records management training has been integrated into Corporate Induction for newly qualified nurses & ward accreditation. This training directly addresses issues with access to paper records and provides best practice guidance for nurses and ward managers. A proposal presented to the Core Learning Committee in February 2026 to make this training mandatory for specific staff groups is currently awaiting decision. A Health Records Survey was shared with all General Managers (Open November 2025 - April 2026) and the insights will be used to help shape improvement activity, and create a comprehensive Health Records Standards Plan. A contingency plan for ward clerk absences has been shared with Senior Divisional Nurses, outlining responsibilities and the process on how to notify The DHR service of ward clerk long term absences. The DHR service remains committed to continue these actions, improvements and engagement efforts to support continuous improvement and open communication.			31/03/2026
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance.	Chief Information Officer	31/05/2025	30/09/2026	Overdue	Overdue	2	OCP still to be completed. The DQ policy will follow when the OCP is completed.			31/03/2026
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	High	3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB "kitemark" will be added to reports so this will be clearly visible.	Chief Information Officer	31/07/2025	30/09/2026	Overdue	Overdue	0	Data strategy launch is scheduled for 13th May. The CoE will be established following this launch.			31/03/2026
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	High	2.1	Switch Patching 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.	Agreed Action: 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. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	31/10/2025	30/06/2026	Overdue		2	March 26 - Resource constraint with re-prioritising workloads and activities has delayed progression of this. The challenges with enabling Firewall rules which has now been overcome, our partner Block Solutions now need to complete their work to bring this service online			31/03/2026
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	High	1.1	BCP and action cards We noted none of the three sampled services had conducted nor scheduled any test exercises of their BCPs. Additionally, we noted the following weaknesses with BCP action cards: • action cards do not record triggers i.e. the event that would trigger their use; • action cards are not role specific; • not all action cards are critical function specific, but are more broad-based describing generic level actions; and • hard copy action cards are not stored in a safe place ready for use.	Agreed Action: The EPRR team will work with all service areas to ensure that local Business Continuity Plans (BCPs) are regularly tested and that action cards are updated to address identified weaknesses. Specifically: • Develop and roll out a train-the-trainer package and supporting test and exercise toolkit to enable divisions/directorates to conduct and record regular BCP exercises. • Support services to review and update all action cards to: - o include clear activation triggers; - o define role-specific responsibilities; and - o align actions to critical functions. • Ensure that hard copies of BCPs and action cards are securely stored and readily accessible in key operational areas. Monitor completion and effectiveness through local BCP assurance audits and reporting to the EPRR Group. Expected Evidence of Implementation • Approved train-the-trainer and test/exercise toolkit. • Records of completed BCP exercises conducted by services. • Sample updated BCP action cards showing: - o documented activation triggers, - o named roles/responsibilities, and - o linkage to critical functions. • Confirmation and/or photographs of securely stored hard copies in operational areas	Head of Planning – Civil Contingencies	31/01/2026	30/09/2026	Overdue		1	Internal audit questionnaire, monthly compliance checks, exercises, and a 2026 training programme are being used to strengthen BC planning and address audit gaps.			31/03/2026

ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	2.1	Training for key staff in their role and responsibilities in respect of delivering business continuity We were advised that in the sample services that we examined, only a small number of senior staff are familiar with the BCP protocols. All three sample services examined acknowledged the need to extend business continuity plan training to further key staff, but had not yet scheduled any training events.	Agreed Action: The EPRR team will ensure that key operational and managerial staff across all divisions/directorates receive appropriate training in their roles and responsibilities for delivering business continuity. Specifically: • Identify and confirm Business Continuity (BC) leads within each division/directorate. • Develop and deliver a stand-alone, role-specific training package focused on staff responsibilities for activating, managing, and maintaining BCPs. • Ensure BC leads are equipped to cascade this training to other key staff within their areas. • Monitor completion and effectiveness through service level audits and regular reporting to the EPRR Group. These actions will ensure that all key staff understand their specific roles within the business continuity framework and can implement BCPs effectively during service disruption. List of appointed BC leads for all divisions / directorates • Approved and issued BC role-specific training package. • Training attendance records demonstrating that BC leads and key staff have completed training. • Evidence that training has been cascaded to relevant operational staff (e.g.	Head of Planning – Civil Contingencies	31/01/2026	30/09/2026	Overdue	1	Bespoke IT downtime exercises and BC assurance for new digital systems are being rolled out with DDaT, alongside continued BC roadshows to raise awareness.			31/03/2026
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	3.1	BCP contact details protocols We noted an instance in the testing where BCP stakeholder contact details were recorded in the form of a SharePoint location that may not be operable in an interruption event and mean key resources cannot be mobilised.	Agreed Action: The EPRR team will ensure that current and accessible contact details for all key stakeholders is available and usable during any service interruption. Specifically: • Each service area will maintain hard copy BCP and action card folders containing up-to-date contact details for all critical staff, partner organisations, and stakeholders. • These folders will be stored securely and accessibly in designated operational areas to ensure they can be used if electronic systems (e.g., SharePoint) are unavailable. These actions will ensure that essential contact information remains accessible during an interruption, enabling timely and effective incident response. Expected Evidence of Implementation: • Confirmation showing hard copy BCP and action card folders are available in each service area.10 • Evidence of up-to-date contact lists included within those folders. • EPRR audit reports confirming that hard copy plans and contact details are in place, accurate, and accessible. Divisional assurance updates presented to the EPRR Group demonstrating ongoing compliance.	Head of Planning – Civil Contingencies	31/01/2026	30/09/2026	Overdue	0	Divisions must evidence BCP coverage, testing, and risk-register gaps, supported by unannounced compliance checks and targeted support for vulnerable services.			31/03/2026
ABUHB-2526-17	Internal Audit	Safeguarding	Reasonable	Director of Nursing	Medium	3.1	Safeguarding Strategy 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.	Agreed Action: 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. Actions will include: • Ratification of the new Safeguarding Strategy for 2025–2028 at the Safeguarding Strategic Group on 18 November 2025. • Incorporation of a review of progress against the 2022–2025 strategy and inclusion of measurable objectives for the new period. • Alignment with the overarching Quality Strategy and integration of recent developments, including the revised reporting framework and Level 3 training requirements. • Publication of the approved strategy on AB Pulse and dissemination through appropriate communication channel Expected Evidence of Implementation: • Minutes from the Safeguarding Strategic Group confirming	Head of Safeguarding	30/11/2025	30/06/2026	Overdue	1	Publication of the NHS Executive Assurance and Accountability Framework is imminent. As such, it has been agreed to delay the agreement of the strategy until the safeguarding Strategic Group in May 26			31/03/2026
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	1.1	Strategic Risk Register The key controls recorded on the Strategic Risk Register against Strategic Risk 006 Part A (SRR 006A) are cyber security focused, however some are outdated or no longer relevant. The current risk and threat recorded for SRR 006A does not explicitly outline cyber security, although all the key controls for this risk and threat are cyber security focused. This could be updated to raise the profile of the cyber security risk to the organisation. The current risk appetite theme for SRR 006A is 'Service Delivery' which indicates an 'Open' risk appetite level. However, the most appropriate risk appetite theme for cyber security may be 'Compliance and Safety' which has a 'Minimal' risk appetite level, and this would mean the current risk score is outside of the risk appetite for the organisation. Agreed Action: At a strategic level, the Strategic Risk Register (SRR) is intended to capture broad organisational risks, rather than focusing on specific areas. Detailed and operationally focused risks, such as those relating specifically to cyber security are more appropriately captured within the Corporate Risk Register (CRR). This approach ensures that sensitive information and specific control measures are managed securely. The SRR will continue to reflect digital risk at a strategic level, with cyber security risks managed and monitored through the CRR where a more granular level of detail and assurance can be	ICT Cyber Security Manager/ Head of Corporate Risk and Assurance	31/01/2026	30/06/2026	Overdue	1	Risk Registers continue to reflect Cyber risk at both Strategic(SRR) and Corporate (CRR) risk levels within the organisation. The Strategic Cyber risk may need amending Risk SRR006A to reflect current cyber threats. Specific detailed Cyber Risks continue to be recorded and reported on at Corporate level with review through Service Delivery and quarterly reviews through the Information Governance Group with further reporting to Risk and Finance by the SIRO if deemed necessary.			31/03/2026	
ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	Medium	3.1	Staff awareness and training Recent phishing simulations indicate a click rate of 12% across the organisation. The absence of targeted training for compromised staff, combined with mandatory Information Governance and Cyber Security training completion rates falling below the Health Board's 85% target, increases the risk of continued vulnerability. It was suggested that staff awareness should be added as a cyber security risk to raise the profile and ensure further monitoring of progress.	Agreed Action: Management accepts the recommendation and will address the findings through the following actions. • Continue the phishing simulation programme, using the established baseline to drive measurable improvement. • Deliver targeted follow-up training modules to individuals who regularly fail simulations, using tailored content linked directly to the exercises. • Report phishing simulation outcomes monthly through relevant governance groups to support monitoring of staff awareness improvements. • Enhance the visibility of cyber security messaging through regular internal communication and security awareness campaigns. • Work collaboratively with Information Governance, Counter Fraud, and other stakeholders to maximise use of available training resources. • Ensure cyber security staff awareness is appropriately reflected within the corporate risk framework for ongoing oversight. Expected Evidence of Implementation: • Monthly phishing simulation results and reports submitted through governance structures. • Governance and Assurance Group minutes demonstrating review of security awareness materials and outcomes	ICT Cyber Security Manager	31/01/2026	30/06/2026	Overdue	1	Cyber has continued with its simulated phishing exercises and staff failing the exercise receive targeted training as part of the campaign. Procurement of the incumbent Phishing Tool has been approved for three years which will help to increase email security awareness. The tool also has a library of security related training that will also be provided over the next three years and can be utilised by teams other than Cyber. Monthly reporting and trending of phishing campaign outcomes will be provided within the monthly Cyber Security Report. Training compliance for staff has now reached 85% and is continually monitored with an aim to improve levels.			31/03/2026

ABUHB-2526-22	Internal Audit	Cyber Security	Reasonable	Director of Digital	High	4.1	Cyber Incident Response Plan • The Cyber Incident Response Plan highlights that the plan should be tested every six months but his has not been done. • The Cyber Security Team do not have the capabilities, expertise or resources to deal with a cyber event internally and they do not have third-party support formally agreed. • The incident response plan highlights that there should be action cards that define the duties of everyone in the Cyber Incident Response Team (CIRT), however these have not been drafted. • Communications have not been drafted for any audience outside of the Health Board.	Agreed Action: A tailored tabletop exercise will be undertaken within the next three months to specifically test the current Cyber Incident Response Plan, as required. The scenario will incorporate the areas identified in the audit findings, including clarity of team responsibilities, escalation pathways and communication requirements. Following completion, the Cyber Security Team will produce a formal post-exercise report that clearly documents lessons learned and required improvements. These improvements may include the creation of action cards, enhanced external communication arrangements and the securing of specialist third-party cyber support. Learning and feedback from the recent national DHCW exercise will also be reviewed and used to strengthen the Health Board's Cyber Incident Response capability in line with the existing plan. Expected Evidence of Implementation: • Copy of the tabletop exercise scenario • Post-exercise report including improvement actions and implementation owners • Updated Cyber Incident Response Plan testing schedule (2026–27) • Documentation confirming the review and options appraisal for external specialist support (e.g., forensic retainer) • Draft or completed action cards supporting the Cyber Incident Response Team roles	ICT Cyber Security Manager	31/01/2026	30/06/2025	Overdue	1	A table top exercise(TTX) specifically aimed to test the Cyber Incident Response plan was undertaken in December 2025. Cyber have provided a post exercise report of recommended actions to include the development of action cards to support the incident management process. Cyber also met with KPMG and DHCW where agreement was reached around a process to call off external cyber expertise provided through DHCW by KPMG if required to support cyber incident management and forensic investigation for ABUHB. A schedule of quarterly TTXs are planned for 2026-27			31/03/2026
4007EA2025	External Audit	Eye Care Review	Not Rated	Director of Planning, Strategy and Partnerships	N/A	2.1	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	Chair of Regional Ophthalmology Programme Board	31/03/2026	31/03/2027	Overdue	0	Workforce plan delayed due to outsourcing project. Workforce plan is a priority for 26/27 with work due to start in April 2026.			31/03/2026

Appendix C: Exceeding Extension Threshold

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to Implementation	Evidence to complete or close recommendation
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	31/01/2027	Overdue	Overdue	4	March 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials are nearing completion. Planning is progressing for the next phase of refresher and review activity, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. A Training Hub has been developed within the RBC ABPulse page, providing a central repository for standard operating procedures. Functionality within WPAS to prompt users to check keynotes is being explored, with ongoing engagement across other Health Boards already using this feature.		
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: Ref Description of the issue Number of patients 1 The alive / deceased patient file was not sent for scanning. - 47 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 3 The Patient was transferred without physical patient record within the HB. - 4 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 5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10 6 Various supplementary paper records left behind after the patient's DHR file was sent for scanning. -8 We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: • no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months.	Agreed Action: 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. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.	Head of Health Records - DHR	31/12/2025	31/07/2026	Overdue	Overdue	4	March 2026 Update: Completed ward engagement visits, providing hands on support and advice to ward clerks with issues that were reported in the Audit. Following feedback from ward clerks, who reported uncertainty with role expectations and records management standards, The Health Records Support Network was established. This network enables real time advice, best practice sharing and access to Standard Operating Procedures. The Network has introduced a Monthly "Spotlight on" feature where a topic, issue or process is selected to share tips and best practice. Supplementary health records management training has been integrated into Corporate Induction for newly qualified nurses & ward accreditation. This training directly addresses issues with access to paper records and provides best practice guidance for nurses and ward managers. A proposal presented to the Core Learning Committee in February 2026 to make this training mandatory for specific staff groups is currently awaiting decision. A Health Records Survey was shared with all General Managers (Open November 2025 - April 2026) and the insights will be used to help shape improvement activity, and create a comprehensive Health Records Standards Plan. A contingency plan for ward clerk absences has been shared with Senior Divisional Nurses, outlining responsibilities and the process on how to notify The DHR service of ward clerk long term absences. The DHR service remains committed to continue these actions, improvements and engagement efforts to support continuous improvement and open communication.		
2020.00	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 CMO/CSO has been a significant step forward. Outwith the Directorate recommendations will be presented to Exco on overarching exec level oversight which is intended to both strengthen accountability but also to ensure Informatics capacity is used to best effect. Benefits realisation training has commenced in Informatics and will form part of reporting. It is in principle agreed that the Health Board adopts a single methodology and framework that should be co produced to manage all priority investments.	Director of Digital / Assistant Director for Strategy, Planning & Design	30/09/2021	30/06/2026	Overdue	Overdue	7	All engagement has now completed with a board briefing in April before Public Board approval in May		
2020.00	Internal	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R14 The asset and configuration management processes developed within the Informatics Directorate should be adopted as Health Board wide documents and departments with devolved control required to comply with the requirements.	Accepted. The HB governance, policy and processes will be reviewed as part of the SIROs objectives with resultant recommendations to Board. Informatics will need to review internal processes and capacity to ensure it can scale to meet the challenge.	Director of Digital	31/12/2021	31/07/2026	Overdue	Overdue	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.		
2022.25	Internal	Integrated Wellbeing Networks	Reasonable	Director of Public Health	Medium	R2	Management should clearly identify what a successful IWN project is, and future projects undertaken by the local IWN communities (e.g. projects identified within the IWN annual plans) should state SMART goals whereby the success of the project can clearly be defined. Management should also identify what success of the IWN programme in each community looks like and once that target is achieved be able to move to other areas of need and implement the programme within those locations	An independent advisory group of academics has been created due to meet in July 2023 to advise on (a) measures of evaluating progress towards the strategic objectives of the IWN programme in each place-based area of operation and (b) longitudinal methods for measuring community wellbeing in an evidence-based manner to understand how and whether the IWN programme is impacting on population wellbeing in its place-based areas. It is anticipated by September 2023 that a new evaluation framework will be proposed by this advisory group, with funding now apportioned for the appointment of a commissioned researcher to undertake an evaluation and embed this framework in programme monitoring for IWN into the longer-term. This will set the direction of success for local IWN projects. allow SMART goal planning and measure the success of the programme to enable exploration of working in other geographic areas in future. The evaluation work will be complete by 31st October 2023. The programme is planning to apply the King's Fund model for community-orientated needs assessment in defining success in each of the IWN areas to set goals for local areas and establish measures of success from 2024/25.	IWN Programme Manager	01/10/2023	31/12/2026	Overdue	Overdue	3	March 2026: The new community model is being implemented, as part of the health board's commitment to place based working. The IWN programme has four distinct functions within the PBC programme: 1. Community engagement and capacity building; 2. Community asset mapping and organising; 3. Bridging, linking and co-ordinating well-being assets; and 4. Individual and group behaviour change. The IWN programme is central to delivery of these four functions and engagement has continued over the last year with RPB development sessions, workshops with ISPBs, GAVO and TVA to ensure a universal model of well-being, proportionate to need. To address the four functions, the IWN team continue to work with communities to identify local issues and priorities to inform decision making and action by strengthening the skills, resources and abilities of communities, and the individuals within them, to be able to thrive; identify, connect and mobilise existing strengths within a community that can be leveraged to enable communities to thrive; and create stronger, integrated support networks that enhance health, wellbeing and resilience of individuals and communities. The IWN programme evidences its impact through regular reporting to Rf, with progress captured against the Rf national dataset and any project and system-level measures to demonstrate project impact; details of inputs, outputs, outcomes and enablers which capture the intended and unintended impacts of the programme; and the provision of case studies to demonstrate impact of the IWN programme in a real-world context. Notable progress has been made with the alignment of behaviour change practitioners (BCPs) to locality areas over the last 6 months. BCPs provide specialist behaviour support and advice to people who want to quit smoking, as well as being equipped with the ability to support people to make changes to their diet, physical activity and alcohol use where appropriate BCPs will be a core part of a place-based neighbourhood teams and will support building the capability of behaviour change amongst professionals and across neighbourhood teams.		
2023.17	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 practise suggests that we have a Configuration Management System that may comprise several CMDBs to suit our environment. That being said there is a plan to ensure that all infrastructure assets are detailed within a single CMDB complete with hierarchies and dependencies, achieved through integration with live tools which will be hosted within our Halo ITSM tool.	Head of Informatics Service	30/11/2024	31/07/2026	Overdue	Overdue	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.		
2023.17	Internal	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	Chief Technology Officer	31/07/2024	31/07/2026	Overdue	Overdue	3	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.		

2020.00	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.	Director of Digital	31/12/2022	30/06/2026	Overdue	Not Yet Due	4	May 2025: No update awaiting Internal Audit work. Internal Audit have been tasked to undertake a specific audit of Shadow ICT as part of their 2025 audit plan. January 2025 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.		
2021.05	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	Assistant Directorate Manager	24/02/2022	01/09/2026	Overdue	Not Yet Due	3	January 2024: Workforce model to address Demand and Capacity gap for Cellular Pathology laboratory has been developed that will allow annual laboratory demand to be repatriated from outsourcing from April 2024. Equipment requirements to support repatriation of outsourcing are identified and included in Divisional Capital request for 24/25. Plan in progress to reconfigure current accommodation in Pathology block in RGH to provide suitable medium term accommodation (ETA for accommodation plan 31/03/24). Wider Cell Path workforce plan to include Digital Cell Path future challenges to be developed (ETA end of 24/25). Microbiology WFP has been developed and continues to be reviewed and updated, with HR input, as the landscape regarding Health Protection Services (HPS [formally COVID]) develops. Current core, HPS and Hot lab WFP being reviewed to define impact to service if current funding streams are not recurrent. All managers were asked to review their workforce plans following the audit. The Cellular Pathology workforce plan is included in sustainability paper. JH has confirmed the paper will need to be re-reviewed if 7 day working is planned. Mortuary workforce plan in progress with follow up meeting 6 weeks from 27/9/22. Microbiology workforce plan in progress to be completed by 5/10/22. Blood Sciences workforce plan in progress to be reviewed 5/10/22 prior to completion. All additional workforce requirements are already factored into annual plan/IMTP.	Time constraints: Accurate workforce planning takes a considerable time to complete. Managers need to manage staff and departments while ensuring other strategic and operational tasks are undertaken on a daily basis to ensure continuation of safe service delivery.	
2021.12	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.	PACS & RADIS Manager	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.		
2021.12	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.	PACS & RADIS Manager	31/03/2022	31/05/2026	Overdue	Not Yet Due	5	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. June 2024 - we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we it 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. Then will have discussions with software development and the CIO over the solution 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. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The UAT has been passed and this is currently being looked at by informatics	Aug 2023: Required scoping, testing and development and planned for software development	Needs to be agreed locally and product developed to suit ABUHB
2021.12	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 as 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.	PACS & RADIS Manager	30/04/2022	31/05/2026	Overdue	Not Yet Due	5	June 2025 - we have reviewed active users in RadIS to only create required users in the new RIS (Soliton) and are trying to work through this to replicate and make users inactive when appropriate. This is a manual task so dependant on admin work and us being made aware of recent leavers. Aug 2024: We are still limited to users outside of Radiology but there is communication for those internal to Radiology though it's not automated and dependant on people informing us of this. Outside of Radiology IT should disable their account in AD which will disable their access to the Healthboards systems. The new RIS/PACS access is dependant on being added to the appropriate AD groups which will be disabled when they leave the Healthboard. June 2024 - the position remains the same, any leavers within Radiology we are informed alongside their Nadex being deactivated by the admin Team in Radiology. In the new PACS/RIS solution provided by Philips and Soliton the accounts will be linked to active directory. This will stop their access to Radiology systems alongside with their access to any PC's in ABUHB. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: Any leavers we will make inactive unless access is required for global imaging within PACS or cross boundary electronic requesting if they are still working within the Welsh NHS. We are still dependant on this list being provided.		
2021.12	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.	PACS & RADIS Manager	31/03/2022	31/05/2026	Overdue	Not Yet Due	5	June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024 - the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution. March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Time and resource in RadIS. As well as pending RISP program may not help development.	
2021.12	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.	PACS & RADIS Manager	30/04/2022	31/05/2026	Overdue	Not Yet Due	5	June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH if there are issues with full functionality. If there are further issues in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution. Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominantly cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUH and a smaller backup in our YAB DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continuity. June 2024 - the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the YAB datacentre if there are issues with the GUH datacentre. March 2024: Position remains the same as started with January 24 Assurance report, further progress expected May 24. January 2024: Please refer to completed assurance report. Aug 2023: The BC plans in radiology are quite extensive and well practiced	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.	

2022.12	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.	DPO & Head of IG	31/12/2023	30/06/2026	Overdue	Not Yet Due	3	*April 2025 - Following recent refreshed audit into Records Management a task & finish sub-group is being setup to ensure any physical issues are identified and remediated where possible. 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. 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. Mar 24- Closure of another library of records achieved at Llangeinlech 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.		
2022.12	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/cube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	DPO & Head of Interim ADI – Governance & Assurance	31/12/2023	30/06/2026	Overdue	Not Yet Due	7	August 2025 - No resources within directorate to move forward with this recommendation, organisational change process within Service Management is underway and this recommendation will be reviewed once this has completed with resource alignment.Jun 24 Business Case for digitisation of remaining services records awaiting agreement so that work can commence as per R5. Further risk identified where existing tracking on former Epex system has not been fully migrated to WCCIS. Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.		
2022.19	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.1	All patient discharges from the care of the Health Board are effectively controlled and evidenced by issuing a timely, completed discharge notification.	The Medical Director is aware that the timeliness of some discharge notifications needs to be improved. A letter was sent to all medical staff outlining their responsibilities in respect of timely discharge notifications in 2021. This is now being followed up by the Assistant Medical Director for Planning who will be leading a task & finish group to develop standardisation of approach. This work will aim to ensure that patients are able to leave hospital with their discharge summary / notification and ensure it will be sent electronically to the GP on the same day	Medical Director/Assistant Medical Director for Planning/ Director of Nursing	01/04/2024	30/09/2026	Overdue	Not Yet Due	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 ofOctober 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		
2022.19	Internal	Discharge Planning	Limited	Director of Nursing	High	R3.3	A consistent discharge approach is adopted for all day care appointments and for inpatient transfers between Health Board sites	In respect of day care episodes of care, there are many diagnostic / treatment areas and specialities who have different methods of notifying both the GP and patient of the care episode. We acknowledge that this is not a standard approach with some departments combining the clinical details as the discharge summary. As part of the Task and Finish group, the Assistant Medical Director for planning will ensure that discharge notifications form part of the standardised approach. For inter-site transfers an SBAR is completed for every patient that outlines the patient's condition, diagnosis and any actions needed to be taken by the receiving site.	Assistant Medical Director for Planning	01/04/2024	30/09/2026	Overdue	Not Yet Due	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 2025/25th 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		
2023.06	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.	Director of Strategy, Planning and Partnerships	31/03/2024	30/09/2026	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 Board's Estates Strategy May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: As per the June updates, the Organisational Strategy is expected to be completed by the end of the calendar year. The PHPPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PHPPC. 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."		
2021.01EA	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.	N/A	30/04/2022	31/12/2026	Overdue	Not Yet Due	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: The roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress once purchased. Current technical issues with procurement. If resolved implementation will commence October 23. Nov 2022 the roll out the newly procured workforce medical e-system will resolve the logging of annual leave centrally. Incremental implementation will progress over the next 9 months.	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.	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Losses and Special payments – 1st April 2025 – 28th February 2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Director of Finance (Financial Systems & Services)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report provides the Audit, Risk & Assurance Committee with information in relation to financial losses and special payments made by the Health Board between 1st April 2025 and 28th February 2026.

Cefndir / Background

Losses and special payments are reported to ARAC because they are *exceptions* to normal expenditure—i.e., items that Welsh Government would not have contemplated when it agreed the Health Board's funding, and which "ideally should not arise". As a result, they are subject to **additional scrutiny, delegated approval limits, and formal reporting** (including disclosure in the Annual Accounts), so ARAC can gain assurance that:

- (1) the underlying control failures/causes are understood,
- (2) appropriate actions and "lessons learnt" are implemented, and
- (3) any recoveries (e.g., Welsh Risk Pool) are correctly pursued and accounted for.

Asesiad / Assessment



The Welsh Government Manual for Accounts (Chapter 6) outlines the types of expenditure which are considered as a loss or special payment (one where they ideally should not arise, or would not have been contemplated when Welsh Government agreed funds for ABUHB. The total cost year to date for ABUHB is £2.3m:

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Losses per Annex 1				
Losses of cash	-	-	-	-
Fruitless payments, including abandoned capital schemes and constructive losses	-	-	-	-
Bad Debts and claims abandoned	-	-	-	-
Damage to buildings and loss of equipment or property	-	-	-	-
Theft of IT Equipment	-	-	-	-
TOTAL LOSSES				
Special Payments per Annex 2				
Compensation payments made under legal obligation	-	-	-	-
Extra contractual payments to contractors	-	-	-	-
Ex gratia payments	-	-	-	-
Loss of personal effects	17	8	-	8
Personal Injury Settlements	102	711	554	157
Clinical Negligence Settlements	256	27,730	26,161	1,569
Other cases	35	-222	-161	-61
Maladministration	-	-	-	-
Patient referrals outside the United Kingdom, the European Economic Area (EEA) and Switzerland	-	-	-	-
Extra statutory or extra regulatory payments	-	-	-	-
Voluntary Early Release Scheme	3	204	-	204
TOTAL SPECIAL PAYMENTS	413	28,877	26,480	2,397
Other - Penalties	61	153	0	153
TOTAL LOSSES AND SPECIAL PAYMENTS	474	29,029	26,480	2,549

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

In addition to the cost recorded above, a provision for clinical negligence and personal injury cases is recorded on the balance sheet and is based on the estimated potential liability, as advised by Welsh Health Legal Services, of the maximum possible future cost for all known cases.

This provision has increased by £14.9m since 31st March 2025 to an overall provision of £213.6m. Of this, it is expected that £207.4m is recoverable from WRP leaving potential future losses to the Health Board of £6.2m.



The remainder of the report gives context to each loss or special payments that has arisen.

Losses

No loss has been recorded in the current year. However, as part of its ordinary year end processes consider those debts considered no longer economical to pursue for write off prior to 31st March 2026.

The authorisation of the individual bad debt write-offs will be determined by the value of the debt outstanding, and will follow the delegated authorised limit, as below:

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

Special Payments

Loss of personal effects

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Loss of personal effects	17	8	0	8

The Health Board has processed a number of Special Payments in the period in relation to the Loss of Personal Effects, whilst in the Health Board's care.

There have been 17 total payments made, totalling £8k. The largest value payment made in this category was £1.5k in relation to the loss of Dentures.

Losses forms are completed for each loss, which are subsequently authorised by the relevant Division and reviewed and approved by the Putting Things Right team.



Clinical negligence with advice

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Clinical negligence with advice	256	27,730	26,161	1,569

A significant volume of claims have been processed in the period which relate to Clinical Negligence cases which have a total value over £25k. The Health Board is liable for the first £25k of each claim, with the remaining amount recoverable from the WRP.

Each payment will have been verified and received appropriate authorisation before processing. Before reimbursement is recoverable from the WRP, a lessons learnt report is required, which is reviewed by the Litigation Committee. Feedback on the lessons learnt is also provided by the Quality and Patient Safety Committee.

Within the case figures above, there have been 12 cases in the period where the total amounts paid by the Health Board are above £300k.

The single largest payment made in the period in relation to a Clinical Negligence case was for £7.37m.

Personal injury with advice

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Personal injury with advice	102	711	157	554

Similarly, a large volume of claims have been processed in the period, which relate to Personal Injury cases, which have a total value over £25k. These also include Personal Injury Benefit payment which the Health Board has processed.

The single largest payment made in the period in relation to a Personal Injury case was for £140k.

Other Clinical Negligence and Personal Injury

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Other Clinical Negligence and Personal Injury	15	178	161	17

This relates to the amounts for cases classified as Redress (or Putting Things Right) which are Clinical Negligence and Personal Injury cases, where the total value of the claim is expected to not exceed £25k in totality. The vast majority of the costs for



these cases are recoverable from the WRP, except for the “Excess” amounts, which are the Defence/ Claimant costs borne by each case.

These have historically been classified as Redress or “Putting Things Right” cases. From April 2026, Welsh Government are re-naming these cases as “Listening to People” cases. As part of this strategy, the limit on the value of cases which are covered by this process will now be increased to £50k, rather than the previous £25k.

Members are asked to note that, from April 2026, the Health Board’s delegated limit for ‘making good’ payments increases to £50k. This change is expected to increase both the **volume** and **value** of cases that may be concluded and settled within Health Board delegation (i.e., fewer cases requiring escalation for approval beyond the Health Board), with a corresponding impact on the profile of losses and special payments reported to ARAC (more settlements clustered in the £25k–£50k range, and potentially fewer cases above the delegation threshold). The Health Board will continue to monitor trends following implementation and will report any material changes in activity or value to ARAC through future losses and special payments updates.

Other

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Other	20	44	0	44

These are losses payments which relate to a variety of cases which the Health Board has been required to make payments towards during the period 1st April 2025 to 28th February 2026.

Included within the above amounts are:

- 2 Employment Tribunal payments, totalling £17.3k
- 3 Settlement payments in relation to Mortuary incidents, totalling £25.2k
- 6 Ombudsman Investigation Cases, totalling £0.7k

Voluntary Early Release Scheme (VERS)

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Voluntary Early Release Scheme (VERS)	3	204-	-	204-

The Health Board may agree a Voluntary Early Retirement/Early Release Scheme where it supports service re-design and delivers sustainable, recurrent workforce savings. Each case is considered on its individual merits, ensuring that the cost of release is recovered within an appropriate payback period (less than one year) and that patient care and business continuity are not adversely impacted.



During the period 1st April 2025 and 28th February, the Health Board has agreed three VERS with staff members.

Each case has been reviewed and formally approved by the Remuneration and Terms of Service (RATS) Committee.

Penalties

Loss Type	No. of Cases	Total £000	Met by the Welsh Risk Pool £000	Net cost to ABUHB £000
Penalties	61	153	0	153

As detailed above, following initial payment by the Health Board, the amounts for Clinical Negligence and Personal Cases which exceed £25k are recoverable from WRP.

However to ensure reimbursement for the amounts recoverable, the Health Board must submit Lessons Learnt report to the WRP Committee which identify the key learnings taken from each case.

Only when the WRP Committee have received a satisfactory Lessons Learnt report which is clearly documented and implemented will they approved reimbursement to the Health Board.

To ensure compliance with this process, the Health Board must submit Lessons Learnt report within an adequate timeframe following the conclusion or final settlement of a case. If the deadline for submitting cases to the WRP Committee is not achieved, the Health Board will receive a £2,500 “penalty” for late submission. The WRP Committee meet every other month, and any failure to submit will face additional penalties at each committee where the report is either not submitted, or not approved as appropriately documented or implemented.

During the financial year, the Health Board has missed the deadline for submission of Lessons Learnt reports to the WRP Committee 61 times, including the following 3+ penalties on single cases:

- 1 case received 5 penalties totalling £12.5k,
- 2 cases received 4 penalties each, totalling £10k per case,
- 2 cases received 3 penalties each, totalling £7.5k per case.

Further to the direct costs of fines, there is a consequential impact on the risk sharing mechanism. The performance of each organisation is considered and forms part of the overall allocation of the risk share pool. IN the most recent allocations ABUHB fell by 0.75% points to 1.91% which resulted in an additional allocation of £270k. 1.91% reflects the third worst performance of all bodies.



	2024/25 RSA %	2025/26 RSA%	Increase/ Decrease %	HCHS Allocation	Claims History	PTR	Cashflow < 1 year	PPO	Audits / Lessons Learned
Aneurin Bevan	16.78%	18.22%	1.43%	5.72%	3.31%	2.54%	2.40%	2.34%	1.91%
Swansea Bay	15.25%	13.97%	-1.28%	3.79%	2.70%	1.77%	2.03%	2.38%	1.30%
Betsi Cadwaladr	19.22%	21.00%	1.79%	6.75%	3.94%	1.93%	3.09%	1.89%	3.40%
Cardiff & Vale	15.86%	16.76%	0.90%	4.08%	4.56%	1.66%	3.67%	1.56%	1.23%
Cwm Taf Morgannwg	14.76%	14.60%	-0.16%	4.49%	2.64%	1.05%	2.34%	1.04%	3.04%
Hywel Dda	9.70%	10.03%	0.34%	3.86%	2.47%	0.77%	1.19%	0.53%	1.21%
Powys	4.13%	2.12%	-2.01%	1.31%	0.02%	0.00%	0.02%	0.17%	0.60%
Public Health Wales	1.14%	0.64%	-0.50%	0.00%	0.08%	0.06%	0.13%	0.00%	0.38%
Velindre	1.15%	0.79%	-0.36%	0.00%	0.05%	0.00%	0.05%	0.00%	0.69%
Welsh Ambulance	2.01%	1.87%	-0.14%	0.00%	0.22%	0.22%	0.07%	0.09%	1.27%
	100.00%	100.00%	0.00%	30%	20%	10%	15%	10%	15%

Clinical Negligence and Personal Injury Provisions

The table below shows the analysis of the estimated liability for losses as at 28th February 2026 compared to the position reported at 31st March 2025. It reflects the estimated liability in relation to cases advised by Welsh Health Legal Services for both clinical negligence, personal injury and redress with the provision updated to reflect new or changed cases.

After the expected recoveries from the Welsh Risk Pool are taken in to account the estimated liability to the Health Board at 28th February 2026 is £6.2m.

Losses & Special Payments Provisions	31-Mar-25		28-Feb-26	
	No. of Cases	£'000	No. of Cases	£'000
Clinical Negligence	286	195,202	330	209,937
Personal Injury	63	158	75	525
Permanent Injury Benefit	21	3,169	21	3,065
Redress	19	164	9	91
Sub Total	389	198,693	435	213,619
Less WRP Recoverable: Clinical Negligence	-175	-192,868	-209	-207,247
Less WRP Recoverable: Personal Injury	0	0	-5	-100
Less WRP Recoverable: Redress	-19	-155	-8	-84
Net Liability	195	5,670	213	6,188

The percentage of recovery for Personal Injury cases is much lower than Medical Negligence cases as most Personal Injury cases are under £25K. Up to the end of February 2026, only 5 of the Personal Injury cases out of the 70 cases are over £25K whereas 209 of the 330 Medical Negligence cases are over £25K.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau)



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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	Is EIA Required and included with this paper A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:



• Workforce • Service Activity & Performance • Financial	Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Single Quotation and Tender Actions from 1st November 2025 to 31st March 2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Finance, Procurement and Value Based HealthCare
SWYDDOG ADRODD: REPORTING OFFICER:	Alex Curley – Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

This report provides the Audit, Risk and Assurance Committee with an update in relation to the single tender / quotation action requests submitted to Procurement and is a standing report covering these key issues as part of the Committee's work plan for the year. The paper reports the outcome of these requests.

Appendix A provides specific detail regarding the Single Tender/Quotation Actions (STQ/STA) that have been submitted and approved for the period 1st November 2025 to 31st March 2026.

Cefndir / Background

Whilst there can be valid reasons for only tendering with a single party, there is a risk that tenders involving only one party do not secure best value for money as a priority.

The monitoring of the use of STAs is also noted by NHS Performance and Improvement as an appropriate process to support robust grip and control.



Consequently, it is a requirement of Aneurin Bevan Health Board Standing Orders and Standing Financial Instructions that all requests for a Single Tender action (STA) or a Single Quotation action (SQA) are submitted to the Director of Finance and Chief Executive for consideration. The Deputy Head of Procurement provides a summary for each Audit, Risk and Assurance Committee detailing all actions submitted for consideration. The Audit, Risk and Assurance Committee's work plan includes a standing item for review of the following at each meeting.

Asesiad / Assessment

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

There has been 11 requests submitted which have been approved during the period with an annual value of £774,994 Ex VAT. Of the request submitted 8 of these were related maintenance of equipment which can only be maintained by the original equipment manufacturer with an annual value of £147,619. A further 2 contracts were awarded for goods/spare parts which again had to be provided by the original equipment manufacturers for compliance with warranty at an annual cost of £72,575.

The final STA was for the continuation of an insourced bowel screening service which required the same provider for business continuity reasons with an annual value of £525,800. Procurement was able to award this contract via a direct call off from a framework however, it was agreed that this would be reported via the STA route as this could have been competed had procurement been engaged earlier in the process help evidence value for money. This has subsequently been competed with the award of a new contract imminent.

Two further STA request have been received by the Procurement team in relation to consultancy/project. This entity had been initially engaged by the Surgery division to assist with the Omnicell project but had remained supporting the division with other projects including procurement support. The first was rejected/not endorsed as the request was retrospective whilst the request for continuation of the STA from April 2026 was also rejected as it did not meet the requirement of an STA as this service could be competed on the open market. Procurement and Finance are currently working through this issue with the Surgery division and will complete a file note to be reported back to committee.

Category under the SFI justifying the use of STA	Occurrences (no.)	Value (£/annum)
Follow-up work where a supplier has already undertaken initial work in the same area (and where the initial work was awarded from open competition);	0	-



A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	10	220,194
The need to retain a particular contractor for genuine business continuity issues (not just preferences)	1	525,800
An interim agreement prior to joining an all-Wales Collaborative Agreement.	0	-
Genuinely Only one Provider	2	275,672
In line with Policy and justified STA	11	745,994
Not in accordance with STA rationale	2	275,672

In addition to the above it has been noted following a recent audit that one contract awarded as part of the wider capital scheme for the Grange University Hospital Emergency Department Extension should have been reported as a Single Tender Action in line with the standing financial instructions. The contract for furniture was completed using a request for approval when in fact this should have been completed using the STA request form. The value of the contract awarded was £11k. This has been addressed with the procurement team with additional training and support provided. The team have amended the checklist to ensure the correct approach is followed and documentation has been updated improve the approvals process and is due to be implemented April 2026.

Argymhelliad / Recommendation

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

1. Assurance that the volume and value of STA/SQA remains low indicative with appropriate and not excessive use;
2. That the SFI process is being followed in most cases, with remedial actions for those specified where due process was not followed.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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



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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



Internal Audit Progress Report

Audit, Risk and Assurance Committee

April 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

2. Progress against 2025/26 Internal Audit Plan

3. Summary of Findings for Recently Completed Work

4. Draft Head of Internal Audit Opinion

5. Draft 2026/27 Internal Audit Plan

6. Summary of Audit Briefs Recently issued

7. Recommendation

Appendix A: Progress against 2025/26 Internal Audit Plan

Appendix B: Audit Assurance Ratings

Appendix C: Audit / Review Briefs Issued

3

3

3

5

5

5

6

7

8

9

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 April 2026 Audit, Risk and Assurance Committee (the 'Committee');
- approve the draft 2026/27 Internal Audit Plan;
- provide an overview of the draft Head of Internal Audit Opinion; 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 12th February 2026:

AUDIT ASSIGNMENT	ASSURANCE RATING
Speaking up Safely	Limited
The Grange Emergency Department	Limited
Strategic Risk and Assurance	Reasonable
Capital Projects: Service Readiness	Reasonable
Directorate Review - CAMHS	Reasonable
Occupational Health	Reasonable

Further information over the assurance rating detailed above is included within Appendix B.

The current position of the 2025/26 Internal Audit Plan is summarised below, with further detail within Appendix A.

Audit Status	Number
Final reports	17
Draft reports	7
Work in progress	3
Planning	0
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 12th February 2026.

Speaking up Safely (limited assurance)

The audit noted that the current approach is manual, time-consuming and does not reliably capture all activity undertaken to progress / manage cases. As a result, a **limited assurance** opinion was concluded, reflecting recurring issues from the previous audit. Key matters include:

- the need for clearer guidance on SUS roles (including the vacant Independent Member lead) and minimum record requirements;
- significant data quality and completeness issues in the spreadsheet, with limited supporting evidence and poor cross-referencing to linked processes;
- risk of apparent premature closure due to incomplete recording of substantial case activity; and
- limited evidence of lessons learned and learning from users' experiences.

The GUH Emergency Department (limited assurance)

The audit of the Grange University Hospital Emergency Department Extension project for 2025/26 concluded **limited assurance** due to significant delays, contractor performance issues, and financial uncertainties, with Phase 1 delayed by 45 weeks and Phase 2 removed for re-tendering in 2026/27. Key management actions include undertaking a lessons-learned review, improving financial reporting, managing contractual changes timely, and revising the benefits realisation plan, while governance and quality assurance were deemed reasonable but with room for improvement in reporting and operational planning.

Strategic Risk and Assurance (reasonable assurance)

The audit report provides **reasonable assurance** that the governance and strategic oversight of risk and assurance are generally effective and aligned with organisational goals. Three key areas were identified for improvement: formalising Executive Committee oversight of the Strategic Risk Register (SRR), strengthening the linkage between the Health Board's strategy and the SRR, and enhancing the completeness and quality of SRR content to support transparency and effective scrutiny.

Capital Projects: Service Readiness (reasonable assurance)

The audit evaluated the arrangements in place on the service side in preparation of opening two Health and Wellbeing Centres. Whilst providing **reasonable assurance**, key findings included the need to update commissioning procedures, enhance monitoring of pre-commissioning plans, earlier establishment and sustained operation of working groups, improved operational compliance and clarity on key roles to ensure consistent and effective commissioning.

Directorate Review – CAMHS (reasonable assurance)

We provided **reasonable assurance** on the risk management, performance monitoring, and governance arrangements within the Children and Adolescent Mental Health Services (CAMHS) Directorate. It did however identify areas for improvement, whilst statutory responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 were well understood and monitored

corporately, there was opportunity to improve the local arrangements within the Directorate.

Occupational Health (reasonable assurance)

We provided **reasonable assurance** over the arrangements in place to manage the occupational health service. This recognised the significant workforce capacity deficits and operational pressures affecting KPI performance. The audit also identified opportunities for enhanced reporting and project tracking.

4. Draft Head of Internal Audit Opinion

In accordance with the Global Internal Audit Standards (GIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations.

Based on the current audit position, this is reasonable assurance overall, but as this is still a draft opinion, this may change as the remaining audits are finalised.

5. Draft 2026/27 Internal Audit Plan

The 2026/27 Draft Internal Audit Plan (the 'Plan') has been produced and is reported to the April Committee meeting for review, discussion and approval. The process for the development of the Plan is the same as for previous years.

The draft Plan reflects the general risk profile of the organisation, as shown in the risk register and rotational coverage of key areas, including Ministerial Priorities. The Plan may require revision, both in terms of coverage and timing when it is appropriate to do so. If required, this will be done through the established governance and approval processes.

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 draft 2026/27 Internal Audit Plan.

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	Reasonable	Final Report
4. Subject Access Requests	Limited	Final Report
5. Benefits Realisation (excluding digital)		Draft Report
6. Business Continuity Plan	Reasonable	Final Report
7. Capital Projects: Service Readiness	Reasonable	Final Report
8. Falls Management		Draft Report
9. Directorate Review - CAMHS	Reasonable	Final Report
10. Professional Staff Registration		Work in Progress
11. Clinical Audit	N/A	Deferred
12. Directorate Review – Ophthalmology / ENT		Deferred / delayed
13. Public Health	Advisory	Final Report
14. Six Goals Programme		Deferred
15. Discharge Planning	Reasonable	Draft Report
16. Safeguarding	Reasonable	Final Report
17. Cancer Referral Rates		Work in Progress
18. Occupational Health	Reasonable	Final Report
19. Overseas Recruitment	Reasonable	Draft Report
20. Speaking up Safely	Limited	Final Report
21. Follow-up of High Priority Recommendations	N/A	Final Report
22. Cyber Security (Including cyber incident response)	Reasonable	Final Report
23. Shadow IT		Draft Report
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	Advisory	Draft Report
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	Limited	Final Report
30. NHH Regional Satellite Centre (deferred from 2024/25)		Draft Report

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
Benefits Realisation	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).
Overseas Recruitment	Brief issued	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.
Professional Staff Registration	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.
Cancer Referral Rates	Brief issued	To determine if the referral and application processes within the Health Board are consistent with the rest of NHS Wales.

Strategic Risk & Assurance

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	2
Appendix A	8

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2526-03

March 2026

April 2026

April 2026

Rani Dash, Director of Corporate Governance

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To determine and evaluate whether the Aneurin Bevan University Health Board’s (the Health Board) governance and strategic oversight of risk and assurance are effective, aligned with organisational goals, and support long-term objectives.

Overview

We concluded **reasonable assurance** on this area. The arrangements observed were robust in many respects, demonstrating that the Strategic Risk Register (SRR) is aligned to the IMTP and is subject to appropriate scrutiny by the Board and its committees. We identified three matters requiring management attention:

- The Executive Committee should provide/ demonstrate regular, formal oversight and scrutiny of the SRR.
- There should be more explicit linkage between the Health Board’s strategy and the SRR, ensuring the SRR remains focused on strategic risk.
- The completeness and quality of SRR content requires improving to strengthen transparency, support effective scrutiny and avoid misinterpretation of genuine or overstated gaps – stemming from template limitations and varied user understanding.

Full details are set out in the Findings & Agreed Action Plan. We also identified opportunities to enhance and streamline the Risk Management Framework and related documents; these do not affect the overall opinion and have been shared informally with the Governance Team.

Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Up-to-date risk management policy and procedures define clear risk management and assurance arrangements aligned to the Health Board’s objectives and strategic direction	-	Substantial
2 Strategic and other key risks are regularly reviewed across the Health Board and at Committee/Board level	1	Reasonable
3 The risk and assurance approaches align with the Health Board’s strategic objectives and risk appetite	2	Reasonable
4 Gaps in control/assurance over strategic risks are identified, and action plans are in place and are being implemented to address the gaps	3	Reasonable

Management Actions



High Priority



Medium Priority

Themes



Risk Types

- Financial Loss
- Quality or Safety Issues
- Legal & Regulatory Non-Compliance
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Up-to-date risk management policy and procedures define clear risk management and assurance arrangements aligned to the Health Board’s objectives and strategic direction

Substantial

Overview / Summary of Observations

All key aspects of good risk-management practice are covered within the Health Board’s Risk Management Framework (RMF) and related documents (together ‘the risk governance documents’).

We noted a small number of areas where the documents could be strengthened, and some repetition between the Framework and the Risk Management Policy & Procedures that could be streamlined for clarity. These observations reflect opportunities for enhancement rather than weaknesses; therefore, no formal finding has been raised, and the points have been shared informally with the Governance Team.

Overview / Summary of Observations

Responsibilities and frequency for the review of the SRR are clearly set out in the Health Board’s Standing Orders, risk governance documents and Committee terms of reference and cycles of business.

Our testing confirmed there is regular review of the SRR, including clear justification and scrutiny of changes to risk, by the Board and its sub-committees.

We saw evidence that individual Executive Leads provide out-of-committee oversight for the risks they are responsible for. However, the Executive Committee only receives the SRR on an ad hoc basis – see finding 1.

Key Findings		Risk & Impact	Agreed Management Action
1	Executive Committee Oversight The Health Board’s approach does not require regular, formal Executive Committee oversight of the SRR. Testing under objective 4 highlighted quality issues across the five SRR risks reviewed. Although multiple root causes are discussed under objective 4, the lack of formal Executive scrutiny heightens the risk of inaccurate or poor-quality SRR reports being submitted to the Board and sub-committees.	The Board and sub-committees do not receive regular updates on risk. Failure to address risks to strategy achievement in a timely manner.	Agreed Action: The Health Board will formalise Executive Committee oversight of the Strategic Risk Register (SRR) by incorporating a standing agenda item for SRR review within the Executive Committee cycle of business. The Executive Committee will: • Receive the full SRR on a quarterly basis aligned to Board reporting cycles. • Undertake documented scrutiny, including review of risk scores, assurance gaps, and progress against mitigating actions. The Risk Management Framework will be to reflect this requirement and clarify roles and responsibilities.
			Expected Evidence of Implementation: • Updated Risk Management Framework including Executive Committee SRR oversight requirement • Executive Committee agendas showing SRR as a standing item • SRR reports presented to Executive Committee • Meeting minutes evidencing documented challenge and scrutiny of SRR risks
			Medium Priority
Theme: Governance		Control Design	Officer: Head of Corporate Risk and Assurance Target Implementation Date: 30 September 2026

Overview / Summary of Observations

Objective Alignment

Risks from the SRR are included in the current IMTP (2025–2028), and our testing showed clear alignment between the IMTP and four of the five SRR risks reviewed. However, SRR risks are not referenced in the newly launched 10-year strategy (Gwent 35, December 2025), and clear alignment between Gwent 35 and the SRR is not evident.

As the SRR is currently informed primarily by the IMTP – which contains both strategic delivery intention and operational priorities – a broader review of the SRR highlighted that some risks appear operational in nature. This was also the case for one of the five SRR risks we tested in detail.

Greater clarity is required to ensure the linkages between Gwent 35 → IMTP → SRR are explicit, and that the SRR is focused on strategic risk – see finding 2.

Risk Appetite Alignment

The Health Board’s Risk Appetite Statement clearly sets out risk appetite and explains its intended application. We identified a small number of enhancement opportunities; these represent improvement points rather than weaknesses, so no formal finding has been raised, and the feedback has been shared informally with the Governance Team.

No issues were identified in applying the Risk Appetite Strategy to the sample of five SRR risks tested.

Key Findings		Risk & Impact	Agreed Management Action
2	Strategic Focus and Alignment The linkages between Gwent 35 → IMTP → SRR should be more explicit, and that the SRR is focused on strategic risk. Our testing identified that: - SRR risks are not referenced in the newly launched 10-year strategy (Gwent 35, December 2025), and clear alignment between Gwent 35 and the SRR is not evident. - As the SRR is currently informed primarily by the IMTP – which contains both strategic delivery intention and operational priorities – some SRR risks appear operational in nature. This was also the case for one of the five SRR risks we tested in detail. Aligning the SRR to Gwent 35 will support more focused Executive scrutiny (see finding 1).	Reduced or diluted focus on strategic risk. Strategic risks may not be identified or addressed in a timely manner. Failure to deliver Gwent 35 goals and objectives.	Agreed Action: The Health Board will review the Strategic Risk Register (SRR) to ensure clear alignment with the Gwent 35 strategy, and to distinguish strategic risks from operational risks. To facilitate this the following actions will be taken: - Map all SRR risks explicitly to Gwent 35 strategic objectives and IMTP priorities. - Identify and include in the SRR any potential risks that could adversely impact delivery of the Gwent 35 Strategy - Review and remove or reclassify non-strategic (operational) risks from the SRR to the Corporate Risk Register (CRR). This will ensure the SRR remains focused on strategic-level risks and supports effective Executive and Board oversight

			Expected Evidence of Implementation: • SRR demonstrating explicit mapping to Gwent 35 objectives • Movement of strategic risks to the CRR where applicable • Version-controlled SRR showing inclusion, removal or reclassification of risks
		Medium Priority	Officer: Head of Corporate Risk and Assurance
	Theme: Risk Management	Control Design	Target Implementation Date: 31 October 2026

Objective 4: Gaps in control/assurance over strategic risks are identified, and action plans are in place and are being implemented to address the gaps

Reasonable

Overview / Summary of Observations

Testing confirmed that key elements of strategic risk reporting are in place, with controls and assurance sources generally well documented and above-appetite risks receiving robust Board and committee scrutiny. However, the quality and consistency of SRR content vary across several sections of the template, which reduces the clarity of assurance and limits visibility of progress. These content-related issues do not reflect weaknesses in risk-management practice itself and are set out in finding 3.

Note: Our work under this objective assessed the quality of SRR content in the identified areas, rather than the underlying control environment; the findings therefore relate to the presentation of the SRR and are not a judgement on actual control maturity.

Key Findings		Risk & Impact	Agreed Management Action
3	SRR Content – Completeness and Quality Testing identified that the SRR template and its completion do not consistently support clear, reliable or complete strategic risk reporting. While existing controls and assurance sources were generally well documented, and key above-appetite risks receive robust Board and committee scrutiny, weaknesses in how several template sections are populated reduce the clarity of assurance. These include: • Poor linkage between controls, assurances, gaps and actions. • Non-SMART or miscategorised planned improvements. • Vague or inaccurate assurance gaps. • No reporting on action implementation. • Limited visibility of action impact due to minimal score movement. These issues – identified across all five SRR risks tested – stem from template limitations and varied user understanding, compounded by the presence of operational risks in the SRR (finding 2) and potentially reduced Executive challenge (finding 1). Together, these dilute focus and reduce the clarity of strategic reporting. Overall, the underlying operation of risk management is sound, with most risks stable and within appetite thresholds. However, improving SRR content quality would strengthen transparency,	Reduced transparency, potentially limiting effective scrutiny and accountability. Genuine control or assurance gaps may be overlooked. Limited resources may be diverted toward overstated or tolerable gaps.	Agreed Action: The Health Board will improve the completeness, clarity, and consistency of SRR content through template enhancement, targeted training, and strengthened Executive scrutiny. 1. Refresh the SRR template to: ◦ Improve structure and clarity of required fields ◦ Strengthen linkage between controls, assurances, gaps, and actions 2. Deliver targeted training and guidance to all SRR risk owners covering: ◦ Completion standards ◦ Definition of SMART actions ◦ Identification of meaningful assurance gaps 3. Introduce structured deep dives into Committee agendas as a standing item, prioritised based on risk exposure, to enable focused review of assurance quality, progress of mitigating actions, and movement in risk trajectory. These actions will improve transparency and support more effective scrutiny without changing the underlying risk management framework. Expected Evidence of Implementation: • Updated SRR template with improved structure

	support more effective scrutiny and reduce the risk of misinterpreting genuine or overstated gaps. Specific details of our findings have been provided to management.		• Completed SRRs demonstrating clear linkage between controls, assurances, gaps, and actions • Evidence of guidance issued (e.g., user manuals or briefings) • Committee papers and minutes evidencing deep dive reviews • SRR extracts showing tracked action progress and impact on risk scores.
		Medium Priority	Officer: Head of Corporate Risk and Assurance Target Implementation Date: 30 September 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

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

Public Sector Internal Audit Standards

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



Capital Projects: Service Readiness

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	2
Findings & Agreed Action Plan	4
Appendix A	13

Review Reference

ABU-2526-07

Fieldwork

November 25 – January 2026

Executive Sign Off

April 2026

Audit Committee

April 2026

Executive Lead

Hannah Evans, Director of Strategy, Planning and Partnerships

Leanne Watkins, Chief Operating Officer

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Rhian Gard, Audit Manager

Audit Team



Executive Summary

Purpose

An evaluation of a sample of projects was completed over the preparedness of services for operational deployment, to ensure a timely commencement of the new / revised operations.

Overview

This audit examined two recently opened Health and Wellbeing Centres:

- the Bevan Health and Wellbeing Centre (Bevan HWBC) in Tredegar, Blaenau Gwent, which opened on 22nd January 2024, and
- the 19 Hills Health and Wellbeing Centre (19 Hills HWBC) in Ringland, Newport, which opened on 13th January 2025.

Both centres were established to modernise healthcare delivery, improve access, and integrate a range of services to better support the health and wellbeing of their local communities. The Bevan HWBC focuses primarily on strengthening Primary Care provision in Tredegar, while the 19 Hills HWBC places additional emphasis on community development and collaboration with third-sector partners.

Leads were in place to front the commissioning process, and this was pivotal in driving progress and ensuring key actions were completed. Substantial work was undertaken to ensure they were prepared to open - delivered through a phased approach, ensuring that buildings, staffing, systems, and processes were operational and able to provide safe, integrated care. It was also evident that lessons learned from the Bevan HWBC were applied to the development and service readiness of the 19 Hills HWBC. As a result, a reasonable level of assurance has been determined.

However, the following matters require management attention to ensure consistent approaches and ongoing compliance with procedures:

- The Capital Procedures and Notes document would benefit from a refresh to ensure there is a detailed focus on the importance of Commissioning and Pre-Commissioning Plans, including examples, as they are a crucial aspect for service delivery.
- Pre-Commissioning plans need to be tracked, monitored and reported more robustly.
- Working groups should be consistently established earlier in the process and then in place for a while after the HWBC's are opened to ensure there is effective management of issues while linking to Commissioning plans to ensure alignment.
- There were some notable operational issues / gaps in compliance on both Bevan HWBC and 19 Hills HWBC, more robust monitoring, tracking and reporting arrangements are required to ensure full assurance and consistent compliance with commissioning requirements.

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

Scope & Assurance Summary

Objectives

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

Related Findings

Assurance

1	Assess whether plans are clearly defined/ documented pre-commissioning with clearly defined milestones, dependencies and resourcing requirements.	1,2	Reasonable
2	A working group and a lead have been assigned to oversee and co-ordinate between project board, service leads and operational units – sufficient time and staff resource has been assigned to ensure successful delivery.	3	Reasonable
3	Assurance on compliance with commissioning plans, this may include staffing plans, recruitment timescales, training programmes, familiarisation arrangements, equipment purchase/ transfer etc.	4	Reasonable

Management Actions

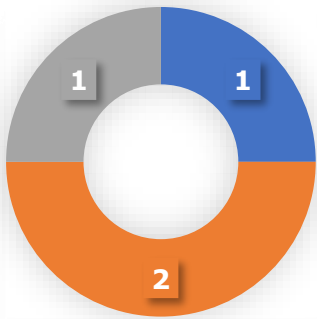


High Priority



Medium Priority

Themes



- Policies & Procedures
- Planning, Delivery & Deadline Management
- Information, Data Quality & Data Accuracy

Risk Types

- Quality or Safety Issues
- Legal & Regulatory Non-Compliance
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Assess whether plans are clearly defined/ documented pre-commissioning with clearly defined milestones, dependencies and resourcing requirements	Reasonable

Overview / Summary of Observations

The Health Board has detailed *Capital Procedures and Guidance Notes* that are due for review in November 2026. The document outlines the key elements and steps of capital projects as well as clearly defined roles and responsibilities. In terms of Commissioning, section 7 details the process and associated roles.

Whilst the procedures require that a pre-commissioning plan is produced to support a structured approach to commissioning, it does not provide details of what a robust commissioning plan should include, along with expectations for their frequency of update and monitoring. Such plans are essential in ensuring pre-commissioning is completed correctly and being service ready when the respective centres open. Strengthening this guidance would support a more consistent approach across projects, as commissioning plans are critical to effective delivery.

From a review of the Bevan HWBC and 19 Hills HWBC it was clear that a structured approach was applied to commission both centres, but there was no documented record of regular monitoring and updating of the key documents.

More detailed and fully developed plans were needed, including clear timelines, logistical arrangements, and operational requirements such as key allocation and ID badge processes. These should have been documented comprehensively and updated to reflect changes. Only first iterations of the plans were shared, so the audit trail of amendments and progress was not clear. A finalised version was not available for review.

A well-maintained and actively monitored Pre-Commissioning Plan is essential for the safe and successful opening of a Health and Wellbeing Centre. These plans act as the operational blueprint, ensuring systems, processes, and equipment are ready before staff and patients occupy the building. Regular updates prevent gaps in compliance, while structured monitoring reduces the risk of missed tasks, unnoticed defects, or delays. Although full evidence of monitoring was not available, no negative impacts were identified.

Key Findings		Risk & Impact	Agreed Management Action
1	Documented Commissioning Procedure The <i>Capital Procedures and Guidance Notes</i> document although is not due for review until November 2026, will benefit from a refresh when it is reviewed to ensure there are clear examples of what Pre-Commissioning plans should look like, include and the frequency of how often they should be updated and monitored.	Limited detailed documentation for Commissioning resulting in an inconsistent approach to commissioning plans, how often they should be updated, monitored and tracked.	Agreed Action: - Review and update the Capital Procedures and Guidance Notes document to include a comprehensive section on commissioning, including: - A standardised pre-commissioning plan template - Clear definitions of minimum requirements (milestones, dependencies, resourcing, risks, operational readiness criteria) - Requirements for version control, update frequency, and monitoring expectations

		○ Practical worked examples illustrating what “good” commissioning documentation looks like • Align the updated commissioning procedure with PMO governance standards, ensuring consistent monitoring and reporting across all capital schemes. • Ensure the revised procedure is approved through the Capital Programme Board and circulated to all project managers and commissioning leads, with implementation required for all new schemes from April 2026 onwards. • Embed the updated procedure into mandatory project documentation (PID and governance templates) to ensure consistent use and early integration in project planning.
		Expected Evidence of Implementation: • Updated Capital Procedures and Guidance Notes document with refreshed commissioning section, approved by Capital Programme Board. • Standardised pre-commissioning plan template, including minimum content standards, monitoring requirements and version control expectations. • Worked examples demonstrating good practice commissioning documentation. • Revised PID and governance templates incorporating mandatory commissioning requirements. • Communication/briefing materials issued to project and commissioning leads confirming new requirements. • Implementation assurance report from PMO confirming the updated procedure has been adopted in new project documentation.
	Medium Priority	
Theme: Policies & Procedures	Control Design	Officer: Assistant Director of Strategic Capital Target Implementation Date: 30 June 2026

2 Commissioning Plans Plans existed for both the Bevan HWBC and 19 Hills HWBC; however, it was difficult to observe how these were monitored and updated to reflect changes/ delays. Plans should be comprehensively updated and tracked regularly to reflect changes.	A lack of detailed controlled plans in place runs the risk of milestones, dependencies and resourcing requirements not being managed and subsequently putting the project at risk of being completely correctly.	Agreed Action: - Develop a standardised commissioning plan template covering milestones, dependencies, resource requirements, risks, operational readiness criteria and key decision points. - Ensure all commissioning plans are version-controlled and stored within the PMO governance environment, with updates logged and accessible to Project Boards. - Introduce routine monitoring of commissioning plans, including RAG status reporting, exception reporting, and clear escalation routes to the Project Board. - Embed commissioning plan review as a standing agenda item within Project Board meetings, ensuring progress, risk and dependencies are scrutinised consistently. - Apply this strengthened commissioning approach to all new projects commencing after April 2026, ensuring consistent practice across all capital and service developments. Expected Evidence of Implementation: - Standardised commissioning plan template approved by PMO. - Completed commissioning plans for new schemes demonstrating: - Milestones and dependencies - Resource requirements - Risk and issue tracking - Operational readiness and acceptance criteria - Clear version control - Version-controlled plan updates stored on PMO SharePoint with change logs. - Project Board papers/minutes showing commissioning plan progress reviews and escalation. - RAG reporting and exception reports evidencing consistent monitoring. - Lessons learned outputs demonstrating application of strengthened planning processes.

		Medium Priority	Officer: Assistant Director of Strategic Capital
	Theme: Planning, Delivery & Deadline Management	Control Operation	Target Implementation Date: To be applied to all future and live capital projects

Overview / Summary of Observations

Clear project leads were in place to coordinate both developments of the Bevan HWBC and 19 Hills HWBC, and Service Delivery Working Groups were established as the centres approached opening. However, the timing and structure of these groups varied. Establishing these groups at the same time as the Project Board and Project Team would provide earlier oversight and ensure consistent engagement throughout the project. Maintaining these groups for at least 12 months post commissioning, ensuring regular attendance of key stakeholder’s post-opening would support effective issue resolution during the critical early operational period.

These groups should also provide structured oversight of the Commissioning Plans, ensuring all elements such as staffing arrangements, working schedules, ID badge processes, and operational logistics—are fully implemented and updated as required. A clear link between the groups’ work and the commissioning documentation would strengthen accountability and ensure readiness activities remain on track.

There is also inconsistency in the naming and structure of service delivery groups across the centres. Adopting a standardised approach to group titles and governance arrangements would improve clarity, support alignment across services, and reduce the risk of confusion among stakeholders.

It is recognised that aspects were picked up by the Project Board/ Team, however a dedicated group would provide the required agenda time, scrutiny and challenge.

Key Findings		Risk & Impact	Agreed Management Action
3	Working Groups Service Delivery Groups were established for each of the centres, but the timing and structure need to be reviewed to ensure they are established at the outset of the project, are well attended and continue through the defect liability period (12 months post completion). This would help provide effective management of any service issues. Linking the group with Commissioning plans would help provide more structure oversight and strengthen accountability. Whilst recognising that the Project Board/ Team covered aspects, and that no specific issues were identified, the Project Board/ Team are not able to replace the role of the service delivery groups as it does not have sufficient time to provide sufficient challenge/ scrutiny.	The groups are not effective resulting in mis management of services. Roles and responsibilities are not clearly defined resulting in confusion	Agreed Action: Although Service Delivery Groups (SDGs) were established for the projects, we agree that aligning their timing, structure, and continuity with ABUHB systems will enhance assurance and accountability. To address this, we will: • Embed SDGs formally within the AB project governance framework, ensuring they are stood up at project initiation rather than later in delivery. • Strengthen links between SDGs and Commissioning Plans, allowing clearer oversight of operational readiness, improved challenge/scrutiny, and a stronger golden thread into the Project Board. • Ensure each SDG remains active throughout the 12-month defect liability period, coordinated through our existing service management and Estate’s workflows to provide consistent monitoring of performance and any emerging

		issues. Clarify the complementary roles of the Project Board and SDGs, recognising that while the Board provides strategic direction, SDGs are essential for operational scrutiny, risk review, and day-to-day service management. These actions will help ensure a more structured, proactive approach to service mobilisation, issue resolution and long-term sustainability for future projects across ABUHB.
		Expected Evidence of Implementation: - Updated governance documentation, including: - Revised PID template showing SDGs included at project initiation - Updated SDG Terms of Reference (membership, purpose, escalation routes) - Revised governance structure flowcharts showing SDG–PB alignment - Commissioning plans demonstrating clear links to SDG oversight (e.g., standing agenda items, risk logs, operational readiness tracking). - SDG minutes and action logs, evidencing consistent attendance, scrutiny of operational issues and escalation to Project Boards. - Defect liability period monitoring records, demonstrating continuity of SDG oversight for 12 months post-completion. - Lessons learned documentation from the application of strengthened SDG processes. - Quarterly PMO assurance reports evidencing compliance with the revised governance arrangements.
	Medium Priority	Officer: Head of Operational Transformation Target Implementation Date: Immediate - for all Future Projects
Theme: Information, Data Quality & Data Accuracy	Control Operation	

Overview / Summary of Observations

There was evidence of individuals taking personal responsibility to ensure tasks were completed correctly and that issues were escalated, by exception, to the Project Board. Some notable operational issues / gaps identified by management on both Bevan HWBC and 19 Hills HWBC include:

- No custodians for the centres, which would help with the smooth running of the centres.
- Clear roles and responsibilities were not outlined for key staff and services to ensure everything ran smoothly.
- No receptionists were considered to be required – due to the integrated care model in place. However, due to the poor signage at both centres, a wayfinder would have assisted patients and staff.
- Commissioning plans were not detailed enough and required better tracking and monitoring. In particular it was not possible to see the final and up to date commissioning plans, and we would expect many different iterations as they were updated with changes in schedules.
- Training was provided by Kier on the centre and fire training implemented. However, further training regarding the fundamentals should have been provided. For example, contacts for service-related issues and steps to follow.

These issues were escalated and discussed via various routes but highlighted the importance of structured monitoring and defined ownership within the commissioning process (**see finding 2**).

Positive learning was evident, particularly from the Bevan HWBC, where several lessons were refined and applied to the 19 Hills HWBC development such as the opening of the centre in a phased approach including the car park.

Overall, while operational delivery remained largely unaffected, more robust monitoring, tracking and reporting arrangements are required to ensure full assurance and consistent compliance with commissioning requirements going forward.

Key Findings		Risk & Impact	Agreed Management Action
4	Compliance There were some operational issues / gaps on both Bevan HWBC and 19 Hills HWBC which were escalated/ managed via various routes (including at Project Board). These gaps highlighted the importance of structured monitoring and defined ownership within the commissioning process to ensure work is not completed in silos.	Changes to the plan not clearly tracked or reported so compliance affected. Requirements may not be met in time, delaying service.	Agreed Action: Despite individuals taking commendable personal responsibility to escalate issues appropriately, these experiences highlight where systems can be better aligned to ensure a more structured and coordinated approach. Building on the learning already applied between Bevan and 19 Hills HWBC, the following improvements will be taken forward: • Embed defined ownership and structured monitoring within AB commissioning processes, ensuring that key roles, such as reception/wayfinding support, and service leads, are identified early and incorporated into mobilisation plans. • Strengthen role clarity for all operational functions, using AB’s established governance frameworks so that

			responsibilities for facilities management, service queries, and operational support are clearly assigned and understood at the outset. • Enhance commissioning plan governance, ensuring plans are detailed, version-controlled, and easily accessible, with routine tracking and monitoring aligned to AB’s standard project controls. This will allow better visibility of changes and provide assurance that all workstreams remain coordinated. • Improve operational training pathways, ensuring that alongside building-specific sessions, staff receive clear guidance on how to manage service-related issues, escalation routes, and day-to-day operational processes • Integrate wayfinding and patient-flow considerations earlier, recognising that the integrated care model still benefits from practical support such as signage and wayfinders, particularly at opening. • Embed lessons learned across all future developments, formalising the positive learning from Bevan HWBC, such as phased openings, to ensure this good practice is systematically applied to future schemes. • Ownership and accountability, across the programme, ensuring engaged and consistent membership of both the project team and project board. This is particularly important given the multi-divisional nature of the site. Strengthening these governance arrangements from project board through to SDG level will be a key action to support effective delivery. Taken together, these actions will help create a more robust, consistent and well-governed commissioning and mobilisation process across ABUHB, supporting smoother openings, clearer accountability, and improved operational readiness for all future capital developments. Expected Evidence of Implementation: • Updated commissioning framework incorporating defined roles, monitoring requirements, and governance flow (stored in PMO SharePoint).

			• Version-controlled commissioning plans demonstrating use of tracking and structured monitoring tools. • Completed training materials and attendance records for operational staff. • Wayfinding and patient flow plans incorporated into early-stage commissioning documentation. • Lessons learned log and application tracker showing how insights from Bevan HWBC were applied to subsequent developments. • Revised Project Board and SDG terms of reference, demonstrating strengthened membership and accountability. • Quarterly monitoring reports evidencing use of PMO project controls and tracking against milestones.
		Medium Priority	Officer: Head of Operational Transformation Assistant Director of Strategic Capital Target Implementation Date: Future Projects
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

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

Public Sector Internal Audit Standards

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



Directorate Review - CAMHS

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	3
Appendix A	9

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2526-09

November 2025 – January 2026

February 2026

April 2026

Leanne Watkins, Chief Operating Officer

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit



Executive Summary

Purpose

To ensure that appropriate arrangements are in place for the management of risk and performance within the Aneurin Bevan University Health Board (the Health Board) Children and Adolescent Mental Health Services (CAMHS) Directorate (the Directorate).

Overview

The Directorate delivers specialist mental health care through a range of services including neurodevelopmental assessments, crisis intervention, eating disorder clinics, and family therapy. There are currently around twenty different teams within the Directorate working to support mental health. A revised governance framework has been established within the Directorate. This change is reinforced by a detailed action plan aimed at enhancing accountability, transparency, and strategic direction throughout the Directorate. An ongoing review is ensuring that all processes are robust, effective, and aligned with the applicable requirements.

Recognising that the Directorate has established a solid governance foundation through revised structures and ongoing work to strengthen risk, performance, and statutory-duty compliance processes, subject to the revised arrangements being fully embedded, reasonable assurance has been determined.

However, the following matters require management attention:

- Although compliance with the statutory duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 is recognised and monitored at a corporate level, local arrangements within the Directorate still require improvement.
- The need to ensure risks captured on the Directorate Risk Register are reported correctly and accurately.
- Performance reporting would benefit from a clinician lead to ensure information is captured and then validated correctly. Subsequent dashboard reporting of performance metrics would benefit from greater structure and the inclusion of proposed next steps.

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

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Review risk management processes within the Directorate to see whether they are embedded and have clear escalation and assurance pathways.		1	Reasonable
2	Assess whether management have established robust performance metrics and reporting mechanisms within CAMHS to track quality, safety, and service outcomes, including the alignment to divisional dashboards with strategic priorities.		2	Reasonable
3	Governance arrangements are in place encompassing reporting and the monitoring of compliance with the statutory duties introduced under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.		3	Limited

Management Actions

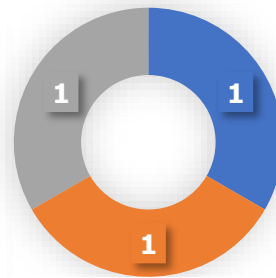


High Priority



Medium Priority

Themes



- Performance Monitoring
- Reporting
- Risk Management

Risk Types

Quality or Safety Issues
Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Review risk management processes within the Directorate to see whether they are embedded and have clear escalation and assurance pathways.

Reasonable

Overview / Summary of Observations

The CAMHS Directorate followed the Health Board's Risk Management Framework (the Framework) but did not have a directorate specific policy. Risks were divided into operational risks and patient-facing WARRN (Welsh Applied Risk and Research Network) risks, the latter being beyond the scope of this review, but emphasises the value of structured risk assessment in CAMHS.

The Framework states that directorate level risks should target a score between 1–6. However, the majority of the risks within the Directorate Risk Register exceeded this range, several of which have remained on the register since 2019. Although a recent review was undertaken of the top five CAMHS risks identified, further work is required to ensure compliance and accuracy.

We identified an inconsistent use of Datix, with two separate accounts and multiple report formats leading to unclear reporting pathways and unreliable data. Several risks remain outdated, and seven entries lacked target ratings or target scores, leaving them incomplete. Six DSE assessments were also inappropriately recorded on the Directorate Risk Register. It was not clear from agendas/ minutes whether risks were discussed or escalated at SMT meetings, however formal reporting is planned from February 2026.

The Corporate Governance Team confirmed risks had been escalated, with no concerns identified. However, strengthening risk management processes is essential to ensure the Directorate Risk Register is accurate, consistently applied, and aligned with the Framework. This will support better decision-making and clearer accountability going forward.

Key Findings		Risk & Impact	Agreed Management Action
1	Risk Management Risk management should be strengthened at a directorate level to ensure risks are consistently scored and aligned with the Health Board’s Risk Management Framework. A review of risks within the Directorate found: - There were two different Datix accounts so there was no clear pathway/ instruction for reporting through Datix. Therefore, not all the risks were being processed correctly. - Numerous risk reports from Datix were being used for reporting. - The top five high priority risks had been highlighted but some dated back to 2019 and would benefit from a review/ revisit.	Inconsistent risk management processes across service areas which may lead to unclear accountability and delayed mitigation / escalation. Reputational risk	Agreed Action: - Ensure staff understand the distinction between the Datix Incident Reporting module and the Datix Risk Register module and receive appropriate training. - Provide local training sessions and maintain a record of staff completion. - Review the Directorate Risk Register monthly to ensure risks are correctly recorded, scored, and include target risk ratings. - Review the top five risks regularly and present updates through the governance framework. - Ensure DSE assessments are managed through the correct Health & Safety process and are removed from the risk register. - Include risk as a standing agenda item at CAMHS QPS and CAMHS Strategic SMT.

• All the risks on the Directorate Risk Register had a current risk rating but seven of the risks did not have a target risk rating and did not have a target risk rating score. • Six DSE assessments were also recorded on the Directorate Risk Register. • There was no allocated/ dedicated agenda time at SMT meetings to discuss risk management and no clear escalation of risks at SMT meetings. A Directorate specific Risk Management policy or document would be beneficial in raising awareness and ensuring risks are captured and scored correctly.		• Ensure processes comply with the Health Board’s Risk Policy, including the application of the risk scoring matrix. Expected Evidence of Implementation: • Training materials and training compliance records. • Risk register documentation showing accurate scoring and target ratings. • QPS and SMT agendas, slides and minutes evidencing discussion of risk. • Updated risk reports showing correct placement of DSE issues.
Theme: Risk Management	Medium Priority Control Operation	Officer: Forensic Lead and Advanced Nurse Practitioner Target Implementation Date: 30 April 2026

Overview / Summary of Observations

There is an established set of national / local performance criteria for CAMHS captured through a dashboard aligned to strategic priorities. Performance data was compiled manually, using conversion rate information from CAMHS teams, supplemented by validated QLIK data. While functional, the dashboard would benefit from improved structure and clearer articulation of the next steps for each of the metrics.

Performance was reported regularly through senior management team (SMT) performance meetings, with three key indicators submitted monthly to Welsh Government, including:

- Care Treatment Plan (CTP),
- Part 1A MHM (appointments attended within 28 days), and
- Part 1B MHM (seen within 28 days of Part 1A).

Part 1A and Part 1B were performing above target in November 2025, supported by proactive work to address backlog and waiting-list pressures when necessary. CTP performance remained below target at 85% against a 90% target. The SMT identified the benefit of appointing a designated clinician for validating and assuring data accuracy, but this position had not been filled at the time of the audit. This appointment should provide added assurance around data accuracy and clarify accountability for the data produced.

Other metrics were performing well, with the exception of ND RTT (Neuro Diversity referral to treatment time) which was not compliant with the 80% target which was achieved in March 2025 but currently in November 2025 the compliance is 59.39%. This was due to significant demand pressures, which were already recognised by the Executive Team.

Arrangements would benefit from a validation process and a clear performance lead. The current Service Manager vacancy also necessitates interim reporting arrangements to ensure operational leads are held to account with regards reporting performance.

Key Findings		Risk & Impact	Agreed Management Action
2	Performance Reporting Reporting of performance needs to be strengthened to ensure there is appropriate accuracy and accountability once the data is collated. Alongside this, the performance dashboard would benefit from more structure in terms of next steps to ensure robust reporting is in place.	Lack of accountability runs the risk of metrics not being validated correctly and reported inaccurately.	Agreed Action: • Collate and present performance data to CAMHS SMT on a quarterly basis. • Strengthen the performance dashboard by adding key actions, leads and timeframes to support clear accountability. • Ensure performance data presented to DMT is accurate and validated. • Explore opportunities to strengthen audit reporting mechanisms, where appropriate.

			Expected Evidence of Implementation: • SMT agenda and minutes including performance reporting. • Updated performance dashboard. • Supporting performance datasets.
		Medium Priority	Officer: General Manager, Family and Therapies
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 31 May 2026

Overview / Summary of Observations

A new governance structure has recently been introduced and is currently being embedded, with monthly SMT meetings now in place for strategic, finance, and performance oversight. An overarching terms of reference has been agreed for the SMT meetings, and operational leads have been provided with defined areas of accountability, reflected within the recently agreed CAMHS Action Plan. However, there was no clearly documented escalation route beyond verbal updates provided at the relevant SMT meetings by the operational leads. Regular reporting continues through Welsh Government Integrated Quality, Planning and Delivery (IQPD) meetings and Health Board Divisional Assurance meetings.

Work was underway to ensure compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020, aligned to the Health Board’s Quality Strategy and statutory Duty of Candour requirements. An operational lead had been identified and attendance at Duty of Candour meetings were evidenced but there was a gap regarding a documented plan or process demonstrating compliance. There should be a clear pathway, so any incidents or issues can be reported to the lead and then formally discussed. A rolling dashboard and structured six-monthly reporting cycle would help evidence compliance.

To strengthen governance, dedicated time within SMT meetings should be allocated for formal updates regarding the Act, ensuring information flows effectively to the SMT and is cascaded to operational teams which would promote awareness within the Directorate.

Key Findings		Risk & Impact	Agreed Management Action
3	Reporting and Monitoring Arrangements would benefit from a documented plan and pathway to demonstrate compliance against the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Within the new governance structure, focused agenda time should be provided to ensure any incidents are discussed and information cascaded, when necessary, especially regarding Duty of Candour. A documented escalation route would ensure reporting and monitoring are structured.	Governance arrangements are ineffective, leading to non-compliance with legislative and regulatory requirements. Reputational risk	Agreed Action: • Develop a mapping document demonstrating CAMHS compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. • Develop a reporting framework setting out what must be reported, how data will be collected, by whom, and the required frequency. • Adapt the divisional Duty of Candour flowchart for CAMHS and ensure all staff complete the required training. • Ensure CAMHS QPS reviews incidents, Duty of Candour cases and top risks and escalates learning appropriately. • Review governance arrangements within CAMHS to ensure clear reporting lines and escalation routes; update structure charts accordingly. • Develop and share an escalation framework/flowchart outlining reporting pathways. • Ensure key learning related to risk, QPS and Duty of Candour is disseminated across CAMHS to support awareness and compliance. Expected Evidence of Implementation:

			• Mapping document for the Act. • Updated governance and escalation framework. • CAMHS Duty of Candour flowchart. • Duty of Candour training compliance. • QPS and Divisional meeting TORs, minutes and action logs.
	Theme: Reporting	High Priority Control Design	Officer: Head of Nursing, Family and Therapies Target Implementation Date: 31 May 2026

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

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

Public Sector Internal Audit Standards

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



Occupational Health

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	4
Appendix A	13

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2526-18

November 2025 – February 2026

26 March 2026

28 April 2026

Sarah Simmonds, Director of Workforce & OD

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To provide assurance over the arrangements and controls in place for the management of the Occupational Health Service within Aneurin Bevan University Health Board (the 'Health Board').

Overview

The Occupational Health Service delivers a range of statutory and advisory functions across four main Health Board sites, the service operates within nationally defined All-Wales Key Performance Indicators (KPIs) and is progressing towards SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation. During 2025, however, the service has experienced sustained operational pressures arising from workforce shortages, process constraints, and increased activity volumes.

We have concluded **reasonable assurance** in this area. However, we recognise that there is a persistent capacity constraint that impacts service timeliness, which is alleviated when additional funding is provided. These constraints impact performance across all services provided, with a cyclical rise and decrease in capacity.

However, alongside these pressures, several improvement initiatives have been progressed, including the rollout of self-booking for selected services, introduction of an occupational therapist to broaden clinical capability, and the continued delivery of a dermatology clinic. The service continues to benchmark activity against peers, and has recently refined its reporting process against a national KPI measure to recognise candidate engagement.

The most significant matters requiring management attention are:

- Significant workforce capacity deficits across all nursing bands (32–52% under capacity), compounded by national shortages of qualified occupational health nurses and increased reliance on external provision and temporary resourcing.
- Deterioration in KPI performance for pre-placement clearances and management referrals between August and October 2025, driven by capacity constraints and operational pressures.
- System limitations within OPAS-G2 (All Wales Occupational Health Software System), including the absence of ESR integration and the disabling of the auto-triage function, resulting in increased manual validation.
- Reporting of All-Wales KPIs at Committee level is focused on a limited subset of activity-based occupational health indicators.
- Further optimisation of the project plan tracker to assist management in monitoring delivery of key actions.

Full details of matters arising are set out in the Findings & Agreed Action Plan.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The Occupational Health Service standard operating procedure library document should be updated to reflect the use of relevant alternatives such as All Wales documentation or Patient Group Directives.
- Increased utilisation of OPAS internal notes to support accurate case categorisation and consistent KPI reporting.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	The Health Board has approved policies and procedures in place for the Occupational Health Service, and these are applied and implemented in practice.	-	Substantial
2	Appropriate resources and processes are in place to ensure staff have timely access to the Occupational Health Service for referrals (both self and line manager.	1, 2	Limited
3	Referrals are appropriately recorded, assessments are undertaken within required timescales, and managers are advised of the potential next steps.	3	Reasonable
4	Appropriate KPIs are in place for the Occupational Health Service which are effectively monitored, reported and used to inform service improvement.	4, 5	Reasonable

Management Actions

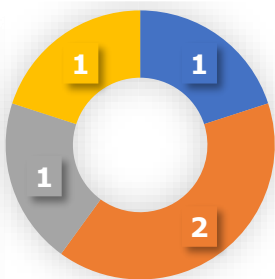


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Performance Monitoring
- Reporting
- Resourcing

Risk Types

Quality or Safety Issues
Public Perception & Reputational Risk

Occupational Health – At a glance

The Health Board’s Occupational Health service is based at four sites (St Woolos Hospital, Grange House, Ysbyty Ystrad Fawr and Nevill Hall Hospital) with additional external monthly vaccination clinics to Ysbyty Aneurin Bevan, County Hospital, Chepstow Community Hospital, alongside providing a dedicated dermatology clinic.

The Health Board performance against the All-Wales KPIs included within our sample testing was as follows:

Service	Measure	August 2025	September 2025	October 2025	November 2025	December 2025
Management Referrals	Number of manager referrals received / eligible for KPI reporting ¹	187 / 174	218 / 166	237 / 194	215 / 172	213 / 181
	All-Wales KPI The first offered appointment date will be within 29 calendar days of the date referral received. KPI that this is achieved 80% of the time. (Activity delivered within KPI timescale)	25.8% (45)	27.70% (46)	45.8% (89)	64.5% (111)	65.7% (119)
	Average wait time / Longest wait time for appointment	37 days / 85 days	35 days / 70 days	31 days / 70 days	27 days / 64 days	27 days / 74 days
Management Referral Reports	Total number of manager referral reports issued	147	198	210	203	231
	All-Wales KPI Where consent is agreed during consultation, the report will be sent to the manager on the same-day of the appointment. KPI that this is achieved 80% of the time. (Activity delivered within KPI timescale)	95.9% (141)	90.4% (179)	94.7% (199)	93.1% (189)	98.3% (227)
Pre-Placement Clearances	Total number of pre-placement questionnaires received / Total number of 'standard clearances' ^{2**}	315 / 213	347 / 259	376 / 279	370 / 259	333 / 208
	All-Wales KPI Completion of the health assessment will enable clearance for 'standard clearances' within 7 calendar days. KPI that this is achieved 80% of the time. (Activity delivered within KPI timescale)	83.5% (178)	22.7% (59)	2.5% (7)	36.6% (95)	92.8% (193)

¹ Does not include those later withdrawn or referred to alternative support.
² Non-standard clearances include overseas recruits, Exposure-Prone Procedure workers, and those which require further assessment. From November 2025 data onwards, this also excludes candidates who do not engage with the service, applications rejected due to incomplete information, and withdrawn requests.

Findings & Agreed Action Plan

Objective 1: The Health Board has approved policies and procedures in place for the Occupational Health Service, and these are applied and implemented in practice	Substantial

Overview / Summary of Observations

The Health Board has an Occupational Health and Safety Policy, last due for review in March 2022. A revised draft has been approved by the Policy Group and was awaiting Executive approval at the close of fieldwork. The draft policy strengthens organisational responsibilities and clarifies Occupational Health (OH) leadership; however, it no longer includes the detailed description of OH services contained in the extant version.

Review of the Health Board intranet confirmed that practical guidance is available on key OH areas, including Immunisations and Vaccinations, Sharps Injury Management, and Health Surveillance. The intranet site also provides access to OPAS and Management Referral information, supporting staff understanding of available services and related processes.

The OH service maintains a library of fourteen standard operating procedures (SOPs). Most were in date at the time of review, with two (Blood-borne Viruses and Sharps Injuries) undergoing update. Health Surveillance SOPs remain under All-Wales development; referencing this formally within the SOP library would strengthen transparency. Management also confirmed that, although Patient Group Directions are not stored centrally, staff are required to sign to confirm they have reviewed them.

Review of three SOPs, General Operating Principles, Pre-Placement Health Assessment, and Well Person Screening, confirmed they provide clear direction, including responsibilities, confidentiality requirements, and process steps.

The OH service is progressing SEQOHS (Safe, Effective, Quality Occupational Health Service) accreditation, the recognised UK industry standard that provides independent assurance over the safety, effectiveness and quality of occupational health services. At the time of fieldwork, management stated that it had submitted its evidence pack for assessment against domains covering governance, clinical practice, information security, and quality assurance, with a site visit scheduled for March 2026.

Overview / Summary of Observations

Referral and triage arrangements for management referrals and pre-placement questionnaires are supported by operational booking guides, which are not formal SOPs but provide step-by-step administrative direction on the use of OPAS-G2 (All Wales Occupational Health Software System), supplemented by a secondary spreadsheet to minimise missed referrals for the former.

Sharps injuries and immunisation contacts are managed through drop-in and scheduled clinics, with appointments input manually. Self-booking functionality has been piloted at two sites and will be rolled out to the remaining two.

Self-referrals remained extremely low (one in the sample period August – October 2025). As these do not result in a formal report to support management action, staff are routinely advised to progress concerns via a management referral.

We also noted that Health Board and non-Health Board staff³ follow the same pathways.

Walkthroughs of pre-employment and management referral processes identified the need for manual validation steps arising from the lack of integration between OPAS-G2 and ESR. OPAS-G2 was originally designed with an auto-triage function to streamline this workflow by categorising low-risk roles from those who require a clinical review, this function has been disabled across NHS Wales due to misclassification risks, resulting in all triages being undertaken manually (See **Key Finding 1**).

An independent review of demand and capacity undertaken in 2024 identified shortfalls of 32–52% across all nursing bands within the service (2.6 WTE Band 6, 2.2 WTE Band 5, and 0.9 WTE Band 7). Additional divisional funding has routinely been provided to the OH service in recent years, but has effectively become core to service delivery, and this activity was included within the demand and capacity analysis (see **Key Finding 1**).

The service therefore continues to rely on overtime and flexible staffing arrangements to maintain operational delivery. These pressures are intensified by the limited national availability of qualified occupational health staff, with research commissioned by the Department for Work and Pensions⁴ identified occupational health nursing roles as among the most difficult to recruit. The service has also experienced significant turnover across all nursing levels, and repeated unsuccessful recruitment campaigns have required the use of external medical provision through an agency to sustain continuity of service. In November 2025, the OH Service Team appointed to its senior leadership post, providing additional stability within the service. However, this has created an internal vacancy that will now need to be backfilled.

³ The Health Board also provides occupational health services to external organisations including other NHS bodies, Universities and Primary Care contractors, through Service Level Agreements.

⁴ [Understanding Occupational Health Provision 2023-24 - GOV.UK](#)

Key Findings		Risk & Impact	Agreed Management Action
1	System and Process Limitations OPAS does not integrate with ESR, resulting in manual verification of job titles, locations, and identity data. The auto-triage function, intended to streamline workflow, has been disabled across NHS Wales due to misclassification risks. As a result, all triage activities require a manual review, increasing administrative workload and introducing potential for variation. Escalation to the supplier will need to take place on an All-Wales basis.	Manual processes increase the risk of processing delays, inconsistent triage decisions, and reduced efficiency, particularly during periods of high demand.	Agreed Action: 1. The limitation regarding OPAS-G2 integration and the disabled auto-triage function will be formally escalated to the All-Wales OPAS-G2 System Group for consideration as a national system development issue. 2. In the interim, the Occupational Health administrative team will continue to undertake manual validation processes using the existing operational booking guides and tracking spreadsheet to ensure referrals are processed consistently. 3. Where administrative demand exceeds available capacity, temporary administrative support will be secured to maintain service delivery and minimise delays
			Expected Evidence of Implementation: • Minutes from the All-Wales OPAS-G2 system group confirming the escalation. • Operational booking guidance and referral tracking records demonstrating manual validation processes. • Records of temporary administrative support utilised during peak demand periods.
		Medium Priority	Officer: Senior Occupational Health Nurse/ Manager Target Implementation Date: 30 June 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	
2	Workforce Capacity Constraints A demand and capacity review undertaken with the University of South Wales identified significant capacity deficits across all nursing bands (32–52% under capacity). These gaps are compounded by national shortages of qualified OH nurses and the wider shift from a physician-led to a predominantly nurse-led model due to limited specialist medical availability. To sustain clinical delivery, the service relies on	Persistent capacity deficits and reliance on short-term or external resourcing may lead to inability to meet demand, delays in statutory OH processes, and	Agreed Action: 1. A clinical workforce development and succession plan will be developed for the Occupational Health service to identify required skills, training pathways and future workforce requirements. 2. The service will work with the University of South Wales to explore the introduction of third-year undergraduate clinical placements in Occupational Health, with the aim of supporting future workforce pipelines.

	external staffing provision, alongside overtime, additional in-year funding, and flexible staffing arrangements. While these measures support operational continuity, they do not fully address the substantial shortfall between demand and available resource, and any withdrawal of the additional in-year funding could have a significant operational impact.	reduced long-term service resilience	3. During periods of increased clinical demand, the service will continue to utilise external Occupational Health provision to maintain service delivery where internal capacity is insufficient.
			Expected Evidence of Implementation: • Documented Occupational Health workforce development and succession plan. • Agreement or placement framework with University of South Wales. • Records demonstrating use of external clinical provision aligned to demand.
Theme: Resourcing		High Priority	Officer: Senior Occupational Health Nurse/ Manager
		Control Operation	Target Implementation Date: Workforce development and succession plan –31 December 2026 Undergraduate placement development – 31 December 2027 <i>(subject to academic cycle)</i>

Overview / Summary of Observations

Our testing combined analysis of OPAS generated reports, verification of KPI reporting, and sample review of 15 individual records within the areas of Pre-placement Clearances, Management Referrals, and Management Referral reports. KPI reports are produced two months in arrears to allow for full capture of the activity which meets the 29 calendar days measure within the All-Wales KPIs. During the sample period from August to November 2025, the clinical team experienced staff vacancies and long-term absences, while also having to manage contact tracing for several outbreak events. Contact-tracing is a statutory requirement and must take precedence over routine OH activity (see **Key Finding 3**).

Pre-Placement Clearances (Pre-Employment Questionnaires)

Pre-placement KPI compliance declined markedly between August 2025 (83%) and October 2025 (2.5%), with some improvement in November 2025 (36.6%) and significant recovery by December 2025 (92.8%) (see **Key Finding 3**). Analysis of 910 suitable pre-placement cases showed that both Health Board and non-Health Board applicants were affected similarly, with turnaround times extending sharply in September and October 2025, internal status tracking demonstrates that the majority of extended cases were linked to service constraints, particularly the availability of blood test appointments, nurse screening slots and immunisation follow-ups. When delay-related cases were removed the underlying process displayed capability of rapid clearance indicating that the primary constraints were appointment availability and clinical screening capacity. Sample testing identified one case where an EPP classification was incorrectly applied but later corrected.

Review of OPAS data also indicated there could be greater use of the internal status field, where OH staff can include narrative notes to assist in accurate classification of clearances, and this was recently a focus of a service improvement day. A revised KPI reporting approach will be implemented from January 2026, this will aim to exclude cases where delays arise from lack of candidate engagement which have historically been included within the service's KPI calculations.

Management Referrals

Reported KPI figures for August 2025 (25.8%) and September 2025 (27.7%) were confirmed as accurate; however, October 2025 performance was initially understated; correction increased compliance to 50%, although still significantly below the 80% target. Performance for Health Board and non-Health Board management referrals was broadly consistent across the period. Average turnaround times showed only marginal variation, with Health Board and non-Health Board referrals averaging 20 and 19 days respectively in August 2025, 32.0 and 31.7 days in September 2025, and 29.2 and 33.0 days in October 2025 (see **Key Finding 3**).

The service has consistently exceeded the KPI relating to the issue of management referral reports on the same-day (where consented) with performance ranging from 90% - 95% across the sample period.

Outcome Recording and Recommendations

Outcomes and recommendations were consistently recorded across the sampled referrals, with all reviewed records containing clear and appropriately documented results. While detailed recommendations could not be reviewed beyond our sample, wider outcome analysis based upon OPAS activity reports indicated a reasonable distribution of advice. Workplace adjustments represented approximately 45% of outcomes, temporary unfitness around 14%, and redeployment remained infrequent. These patterns suggest that the service continues to provide a proportionate range of recommendations to support staff and managers.

Key Findings		Risk & Impact	Agreed Management Action
3	Occupational Health Service Performance KPI performance for pre-employment clearances (Pre-placement questionnaires) and management referrals deteriorated significantly between August and October 2025. Pre-placement compliance reduced from 83% to 2.5%, and management referral compliance in October 2025 was under-reported. Delays appear linked to operational pressures and service capacity constraints. Arrangements should be reviewed to identify opportunities to reduce variability in performance.	The decline in clearance performance exposes the organisation to recruitment delays and impaired management of staff health needs	Agreed Action The Occupational Health service has reviewed the methodology used for KPI reporting to ensure it accurately reflects Occupational Health activity and excludes cases outside the service's control (for example DNAs, candidate non-engagement and cases redirected to alternative services). This revised reporting approach has been implemented and benchmarked with other NHS Wales Health Boards to ensure consistency of interpretation.
			Expected Evidence of Implementation: This has been implemented and evidence sent to Internal Audit. • Revised KPI reporting methodology. • Evidence of benchmarking with other Health Boards. • Monthly KPI reporting included within the Workforce and OD performance report.
	Theme: Performance Monitoring	Medium Priority Control Operation	Officer: Senior Occupational Health Nurse/ Manager Target Implementation Date: Implemented February 2026

Objective 4: Appropriate KPIs are in place for the Occupational Health Service which are effectively monitored, reported and used to inform service improvement

Reasonable

Overview / Summary of Observations

The OH Service collects and submits activity-based KPIs to Welsh Government in line with the All-Wales Minimum Service Standards and as defined in its General Principles SOP. These include management referrals, management referral reporting, pre-placement clearances, and self-referrals, which are measured and submitted monthly. The SOP also defines additional KPI domains, including immunisation processes, Violence & Aggression (3-day appointment standard), and Well Person Screening (29-day appointment standard), which form part of the national scope of practice. However, no activity-based performance reporting for these latter areas was available during our fieldwork as they are not routinely reported due to low case volumes.

KPI performance is reviewed at monthly senior team meetings, and the Director of Workforce and Organisational Development receives the full Minimum Service Standards return. However, only a limited subset of KPIs is routinely reported to the People & Culture Committee. The absence of granular process time metrics limits the Committee’s ability to interpret trends accurately or assess underlying drivers of delay, and there could be scope to expand reporting to include qualitative and outcome measures (see **Key Finding 4**).

In August 2025 the OH service senior team introduced a project plan tracker within its senior team meeting to strengthen oversight of performance and service-improvement actions. As at December 2025, 26 actions were complete, 20 ongoing, and 12 not started. While the tracker includes narrative updates, the addition of start and target completion dates would provide structure to delivering the remaining actions (see **Key Finding 5**).

Benchmarking is undertaken through the national Management of Health at Work Knowledge (MoHaWK) tool undertaken on a six-monthly basis, which provides anonymous comparison against public and private providers across clinical quality, timeliness, and outcome-related indicators. The Health Board is one of only two within NHS Wales who undertake this benchmarking. The most recent MoHaWK results available at the time of fieldwork (June 2025) show several areas of strong performance, including high compliance in assessment quality and positive satisfaction levels from both staff and managers (92% and 90% against an 80% target), demonstrating strengths in user experience and clinical practice.

Key Findings		Risk & Impact	Agreed Management Action
4	KPI Reporting Although the full activity-based All-Wales KPI set is submitted to Welsh Government and received by the Director of Workforce and OD, only a small subset of management referral timeliness, same-day reporting, and pre-placement clearance, is regularly provided to the People & Culture Committee. The Committee does not currently receive wider qualitative indicators, service user feedback, or comparative analysis of performance between internal health board provision and externally delivered services under SLA arrangements. Given that the OH team delivers services to both internal and external bodies, disaggregating reporting to show internal versus external performance would provide greater insight and assurance.	Limited reporting of Occupational Health KPIs reduces Committee-level assurance and may delay the identification of emerging performance issues, gaps in service delivery, or areas requiring improvement.	Agreed Action: 1. The Occupational Health performance dashboard will be expanded to include MoHaWK benchmarking data and qualitative service user feedback, where available, to support broader performance oversight. 2. The service will continue to monitor referral waiting times across all referrals. As referrals are triaged strictly by date received, waiting times are consistent across internal and external referrals; therefore, additional disaggregation will be kept under review to ensure reporting remains meaningful and proportionate.
			Expected Evidence of Implementation: • Updated Occupational Health performance dashboard including MoHaWK data. • Dashboard included within Workforce performance reporting and reported to the People & Culture Committee.
		Medium Priority	
	Theme: Reporting	Control Operation	Officer: Senior Occupational Health Nurse/ Manager Target Implementation Date: 31 August 2026
5	Project Plan Tracker In August 2025 the OH Service senior team introduced a project plan tracker to strengthen oversight of performance and service-improvement actions. The addition of start and target completion dates would provide further structure in the delivery of the remaining 8 high and 19 medium priorities.	Actions are not addressed in a systematic way based on risk/priority.	Agreed Action: 1. The Occupational Health project plan tracker will be updated to include start dates, target completion dates and responsible leads for all actions. 2. The tracker will be reviewed at each Occupational Health Senior Team meeting to monitor progress and prioritise actions according to risk.
			Expected Evidence of Implementation: • Updated project plan tracker including dates and responsible leads.

			Senior Team meeting minutes demonstrating review and oversight.
		Medium Priority	Officer: Senior Occupational Health Nurse/ Manager
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 30 September 2026

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

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

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

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

Public Sector Internal Audit Standards

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



Internal Audit Plan 2026/27

Aneurin Bevan University Health Board

Contents

- 1. Introduction.....1
- 2. Developing the Internal Audit Plan 2
- 3. Audit risk assessment.....5
- 4. Planned internal audit coverage.....5
- 5. Resource needs assessment.....6
- 6. Action required.....7
- Appendix A: Internal Audit Plan 2026/27 8
- Appendix B: Key performance indicators (KPI).....15
- Appendix C: Internal Audit Mandate and Charter.....16
- Disclaimer.....22

1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Aneurin Bevan University Health Board's (ABUHB) management to improve governance, risk management, and control within their operational areas.

The Global Internal Audit Standards (the 'Standards') require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives. Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

- 1) Consideration of key governance and risk areas: we have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Strategic Risk Register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Aneurin Bevan University Health Board systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of ABUHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of ABUHB's governance and assurance arrangements and the contents of the strategic risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee).
- Key strategic risks identified within the strategic risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and strategic risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers strategic risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the strategic risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit, Risk and Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by ABUHB, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by ABUHB in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Stephen Chaney
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
1. Policy Management (Assurance) To ensure the policy management arrangements at the Health Board are effective and consistently applied to support compliance and governance – reflecting on recommendations raised at the Limited assurance report issued in 2022/23.	SRR 001 C Leadership Effectiveness	Director of Corporate Governance	Q4
2. Governance of Escalation Level (Assurance) A review of the Health Board's governance and processes for managing, monitoring and reporting progress around the escalation framework and de-escalation actions.	SRR 001 G SRR 001 I SRR 005 A Financial Sustainability, System Change	Director of Strategy, Planning and Partnerships	Q2
3. Sustainable Funding (Assurance) The audit will assess the adequacy and effectiveness of the Health Board's financial grip and control arrangements, focusing on budget management, forecasting, decision-making governance, and compliance with NHS Wales financial policies. It will also review the completeness, accuracy, and reliability of the self-assessment completed.	SRR 001 G Financial Sustainability	Executive Director of Finance & Procurement / Chief Operating Officer	Q4
4. Charitable Funds (Assurance) To assesses the adequacy and effectiveness of key controls over donations, restricted funds, financial reporting, and decision-making by the Charitable Funds Committee.	SRR 001 G Financial Sustainability Rotational	Executive Director of Finance & Procurement	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
5. Stakeholder Engagement (Assurance) To ensure stakeholder engagement arrangements within the Health Board are effective, inclusive, and embedded in decision-making, supporting transparency and service improvement.	SRR 007 A & B Collaboration and Strategic Partnerships	Director of Strategy, Planning and Partnerships / Executive Director of Public Health and Strategic Partnerships	Q1
6. Duty of Quality (Assurance) To provide assurance that the Health Board is implementing the requirements of the Duty of Quality.	SRR 001 D Maintain High Quality, Safe and Sustainable Services	Medical Director / Executive Director of Allied Health Professions & Health Science / Executive Director of Nursing / Director of Public Health and Strategic Partnerships	Q1
7. Value and Sustainability (Assurance) To review the value and sustainability approach to savings identification, reporting, monitoring and delivery.	SRR 001 G Financial Sustainability	Executive Director of Finance & Procurement	Q1
8. Welsh Risk Pool Lessons (Assurance) The overall objective is to determine if lessons learnt and associated actions from Welsh Risk Pool claims are fully implemented, to prevent a re-occurrence.	SRR 001 G SRR 008 Financial Sustainability, Patient Experience	Executive Director of Nursing	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
9. Hospital Sterilisation and Disinfection Unit (HSDU) (Assurance) This audit will evaluate the processes and procedures that support the delivery of the Hospital Sterilisation & Disinfection Unit (HSDU) across the Health Board.	SRR 001 F SRR 005 A Service Delivery	Chief Operating Officer	Q1
10. Patient Experience (Assurance) To review the arrangements and processes in place within the Health Board for capturing and utilising patient experience.	SRR 008 Patient Experience	Executive Director of Nursing	Q4
11. Dementia Care (Assurance) To provide assurance on whether the Health Board has effective processes to adhere to the All-Wales Dementia Care Pathway of Standards, ensuring consistent, equitable and person-centred dementia care across all settings.	SRR 008 Transformation Partnership Working Rotational	Executive Director of Nursing	Q3
12. Mental Capacity Act - Deprivation of Liberty Safeguards (Assurance) To ensure the processes for Deprivation of Liberty Safeguards (DoLS) applications are managed in accordance with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures.	SRR 005 Service Delivery	Executive Director of Nursing	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
13. Cancer Referrals (Assurance) To provide assurance over the effectiveness of cancer pathway delivery, referral processes, and demand forecasting, to ensure waiting list targets are achieved. This will build on the 2025/26 audit of referral rates.	SSR 001 F Service Sustainability Ministerial Commitment Delivery	Chief Officer Operating	Q4
14. Discharge Planning To provide further assurance over the Health Board's discharge planning arrangements, building on the recent 2025/26 review to assess revised governance arrangements, processes, multidisciplinary working and performance in supporting timely, safe and patient-centred discharges.	SRR 005 Service Delivery Ministerial Commitment Delivery	Chief Officer Operating	Q3
15. Primary Care and Community Services Divisional Review (Assurance) An assessment of a sample of operational and functional management arrangements, including the delivery of divisional IMTP objectives and the management of key risks.	SSR 001 F Service Sustainability	Chief Officer Operating	Q3
16. Clinical Audit (Assurance) To provide an opinion over whether there are effective processes in place to manage and deliver local clinical audit plans, including the assessment of clinical risk.	SRR 001F Service Models	Medical Director	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
17. Job Planning (Assurance) To provide assurance that arrangements are in place and operating effectively for consultant job planning.	SRR 001F Service Models	Medical Director	Q2
18. Rostering & Operational Workforce Management (Assurance) To ensure rostering arrangements are effective, compliant, and optimised to support safe staffing, workforce wellbeing, and efficient use of resources (e.g. reduce agency requirement). We will also consider workforce plans for a sample of areas across the Health Board and consider how demand and capacity plans are linked to these.	SRR 001F Service Models	Executive Director of Nursing / Medical Director	Q4
19. Vaccination Programme Evaluate the processes in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.	SRR 001 E Ministerial Commitment Delivery	Executive Director of Public Health and Strategic Partnerships	Q3
20. Job Evaluation (Assurance) To ensure the requirements of the NHS Job Evaluation Handbook are being applied in a fair, consistent and equitable manner by the Health Board.	SRR 001A SRR 001B Staff Wellbeing, Recruitment and Retention	Director of Workforce and Organisational Development	Q3
21. Follow-up of Audit Recommendations To assess whether high priority internal audit recommendations have been implemented.	Annual review of audit recommendation		Q4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
	implementation as set out within the Global Internal Audit Standards	Director of Corporate Governance	
22. Electronic Prescribing and Medicines Administration To determine if Electronic Prescribing and Medicines Administration (ePMA) is governed and delivered effectively, with appropriate controls to support safe implementation, clinical benefit realisation, and value for money.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital	Q4
23. Project Management Office (Digital) To determine whether a sample of programmes and projects establish clear, measurable milestones and defined outputs at initiation, supported by robust planning and governance arrangements. It will also evaluate controls in place to prevent scope creep, ensuring changes are formally assessed, approved, and aligned to agreed programme objectives.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital	Q3
24. Procurement of Digital Services To ensure that the procurement of digital services complies with the new NHS Wales procurement regulations, including governance, controls, and adherence to statutory and organisational requirements.	SRR 001 G Financial Sustainability SRR 006 B Implementation of new systems	Director of Digital / Executive Director of Finance & Procurement	Q4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Strategic Risk Register (SRR)] / Rationale	Executive Lead/Responsible Director	Planned start
25. Networks To provide assurance over how the network is provided, managed, monitored and supported to enable digital connectivity across the Health Board.	SRR 006 A Existing Digital Infrastructure	Director of Digital	Q2
26. Capital Systems (Assurance) The audit will focus on the targeting of TEF funding and the delivery of the resulting projects in line with local/ national procedures and the conditions of funding.	SSR 001 G, Financial Sustainability SSR002 B Backlog maintenance and structural impairment	Chief Operating Officer/ Director of Strategy, Planning and Partnerships/ Director of Allied Health Professions and Health Science	Q2
27. Estates Assurance (Assurance) We will await the outcome of the Audit Wales review of Estates prior to confirming the focus of this audit. One potential area of review might be the Control of Contractors, ensuring that they comply with contractual, performance, financial and health & safety requirements.	SSR 001 G Financial Sustainability SSR002 B Backlog maintenance and structural impairment Compliance with H&S requirements	Chief Operating Officer / Executive Director of Finance & Procurement	Q2
Audit management, reporting, Audit, Risk and Assurance Committee attendance, development of Integrated Audit Plans, attendance at associated project/programme boards meetings and associated UHB Committees etc.			

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	Y	To deliver plan
Audit opinion 2025/26 delivered by 31 May	Y	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	Y	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	Y	95%
Report turnaround management response to draft report [15 working days maximum]	Y	80%
Report turnaround draft response to final reporting [10 working days]	Y	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Aneurin Bevan University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit, Risk and Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Aneurin Bevan University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit, Risk and Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:
- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
 - the appropriate assessment and management of risk, and the related system of assurance.
 - the arrangements to monitor performance and secure value for money in the use of resources.
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.
- 2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

- 3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit, Risk and Assurance Committee and Accountable Officer.
- 3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit, Risk and Assurance Committee on behalf of the Board. Such functional reporting includes the Audit, Risk and Assurance Committee:
- approving the internal audit mandate and charter.
 - approving the risk based internal audit plan.
 - approving the internal audit resource plan.
 - receiving outcomes of all internal audit work together with the assurance rating and

- reporting on internal audit activity's performance relative to its plan.
- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
 - 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
 - 3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
 - 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit, Risk and Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit, Risk and Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit, Risk and Assurance Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit, Risk and Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit, Risk and Assurance Committee also has regular private meetings with the Head of Internal Audit.
- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit, Risk and Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit, Risk and Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit, Risk and Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee

which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned.
 - reviewing specific operations at the request of the Audit, Risk and Assurance Committee or management, this may include areas of concern identified in the strategic risk register.
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
 - ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.
- 7.3 If the Head of Internal Audit or the Audit, Risk and Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Mandate & Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

- 8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:
- the provision to the Accountable Officer and the Audit, Risk and Assurance Committee of an overall opinion each year on the organisation’s risk management, control and governance, to support the preparation of the Annual Governance Statement.
 - audit of the organisation’s risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation’s objectives and risks.
 - improvement of the organisation’s risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

- 8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.
- 8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.
- 8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.
- 8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit, Risk and Assurance Committee on behalf of the Board.
- 8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.
- 8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

- 9.1 Internal Audit will report formally to the Audit, Risk and Assurance Committee through the following:
- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
 - The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification.
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

- d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.
- e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and
- f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit, Risk and Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit, Risk and Assurance Committee requirements; and
- The Audit, Risk and Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit, Risk and Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit, Risk and Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit, Risk and Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit, Risk and Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit, Risk and Assurance Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit, Risk and Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2026

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Mandate and Charter as approved by the Audit, Risk and Assurance Committee.

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

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

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

Global Internal Audit Standards



Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Head of Internal Audit Opinion & Annual Report 2025/26

Aneurin Bevan University Health Board



Contents

1.	Executive Summary	1
2.	Head of Internal Audit Opinion	3
3.	Other work relevant to the Trust	14
4.	Delivery of the Internal Audit Plan	15
5.	Risk based audit assignments	16
6.	Acknowledgement	22
	Appendix A	23
	Appendix B	25

Report status:	Draft
Draft report issued:	XX April 2026
Final report issued:	XXX
Author:	Stephen Chaney
Audit, Risk and Assurance Committee:	April 2026



1. Executive Summary

1.1 Purpose of this Report

Aneurin Bevan University Health Board’s (the Health Board) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Global Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2025/26

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board’s own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2025/26 is:

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

The plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit, Risk and Assurance Committee (the ‘Committee’). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Global Internal Audit Standards.

The Internal Audit Plan for 2025/26 year, was approved by the Committee in April 2025. Changes to the plan have been made during the year and these changes have been reported to the Audit, Risk and Assurance Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP and the new NHS Wales Joint Commissioning Committee (JCC) that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023, stated we

'Fully Conform' to the relevant standards. Our own annual Quality Assurance and Improvement Programme (QAIP) confirmed that our internal audit work continues to 'generally conform' to the requirements of the Global Internal Audit Standards (GIAS) for 2025/26. We can therefore, state that our service 'conforms to the IIA's professional standards and to GIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the substantial and reasonable areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2025/26

Substantial Assurance	• Standing Orders Compliance • Welsh Intensive Care Information System
Reasonable Assurance	• Financial Sustainability (2024/25) • Waiting List Management (2024/25) • Strategic Risk and Assurance • Business Continuity Plan • Capital Projects: Service Readiness • Directorate Review – CAMHS • Safeguarding • Occupational Health • Cyber Security • RGH Central Decontamination Unit • Overseas Recruitment (Draft Report) • Satellite Radiotherapy (Draft Report) • Discharge Planning (Draft Report)
Limited Assurance	• Subject Access Requests • Grange University Hospital - Emergency Department Extension • Speaking Up Safely

Unsatisfactory	N/A
Advisory/Non-Opinion	- Follow-up of High Priority Recommendations - Public Health - Estates Assurance - Space Utilisation
Yet to be Determined	- Divisional Budgetary Control - Benefits Realisation (excluding digital) - Falls Management - Professional Staff Registration - Cancer Referral Rates - Shadow IT

Please note that our overall opinion has also considered both the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work.

2. Head of Internal Audit Opinion

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation’s objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Quality Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board’s risk management process and system of assurance should bring together all the evidence required to support the Annual Governance Statement.

In accordance with the Global Internal Audit Standards (GIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit, Risk and Assurance Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks.

As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit, Risk and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Aneurin Bevan University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators, including Healthcare Inspectorate Wales, in assessing compliance with the Health and Care Quality Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2025/26 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of GIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes

we have shown the results using the eight areas that were previously used to frame the audit plan at its outset (see section 2.4).

2.4 Head of Internal Audit Opinion

Scope of opinion

As noted already, the scope of my opinion covers both those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit, Risk and Assurance Committee, and other information obtained during the year that we deem to be relevant to our work. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management, and control is set out below.

Reasonable assurance		The Board can take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised from reviews.

Focus should be placed on the agreed response to the three limited assurance opinions issued during the year and the significance of the recommendations made across other audits (of which there were 24 audits, two advisory and one non-opinion reviews in 2025/26) as well as addressing the implementation of any outstanding recommendations from previous year reviews.

Basis for Forming the Opinion

The audit work undertaken during 2025/26, and reported to the Audit, Risk and Assurance Committee, has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit, Risk and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements.
- The results of any audit work related to the Health & Care Quality Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the leadership standard.

- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key Committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and Inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified some reviews during the year concluded positively with effective control arrangements operating in some areas.

From the opinions issued during the year, two were allocated Substantial Assurance, XXXX were allocated Reasonable Assurance, three were allocated Limited Assurance with none allocated an Unsatisfactory assurance opinion. Three advisory or non-opinion reports were also issued.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit, Risk and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming the overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Health Board’s activities that we had previously used to structure our strategic and one-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken three reviews in this area.

- **Follow-up of Internal Audit Recommendations** – For this review, we considered whether a sample of 2024/25 internal audit recommendations were implemented in a timely manner, with supporting evidence. We also assessed the accuracy of the Audit Recommendation Tracker, to ensure audit actions had been correctly recorded, including any implementation timeframe extension. No matters were identified for reporting.
- **Standing Orders Compliance** - We sample tested the Health Board’s compliance with the Welsh Government’s Model Standing Orders and Standing Financial Instructions. Overall, the review concluded **substantial assurance**, indicating strong adherence to governance and financial control requirements. The Health Board has appropriately tailored the Welsh Government template for its governance framework, including Board structures, committees, and meeting cycles. A comprehensive internal review against the Standing Financial Instructions was completed, covering all 95 sub-sections, with eight gaps identified and documented in an action plan. The only

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

- **Subject Access Requests** – 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.

Strategic Planning, Performance Management & Reporting

We have undertaken two reviews in this area.

- **Strategic Risk and Assurance** – The audit report provides **reasonable assurance** that the governance and strategic oversight of risk and assurance are generally effective and aligned with organisational goals. Three key areas were identified for improvement: formalising Executive Committee oversight of the Strategic Risk Register (SRR), strengthening the linkage between the Health Board’s strategy and the SRR, and enhancing the completeness and quality of SRR content to support transparency and effective scrutiny.

Discharge Planning (draft report) -

Financial Governance and Management

We have undertaken two reviews in this area.

- **Financial Sustainability (2024/25)** - The review focussed on the framework for managing recovery plans to assist with achieving a sustainable financial position, including the impact of any associated reduction in non-recurrent funding.

In 2024/25, the Health Board used a multi-stage budget approach, allocating funds to divisions and supplementing them based on savings and cost pressures. Key efficiencies were achieved through workforce optimisation, medicines management, service redesign, and data tools. The Value and Sustainability Board regularly monitored savings across categories and ensured targets were met. Welsh Government provided £40.5m in extra funding, reducing the deficit to £7.356m. Financial monitoring was continuous, with divisional and executive oversight, active risk management, and regular reporting to the Welsh Government.

The matters requiring management attention include:

- Gaps in the highlight reporting by the Value and Sustainability Board category leads to the Executive Team meetings; and
- Outstanding actions logged to address issues contributing to the underperformance of savings schemes.

Divisional Budgetary Control –

Quality & Safety

We have undertaken three reviews in this area.

• **Falls Management –**

- **Safeguarding** – The audit of safeguarding arrangements within the Health Board confirmed that statutory obligations are being met and appropriate governance structures are in place to protect vulnerable individuals. The audit reviewed safeguarding policies, procedures, training compliance, and governance, including a sample of staff-related allegations. Notably, safeguarding referrals have surged since 2022/23, with a 94% increase in adult cases and 132% in child cases. In 2024/25, 105 staff-related safeguarding concerns were raised, with 26 substantiated and 29 progressing to criminal investigation. The Safeguarding Team were supported by a revised team structure and increased capacity.

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

• **Cancer Referral rates –**

Information Governance & Security

We have undertaken three reviews in this area.

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

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

• **Shadow IT –**

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

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

Operational Service and Functional Management

We have undertaken six reviews in this area.

- **Waiting List Management (2024/25)** – The review of Waiting List Management focused on adult weight management, which has Health Board derived targets in the absence of national targets.

The assurance assessment does not evaluate performance against targets, as these can be affected by factors like policy or resource prioritisation. Expectations were clearly documented and reporting was robust, management should therefore focus on enhancing performance management, especially in the following areas:

- Incremental targets: Whilst overall targets have been set, incremental targets should be agreed to assist staged achievement.
- Action tracking: A formal rolling action plan should be fully maintained with SMART actions.
- Recorded actions: To ensure the action plan is comprehensive, it should be updated to record the recent initiatives/ actions to date and their impact. This will then act as a single log of activities.

• Benefits Realisation (excluding digital) –

- **Business Continuity** – We reviewed the adequacy of business continuity plans (BCPs) (excluding digital / disaster recovery plans) within a sample of service areas across the Health Board. The Health Board, as a Category 1 responder under the Civil Contingencies Act 2004, must maintain robust emergency preparedness and resilience arrangements. The audit confirmed that BCPs exist for the sampled services, including action cards, but we identified gaps in testing, staff awareness, and documentation. None of the three services sampled had tested their BCPs, and action cards lacked clarity on activation triggers, role-specific responsibilities, and secure storage. Whilst we provided **reasonable assurance**, noting that while the framework is sound, improvements are required to ensure plans are practical and effective during disruptions.
- **Capital Projects: Service Readiness** – The audit evaluated the arrangements in place on the service side in preparation of opening two Health and Wellbeing Centres. Whilst providing **reasonable assurance**, key findings included the need to update commissioning procedures, enhance monitoring of pre-commissioning plans, earlier establishment and sustained operation of working groups, improved operational compliance and clarity on key roles to ensure consistent and effective commissioning.
- **Directorate Review: CAMHS** – We provided **reasonable assurance** on the risk management, performance monitoring, and governance arrangements within the Children and Adolescent Mental Health Services (CAMHS) Directorate. It did however identify areas for improvement, whilst statutory responsibilities under the Health and

Social Care (Quality and Engagement) (Wales) Act 2020 were well understood and monitored corporately, there was opportunity to improve the local arrangements within the Directorate.

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

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

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

Workforce Management

We have undertaken four reviews in this area.

- **Professional Staff Registrations –**
- **Overseas Recruitment (draft report) –**
- **Occupational Health** – We provided **reasonable assurance** over the arrangements in place to manage the occupational health service. This recognised the significant workforce capacity deficits and operational pressures affecting KPI performance. The audit also identified opportunities for enhanced reporting and project tracking.
- **Speaking-up Safely** – A prior review of Speaking Up Safely was completed during 2024/25 based on the NHS Wales Speaking Up Safely Framework (the 'Framework'), where we provided limited assurance. Revised Speaking Up Safely monitoring arrangements were introduced in December 2024; however, no concerns had been processed at the time of the original audit, and therefore it could not be considered in deriving the opinion – which was assessed as providing limited assurance.

The focus of this year's audit has been the revised arrangements introduced during December 2024. The audit noted that the current approach is manual, time-consuming and does not reliably capture all activity undertaken to progress / manage cases. As a result, a **limited assurance** opinion was concluded, reflecting recurring issues from the previous audit. Key matters include:

- the need for clearer guidance on SUS roles (including the vacant Independent Member lead) and minimum record requirements;
- significant data quality and completeness issues in the spreadsheet, with limited supporting evidence and poor cross-referencing to linked processes;
- risk of apparent premature closure due to incomplete recording of substantial case activity; and
- limited evidence of lessons learned and learning from users' experiences.

Capital & Estates Management

We have undertaken four reviews in this area.

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

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

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

- **Grange University Hospital - Emergency Department Extension** - The audit of the Grange University Hospital Emergency Department Extension project for 2025/26 concluded **limited assurance** due to significant delays, contractor performance issues, and financial uncertainties, with Phase 1 delayed by 45 weeks and Phase 2 removed for re-tendering in 2026/27. Key management actions include undertaking a lessons-learned review, improving financial reporting, managing contractual changes timely, and revising the benefits realisation plan, while governance and quality assurance were deemed reasonable but with room for improvement in reporting and operational planning.

• Satellite Radiotherapy

• Estates Assurance – Space Utilisation

2.5 Approach to Follow Up of Recommendations

As part of our Follow-up of Previous Recommendations review work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

However, it remains the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management. Where appropriate, we have adjusted our approach to follow-up work to reflect these challenges.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the GIAS) and the level of overall assurance that we can give.

The Health Board's recommendation tracking process continued during 2025/26 which was found to be operating effectively.

2.6 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems.

2.7 Period Covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2025/26 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit, Risk and Assurance Committee after this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.8 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2025/26.

2.9 Statement of Conformance

The Welsh Government determined that the Global Internal Audit Standards (GIAS) would apply across the NHS in Wales from 1 April 2025.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with GIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023, reported in April 2023 stated who concluded we 'Fully Conform' with the relevant standards.

The NWSSP Audit and Assurance Services can assure the Audit, Risk and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Global Internal Audit Standards for 2025/26.

Our conformance statement for 2025/26 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2025/26 which will be reported formally in the Summer of 2026; and
- The results of the External Quality Assessment.

We have set out, in **Appendix A**, the key requirements of the Global Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2025/26 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Health Board's audit programme for 2025/26.

The Head of Internal Audit has unfettered access to the Chief Executive, Chair of the Audit Committee and Chair of the Health Board.

2.10 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to consider other assurances and risks when preparing their Statement. These sources of assurances will have been identified within the Board’s own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Quality Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales, Healthcare Inspectorate Wales and Health and Safety Executive.

3. Other work relevant to the Health Board

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation’s audit programme, will cover activities relating to other health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership; and
- NHS Wales Joint Commissioning Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To review the adequacy of the systems and controls in place for key risk areas in the accounts payable process, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report.

Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Recruitment Services	Substantial	To review the adequacy of systems and controls in place for Recruitment Services.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. All audits in this programme are reported to the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership. The overall Head of Internal Audit Opinion for NWSSP is **Reasonable Assurance**.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Programme Management	Reasonable	To provide assurance over the timely rollout of a sample of digital programmes / projects across Wales and steps taking place to overcome obstacles, challenges and manage the delivery of benefits.
Cyber Security	Reasonable	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
GMS Clinical System Migration Project	Reasonable	To assess the management and delivery of the HMS Clinical System Migration project.
CaNISC	Reasonable	To ensure the risks associated with the withdrawal / replacement of the Cancer Network Information System Cymru (CaNISC) are appropriately managed.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

4. Delivery of the Internal Audit Plan

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit, Risk and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit, Risk and Assurance Committee during the year. Audits that remain to be reported, but are

reflected within this Annual Report, will be reported alongside audits from the 2025/26 operational audit plan.

The audit plan approved by the Committee in April 2025 contained 26 planned reviews. The opinion for 2025/26 includes a further two audits brought forward from the 2024/25 audit plan and an additional two audits under Integrated Audit & Assurance Plans. We also deferred two reviews and delayed the commencement of one review. These changes have been reported to, and approved by, the Audit, Risk and Assurance Committee.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit, Risk and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to Audit, Risk and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2025/26	G	April 2025	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2025/26	G	xxxx	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	xxxxx	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	A	xxxxx	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	xxxx	95%	v>20%	10%<v<20%	v<10%

Key: v = percentage variance from target performance

5. Risk based audit assignments

The overall opinion provided in Section 1 and our conclusions on individual reviews is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 27 audit reviews were reported during the year. Figure 1 below presents the assurance ratings, and the number of audits derived for each.

Figure 1 Summary of audit ratings

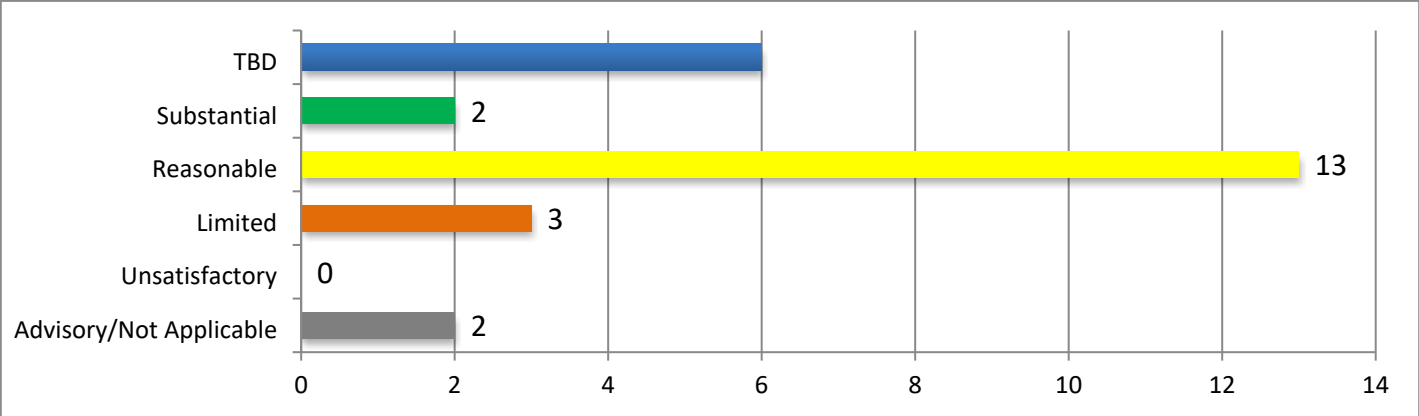


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there was one audit that did not proceed following preliminary planning and agreement with management. This audit is documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Dark Green)



In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title			Objective
Standing Orders Compliance			To assess adherence to the model Standing Orders (Reservation and Delegation of Powers) and Standing Financial Instructions, as determined by the Welsh Government, including any associated risks with the availability of Independent Members.
Welsh Intensive Care Information System		Care	To ensure lessons learnt and / or any associated actions regarding the work completed to date on the Welsh Intensive Care Information System are appropriately addressed.

5.3 Reasonable Assurance (Light Green)



In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Financial Sustainability (2024/2025)	To determine if appropriate recovery plans are in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent public health funding.
Waiting List Management (2024/2025)	To review the arrangements in place to reduce the patient waiting lists of services not reported at a national level.
Strategic Risk and Assurance	To determine and evaluate whether the Health Board’s governance and strategic oversight of risk and assurance are effective, aligned with organisational goals, and support long-term objectives.
Business Continuity Plan	Evaluate the effectiveness and comprehensiveness of the organisation's business continuity planning, focusing on risk assessment, preparedness, response strategies, and recovery procedures to ensure minimal service disruption during unforeseen events (e.g. loss of suppliers).
Capital Projects: Service Readiness	Evaluate the preparedness of services for operational deployment in capital projects, focusing on compliance with project timelines, resource allocation and risk management processes, to ensure a timely commencement of the new / revised operations.
Directorate Review – CAMHS	To ensure that appropriate arrangements are in place for the management of risk and performance within the CAMHS directorate.
Safeguarding	To ensure key policies and procedures are embedded and adhere to safeguarding regulations.

Review Title	Objective
Occupational Health	To provide assurance over the arrangements and controls in place for the management of the occupational health service.
Cyber Security (including cyber incident response)	To assess the governance process for cyber security, associated risk statements and the management and delivery of improvement plans.
RGH Central Decontamination Unit	The UHB has been successful in obtaining capital funding of £4.714m for the development of a Centralised Decontamination Unit at Royal Gwent Hospital (RGH) to address the current inadequate and non-compliant facilities. The audit will examine the delivery of the project against the key project parameters inc. time, cost and quality. This will be the only audit of the project.
Satellite Radiotherapy (Draft Report)	The audit focused on the delivery and management arrangements established jointly by Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) to progress the development of the Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital. This was the third audit undertaken of the project and it had been commissioned in accordance with the agreed audit plan provided within the approved Full Business Case (FBC) for the project.
Overseas Recruitment (Draft Report)	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.
Discharge Planning (Draft Report)	To provide an opinion over the discharge planning process of the Health Board, with a focus on the management and delivery of planned discharges. This audit will consider the recommendations raised within the 2022/23 internal audit of Discharge Planning.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Subject Access Requests	To ensure the Health Board is complying with legal and regulatory obligations with effective processes and whether the system for managing subject access requests (SARs) is robust, secure, and efficient.
Grange University Hospital - Emergency Department Extension	This audit was commissioned in accordance with the Integrated Audit Plan provided within the Business Justification Case (BJC). The audit reviewed the arrangements in place to progress the extension of the Grange University Hospital (GUH) Emergency Department. This was the second audit of the project, and covered project activity from September 2024 onwards (i.e. following the period covered in the 2024/25 audit).
Speaking Up Safely	The audit sought to ensure the revised Speaking Up Safely process (implemented in December 2024) fully incorporated the requirements of the All-Wales Speaking Up Safely Framework issued by the Welsh Government.

5.5 Unsatisfactory (Red)



No reviews were assigned an 'unsatisfactory' opinion.

5.6 Advisory/Assurance Not Applied (Grey)



The following review was undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for this review is deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate, but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Public Health (Advisory)	To determine if the Health Board has effective controls in place to ensure that public health objectives are being met at a local level, in support of the IMTP and the requirements of the Well-being of Future Generations (Wales) Act 2015, whilst recognising the responsibilities of Public Health Wales.

Review Title	Objective
Estates Assurance - Space Utilisation	To assess the systems and controls in place within the UHB to measure the efficiency and effectiveness of space utilisation across the UHB's facilities ensuring the optimal use of available space and identifying opportunities for improvement.
Follow-up of High Priority Recommendations	To assess whether high priority internal audit recommendations have been implemented.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reports issued. Therefore, the conclusions of our audit work have been taken into account for the 2025/26 Head of Internal Audit Opinion.

Review Title	Objective
Divisional Budgetary Control	To ensure the Budgetary Control FCP is adhered to at a sample of divisions, with the overall objective of determining if financial sustainability is being maintained.
Benefits Realisation (excluding digital)	To ensure appropriate processes are embedded for the management and achievement of anticipated benefits arising from change management within the Health Board.
Falls Management	To provide assurance that the Falls Policy for hospital adult inpatients was being adhered to by staff and monitored appropriately.
Professional Staff Registration	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.
Cancer Referral Rates	To determine if the referral and application processes within the Health Board are consistent with the rest of NHS Wales.
Shadow IT	To ensure that appropriate processes are in place to assess the presence and impact of unauthorised IT systems and applications within the Health Board, including identifying security vulnerabilities, compliance issues and potential risks to data integrity.

5.8 Audits not undertaken

Additionally, the following audits were deferred / delayed for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Rationale
Clinical Audit	Clinical Audit – The extraordinary Audit, Risk & Assurance 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 was therefore proposed and approved that this audit is delayed until the revised arrangements are established.
Six Goals Programme	Six Goals Programme – Audit Wales concluded their review of <i>Urgent and Emergency Care: Arrangements for Managing Demand</i> 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, the committee approved the deferral of this audit.
Directorate Review – Ophthalmology / ENT	Directorate Review - Ophthalmology/ ENT – we agreed for this review to be expanded to cover recent significant increased investment for cataracts and regional working in this area. The committee approved 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.

6. Acknowledgement

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2025/26 plan.

Stephen Chaney
Pennaeth Archwiliad Mewnol/Head of Internal Audit
Gwasanaethau Archwilio a Sicrwydd/Audit and Assurance Services
Partneriaeth Cydwasanaethau GIG Cymru/NHS Wales Shared Services Partnership
Ebrill 2026/ April 2026

Appendix A

Internal Audit compliance with the Global Internal Audit Standards and the UK Public Sector Practice Note

Global Internal Audit Standards – Domains, Principles & Standards	Requirements & Response
Domain I: Purpose of Internal Auditing	Internal auditing strengthens the organisation’s ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight. Advice and assurance are provided primarily through a risk-based audit plan approved and monitored by the Audit Committee. Audit & Assurance uses the results of its audits, together with focused research, to provide insight and foresight.
Domain II: Ethics & Professionalism Principles 1 (Demonstrate Integrity), 2 (Maintain Objectivity), 3 (Demonstrate Competency), 4 (Exercise Due Professional Care), and 5 (Maintain Confidentiality). 13 individual standards.	Audit & Assurance has established processes for dealing with both the ethics and professionalism of Internal Audit and the need to maintain client confidentiality. This encompasses training, declarations of interest returns, our audit processes, and the requirements (where appropriate) of professional accounting and audit bodies.
Domain III: Governing the Internal Audit Function Principles 6 (Authorised by the Board), 7 (Positioned Independently), and 8 (Overseen by the Board). 9 individual standards.	How we interact and work with each NHS Wales organisation is set out in the Internal Audit Mandate and Charter which is updated annually. There are appropriate arrangements in place for Internal Audit to act independently and interact with the Board to ensure effective Governance arrangements.
Domain IV: Managing the Internal Audit Function Principles 9 (Plan Strategically), 10 (Manage Resources), 11 (Communicate Effectively), and 12 (Enhance Quality). 16 individual standards.	The Internal Audit function for NHS Wales is managed through the NHS Wales Shared Services Partnership (NWSSP). The Audit & Assurance service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual plan is developed for each NHS Wales organisation. The annual plan gives detail of specific assignments and sets out the overall resource requirement. The audit

	strategy and annual plan is approved by the Audit Committee. Quality assurance and control arrangements are in place and are subject to an external assessment at least once every five years. Policies and procedures which guide the Internal Audit activity are in place. There is structured liaison with Audit Wales, HIW and Counter Fraud.
Domain V: Performing Internal Audit Services Principles 13 (Plan Engagements Effectively), 14 (Conduct Engagement Work), and 15 (Communicate Engagement Results and Monitor Action Plans). 14 individual standards.	Audit & Assurance has a Quality Manual that sets out how we will conduct and monitor audit engagements and this is then replicated in our Electronic Working Paper system (ESRA) and other files. This ensures that we meet the requirements to plan, conduct and communicate audit engagement appropriately and follow-up management actions.

[Global Internal Audit Standards](#)

[UK Public Sector Application Note](#)

Appendix B

Assurance Opinion

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee. Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Aneurin Bevan University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party. The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of 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.

Prioritisation of Findings

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

Public Sector Internal Audit Standards

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



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



Aneurin Bevan University Health Board – Audit Committee Update

Date issued: April 2026



Contents

Contents	2
Introduction	4
Accounts audit update	5
Performance audit update	6
Other relevant publications	8
Further information	9

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

The Auditor General, Wales Audit Office and staff of the Wales Audit Office accept no liability in respect of any reliance or other use of this document by any member, director, officer or other employee in their individual capacity, or any use by any third party.

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.

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

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 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 complete. Final accounts audit due to start on 1 May 2026.
- **Expected committee date:** 23 June 2026

Audit of the 2025-26 Charitable Fund Accounts

- **Executive Lead:** Director of Finance and Procurement
- **Focus of the work:** To provide an audit opinion on the 2025-26 Charitable Fund Annual Report and Accounts
- **Status:** Not started
- **Expected Board date:** January 2027

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 at this committee
- **Expected committee date:** April 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Digital
- **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 at this committee
- **Expected committee date:** April 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Chief Operating Officer
- **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:** June 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.

<u>Additional Learning Needs: do public bodies know if the system is working</u>	April 2026
<u>Managing the Regional Integration Fund</u>	March 2026

Since the last committee update, Audit Wales has also published the following corporate documents.

<u>Annual Plan 2026-27</u>	April 2026

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.



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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



Aneurin Bevan University Health Board – Audit Plan 2026

Date issued: March 2026



Contents

Introduction	4
Our aims and ambitions	5
Financial audit work	6
Performance audit work	14
Audit fee	18
Audit team	20
Audit quality	21
Further Information	22

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

The Auditor General, Wales Audit Office and staff of the Wales Audit Office accept no liability in respect of any reliance or other use of this document by any member, director, officer or other employee in their individual capacity, or any use by any third party.

[mailto:](#)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.

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



Adrian Crompton

Auditor General for
Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My [Code of Audit Practice](#) provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three

lines of assurance model (page 21) sets out how we will ensure those standards of quality are met. Our latest annual [Audit Quality Report](#) provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other [national audit work](#) that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose



Assure people that public money is being managed well



Explain how that money is being spent



Inspire the public sector to improve

Our vision



Fully exploiting our unique perspective, expertise and depth of insight



Strengthening our position as an authoritative, trusted and independent voice



Increasing our visibility, influence, and relevance



Being a model organisation for the public sector in Wales and beyond

Our areas of focus



A strategic, dynamic, and high-quality audit programme



A targeted and impactful approach to communications and influencing



A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our [Annual Plan 2025-26](#) and Our [Strategy 2022-27](#).

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our [Statement of Responsibilities](#).

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

There have been no limitations imposed on me in planning the scope of this audit.

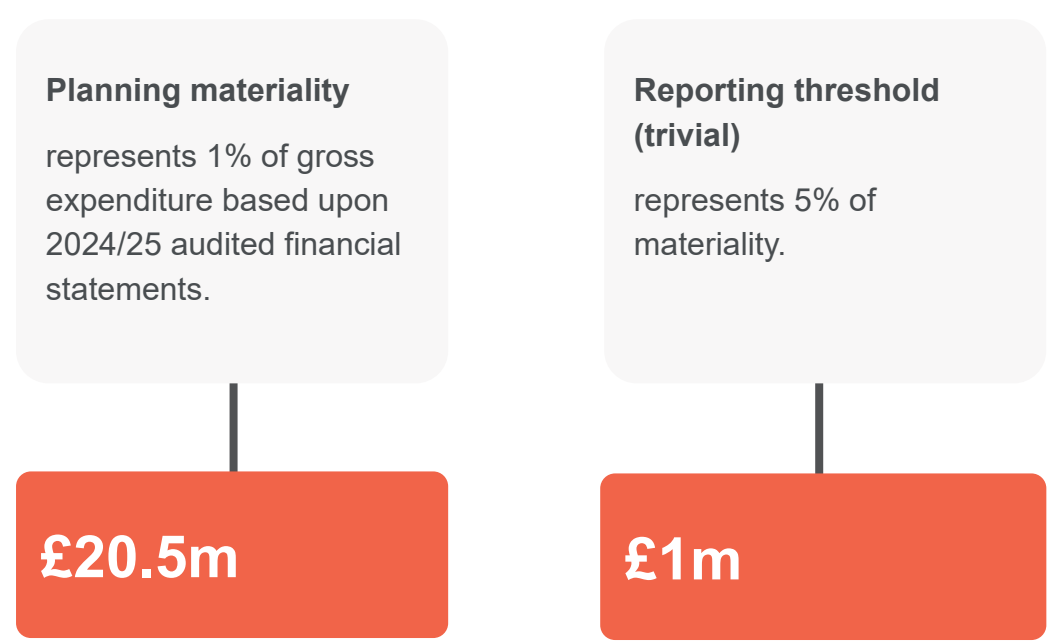
Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.
- The levels at which I judge such misstatements to be material is set out below.



There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:



My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Failure of first financial duty

The Health Board's first financial duty is to break even over a three-year period. The position at month 10 shows a year-to-date deficit of £17.6 million and a forecast year-end deficit of £18.3 million. This, combined with the outturns for 2023-24 and 2024-25, predicts a three-year deficit of £75 million.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

The second financial duty requires LHBs to prepare and have approved by Welsh Ministers a rolling three-year integrated medium-term plan. Should you fail this financial duty, we will place a substantive report on the financial statements highlighting this.

Our planned response

- continue to monitor the Health Board's financial position for 2025-26 and the cumulative three-year period to 31 March 2026;
- perform substantive testing on areas in the financial statements where transactions are at higher risk of being reported in the incorrect period or misclassified between capital and revenue; and
- consider the impact of any relevant uncorrected misstatements over the three-year period to 31 March 2026.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Remuneration report disclosures

Remuneration paid to senior officers and board members continues to be of high interest and is material by nature. We have also previously identified material issues with these disclosures.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence, completing testing as part of our interim work where possible;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2026.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer, who provide indices to management and undertake valuations as necessary;
- test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the LHB and the other body/party.

The LHB has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Provisions and contingent liabilities

The financial statements include provisions for legal obligations, particularly in relation to clinical negligence.

There is a significant degree of subjectivity and uncertainty in the measurement and valuation of these provisions.

This subjectivity and uncertainty increases the risk of material misstatement.

Our planned response

My audit team will:

- Review management's estimation process for the valuation of provisions;

- Consider the competence, capability and objectivity of the management experts who are prepare the estimates; and
- Ensure that disclosures are in accordance with the FReM and Welsh Government's Manual for Accounts.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning January - February 2026	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Draft Audit Plan
Interim February - March 2026	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing
Fieldwork May - June 2026	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting June - July 2026	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru Annual audit summary Post project learning

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

 Strategic planning	 Asset management
 Financial planning	 Collaborative working
 Performance and risk management	 Overall governance.
 Workforce planning	

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.

The **Sustainable development principle** is defined as acting in a manner...

...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

To do this, they must take account of the '**five ways of working**'.



Long-term



Prevention



Integration



Collaboration



Involvement

I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the audit work my audit teams do at each NHS body.

My 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources.

This work will also review how the audited body tracks progress against previous audit recommendations. This helps the audit team check that improvements identified in earlier audits are being addressed. It also helps us measure the impact of our work more clearly.

My 2026 Structured Assessment work will also inform our thinking on whether we should undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

All-Wales thematic review of the management and prevention of diabetes

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, it will focus on the ambitions set out in the Tackling Diabetes Together Programme, and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.

Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – Operating Theatre efficiency and effectiveness

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. The local performance audit work will focus on the management of operating theatres and the extent that arrangements support efficient, effective and good quality services.

Indicative timescales

We will discuss the delivery timescales with senior management early in the 2026-27 financial year.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and progress will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Based on those requirements, my estimated audit fee for 2026 will be £469,664, an increase of 5.3% on my estimated 2025 fee.

Your estimated total audit fee: £469,664

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£)¹

Audit of financial statements ²	Performance audit work ²	Grant certification ³
£268,712	£196,952	£4,000
Total fee: £469,664		

Estimated fee for 2025 (£)

Audit of financial statements	Performance audit work	Grant certification
£255,069	£187,019	£4,000
Total fee: £446,088		

¹ The fees shown in this document are exclusive of VAT.

² Payable November 2025 to October 2026

³ Payable as work is undertaken

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Richard Harries richard.harries@audit.wales	
	Financial Audit	Performance Audit
Engagement Lead	Richard Harries richard.harries@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Manager	Julie Rees julie.rees@audit.wales	Andrew Doughton andrew.doughton@audit.wales
Audit lead	Dafydd Parker dafydd.parker@audit.wales	Sara Utley sara.utley@audit.wales

I can confirm that my team members are all independent of the LHB and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our [Audit Quality Annual Report](#).



Our People

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



Arrangements for achieving audit quality

Selection of right team

• Audit platform	• Learning and development
• Ethics	• Leadership
• Guidance	• Technical support
• Culture	



Independent assurance

• EQRs	• Peer review
• Themed reviews	• Audit Quality Committee
• Cold reviews	• External monitoring
• Root cause analysis	

Further Information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide 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.



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

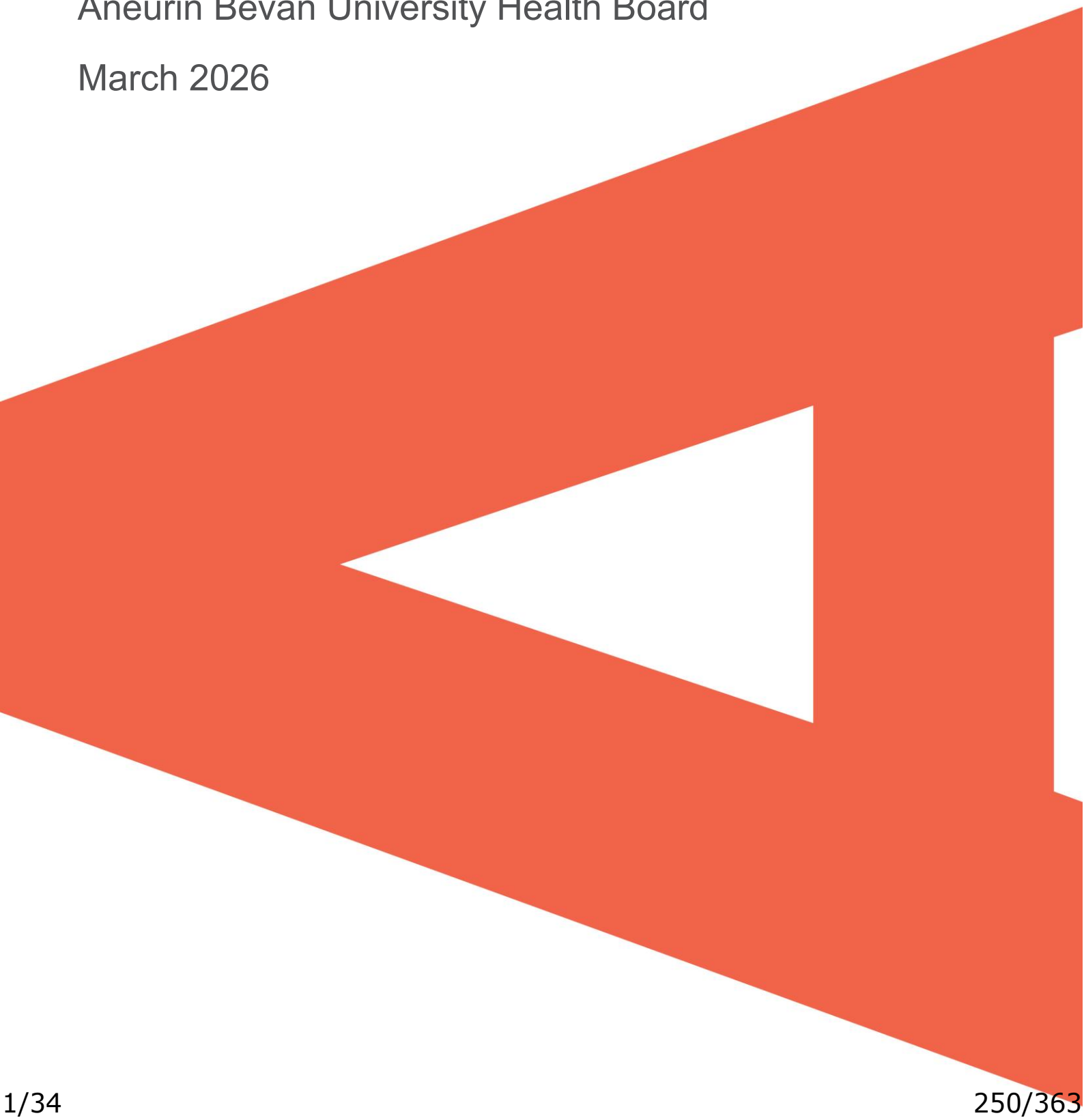
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



Digital Transformation

Aneurin Bevan University Health Board

March 2026



About us

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

© Auditor General for Wales 2026

You may re-use this publication (not including logos except as an integral part of the document) free of charge in any format or medium.

If you re-use it, your re-use must be accurate and must not be in a misleading context. The material must be acknowledged as Auditor General for Wales copyright, and you must give the title of this publication. Where we have identified any third-party copyright material you will need to obtain permission from the copyright holders concerned before re-use.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

- call us on 029 2032 0500
- email us at info@audit.wales

You can use English or Welsh when you get in touch with us – we will respond to you in the language you use.

Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot	4
Key facts and figures	7
Our findings	8
Recommendations	24
Appendices	26
1 About our work	27
2 Key terms in this report	30

Audit snapshot

What we looked at

- 1 We looked at how Aneurin Bevan University Health Board's approach to digital transformation is supporting service improvement. This included the approach to strategy, leadership, and skills development. And we considered how the organisation manages risks around digital infrastructure, cyber resilience, and artificial intelligence.

Why this is important

- 2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.
- 3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another and organisations must manage ever-growing risks around cyber resilience.
- 4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

- 5 The Digital Strategy is out of date, and the Health Board is currently updating this, with the aim of this work being completed by May 2026. Despite this, the Health Board is making steady progress in delivering aspects of its local digital programme, supported by committed leadership. The Health Board is also adopting national digital developments which help to support service modernisation. Increased investment is needed to effectively deliver digital transformation at the scale and pace required.
- 6 The Board needs to improve its oversight of its local digital transformation projects and widen this to gain assurance on the progress on regional working. Whilst the Board has good oversight of digital and artificial intelligence risks, there needs to be stronger oversight on how well the Health Board is managing cyber risks. Cyber resilience arrangements are well established but would benefit from a detailed cyber security plan.
- 7 The Health Board recognises the importance of digital skills but needs to better assess digital capability across the organisation. There is limited capacity to support digital training, and the Health Board would benefit through stronger collaboration between digital and workforce teams to address this issue. The Health Board does not have a strategic approach to digital inclusion, and there is no designated lead in place.
- 8 The Health Board is demonstrating strong engagement with digital partners including Digital Health and Care Wales (DHCW), Health Education and Improvement Wales (HEIW) and Welsh Government. The Health Board also has a strong approach to benefits realisation. However, regional working with partners is at its infancy.

What we recommend

- 9 We have made seven recommendations to the Health Board which focus on:
 - updating its current digital assurance report to add oversight of financial delivery;

- clarifying the status of the proposed new digital directorate governance model;
- developing a stand-alone cyber risk;
- ensuring its digital strategy reflects an approach to cyber security;
- developing a coordinated approach to assess and build digital capability across the organisation;
- assigning a strategic lead for digital inclusion and developing a clear plan to reduce digital exclusion; and
- improving oversight of regional working.

Key facts and figures

Of the Health Board's workforce of approximately 15,994 staff, only 289 have completed the 'HEIW interactive self-evaluation tool' as part of the Digital Capability Framework.

The Health Board was assessed at Stage 1 of the HIMSS EMRAM model in 2022 meaning core digital systems are in place, but overall digital maturity is still at an early stage.

Since March 2025, the Health Board has had no reportable incidents to the cyber resilience unit.

From 2022-23 to 2024-25, the Health Board invested approximately £126.4 million in digital revenue and £22.7 million in capital.

Our findings

Strategy, Planning and Leadership

The Health Board's digital leadership and planning are improving, but outdated strategy, gaps in oversight may limit the impact of its digital ambition

Digital strategy and plans

10 The Board agreed its Digital Strategy in 2019 and as such is now out of date. This legacy strategy is shaped around four key themes: digital community, digital organisation, digital data, information and intelligence, and digital foundations. The Health Board developed it in a way that aligned appropriately with national and local priorities including *A Healthier Wales* and the Health Board's Clinical Futures strategy. It explains:

- how digital technologies will support a long-term shift in how it will deliver health and care services across Gwent.
- the use of digital tools to help people manage their own health; and
- support staff to deliver high-quality care and help to move care into communities.

11 In the absence of an up-to-date strategy, the Health Board's current Integrated Medium-Term Plan (IMTP) sets out high level digital plans and priorities for the next three years. This includes 12 digital priorities covering Board development, regional working, directorate structure and governance improvement and electronic health and care record. The Health Board has then broken down these commitments into a roadmap. These list the specific digital projects that the Health Board aims to deliver each year.

12 The IMTP also sets out how digital can, alongside workforce and estates changes, help to enable sustainable services. This includes how digital tools and real-time information can improve urgent care patient flow. The Digital, Data and Technology directorate then monitor progress, which we discuss later.

13 At the time of our work the Health Board was developing a new Digital Transformation Strategy. This is because the digital landscape has changed significantly since 2019. The Health Board has conducted a comprehensive engagement process and Board development sessions to help shape the new strategy. The Board should approve the new strategy at its May 2026 meeting. It is intending that the new strategy will:

- align with the Health Board's 10-year plan, *Gwent 2035 – Better Health, Better Care, Better Lives*, approved in July 2025;
- consider the rapid growth of artificial intelligence and what this means for healthcare;
- enable faster delivery of digital solutions, and
- meet rising expectations about how digital transformation can support better healthcare and stronger communities.

14 The Health Board could use the strengths and weaknesses of its 2019 strategy to shape its new strategic approach. It can make sure the new strategy fits well with national and local healthcare priorities. It can also set out a clear and current picture of its digital strengths, weaknesses, and overall maturity. By learning from the last strategy, the Health Board can explain what resources it needs, set out the main risks to delivery, and how it will track progress and measure impact.

Board ownership of digital transformation

- 15 The Board recognises the potential of digital technology and the benefits it can bring to the organisation. It also has strong digital leadership. It includes a Director of Digital and an expert Independent Member for Digital both take part in Board and various committee meetings relevant to their roles. This helps to ensure the organisation has the right expertise to guide its digital plans. The Health Board also continues to take part in the All-Wales Directors of Digital and Independent Member Digital Network meetings. This allows organisations to share learning, good practice, and join national digital discussions that support the Health Board's digital transformation.
- 16 The Health Board has not recently delivered training sessions for Board members, but it has commissioned an external provider to do so. The proposed training should help Board members discharge their functions, scrutinise digital plans, understand digital risks and oversee the impact from digital transformation. These sessions will be delivered over the next year with the aim of improving Board members' knowledge and strengthening oversight of digital work. This should help them to make informed decisions on the digital strategy and consider the consequent resource commitment it needs to support to effectively deliver its digital priorities.

Roles, responsibilities, and accountability

- 17 Although the Board has structures in place for oversight of digital work, current reporting does not give the Board sufficient visibility of the financial position or longer-term strategic progress of digital programmes. The Finance and Performance Committee is responsible for oversight of digital operational delivery, and the Partnerships, Population Health, and Planning Committee oversees the delivery of the digital strategy. The Director of Digital gives an assurance report at every Finance and Performance Committee meeting, updating the Committee on project delivery, key milestones, risks, and the actions in place to manage them. However, the reports do not set out financial details such as budgets, cost pressures, or any cost overruns. Without this information, the Board cannot fully understand the financial position of digital programmes. Independent Members provide strong scrutiny at the Finance and Performance Committee. But most of their time goes to national digital programmes. This means they spend less time on local digital projects. It also reduces wider discussion on longer-term digital change beyond project delivery.
- 18 Digital services are well managed at an operational level, with clear roles and responsibilities. The Digital, Data and Technology Directorate (DDaT) leads the Health Board's digital transformation and ICT programmes. The Digital Portfolio Progress Subgroup monitors day-to-day delivery. It meets each month and reports to the Finance and Performance Committee. We observed this sub-group and found it well attended and demonstrating a strong grip on programme delivery. The group reviewed the status of each programme, assessed risks, and considered the level of confidence in delivering projects.
- 19 There is currently insufficient oversight of the digital strategy delivery and the impact that it is having. This limits assurance to the Board that delivery is on track and that risks, issues, and benefits are managed effectively. The Health Board oversees delivery of its Digital Strategy through the Partnerships, Population Health, and Planning Committee. The Independent Member for Digital is a member of this committee. However, although the committee's workplan states it will receive an annual update on the Digital Strategy, we found no evidence that this has happened.

20 In summer 2025, DDaT proposed a new governance structure to strengthen operational oversight of digital programmes, risks, and escalation routes. The proposal included creating a Digital, Data and Technology Group to provide strategic direction and assurance across digital services. The group would be chaired by the Director of Digital and supported by the Chief Information Officer. Membership would include senior leaders from digital, clinical, operational, workforce, finance, and Information Governance. The progress of this proposal is still unclear. The Health Board now needs to ensure that any changes support the new digital strategy and help deliver its priorities

Identifying and managing risks

The Health Board manages digital risks and recognises emerging AI risks, but it still needs stronger assurance on the effectiveness of cyber security

Strategic digital risks

21 The Health Board's strategic risk register includes one overarching digital risk, that the Health Board has inadequate digital infrastructure and systems to maintain high quality safe service delivery. It has broken down the risk into three distinct high-rated threats:

- the full or partial failure of existing digital infrastructure and systems;
- the adverse impact on service delivery in the implementation of the new digital systems; and
- the failure to develop digital solutions that are sustainable and fit for the future.

22 These risks receive routine scrutiny from both the Board and the Audit and Risk Committee. However, while there is reasonable assurance on the risk controls in place, risk ratings remain consistently high particularly in relation to national system delays and the scale of infrastructure modernisation required.

23 The Health Board is not yet giving cyber risk the strategic focus it needs. It has begun to identify and assess cyber security risks, but it still does not treat cyber security as a full organisational risk. Cyber threats can cause major harm, including system outages, data loss, and delays to patient care. Because of this, the Board needs a clear, standalone cyber security risk that assessed in depth. This would help ensure that threats are properly understood, resources are directed to the right controls, and the organisation can protect services and sensitive information with confidence.

Digital infrastructure risks

- 24 The Health Board is aware of gaps in its physical IT infrastructure, including ageing and unsupported hardware and monitors these through its ICT asset register, which it uses to prioritise capital investment. At the time of our work, this register included only physical ICT assets, but the Health Board was developing an applications list to identify which systems should be prioritised for replacement.
- 25 The Health Board has also invested in software to identify shadow IT on its network, which addresses the risk of unapproved tools being used which may introduce security vulnerabilities. There has been good progress in rolling out Windows 11. However, plans remain constrained by limited funding. Of most concern is the need to replace the Clinical Workstation. This is a portal that enables staff to access a variety of clinical and administrative information in once place. This system is more than thirty years old and becoming obsolete. During our work, the Health Board was developing a business case for the Clinical Workstation replacement to address current risks and priority.
- 26 The new digital strategy and supporting plans must show how the Health Board will replace and modernise its legacy infrastructure, building on work already underway. However, the Health Board's programmes to replace outdated equipment are already improving resilience and creating a stronger foundation for future digital transformation. These include work to address outdated services and end-of-life systems, such as the critical service refresh programme that is replacing servers. The Health Board is also updating legacy communication tools, including pagers, and progressing upgrades for systems that require improvement.

Cyber resilience

- 27 The Health Board does not have a stand-alone Cyber Security Strategy, which limits its ability to set clear direction and priorities for cyber resilience. The new digital strategy must fully address cyber security risks, defining the current and future risks, threats, and opportunities, as well as mitigations.

- 28 The Health Board has a dedicated cyber security team in place who oversee cyber security. This consists of a Cyber Security Manager and a team of senior specialists. There are clear governance arrangements in place, through the Information Governance Group which reports to the executive team. Cyber security is a standing item at the divisional governance assurance meetings. This helps to raise awareness and strengthen the cyber security team's oversight across the organisation.
- 29 In December 2025, Internal Audit reviewed the Health Board's cyber security arrangements. The report gave reasonable assurance but said the Health Board needs to improve how it communicates cyber risks, monitors training compliance, and tests its cyber plans. It also noted that rising demand and growing complexity may create capacity pressures for the cyber team.
- 30 The Health Board works closely with national NHS cyber specialists and takes part in resilience exercises. However, information governance and cyber training completion stood at 77% in September 2025, below the 85% target. The cyber team also runs phishing tests to boost staff awareness, but recent results show there is still room to improve. The Health Board actively monitors cyber incidents. As of July 2025, it had no reportable cyber-related incidents in the previous year.
- 31 The cyber security team produces monthly performance reports that give assurance on key safeguards. These reports confirm that anti-virus software is active and any issues are dealt with quickly. The Cyber Security team assess risks for new projects and systems. The Health Board has strengthened its procurement process which has led to it building in cyber security requirements in new contracts. The Health Board is making reasonable progress in delivering the cyber security action plan in response to the findings from the cyber resilience units audit of its cyber assessment framework self- assessment.

Artificial intelligence

- 32 The Health Board recognises that Artificial Intelligence (AI) could bring important benefits, and some teams already use AI tools in areas such as imaging. However, its approach is fragmented because no one is coordinating the approach across the organisation. The Health Board has confirmed that the new Digital Strategy will include a clearer approach to AI.
- 33 In January 2026, the Board received an update on the Health Board's current use of Artificial Intelligence and the work underway to strengthen governance. The Health Board recognises that its AI policy for clinical practice needs updating and that staff need clearer guidance on the safe use of AI. To support this, the Health Board is establishing a new AI subgroup in early 2026 within the DDaT directorate. This group will oversee proposed AI applications and ensure they align with NHS Wales AI principles. It will include representatives from clinical, digital, governance, and quality and safety teams.
- 34 The Health Board has considered the risks linked to AI, and it added an AI related risk on its corporate risk register. This risk notes that inaccurate or unsafe clinical decisions could happen if AI tools are used in the wrong way, without proper checks, or without good oversight in clinical or operational settings.

Digital skills

The Health Board lacks a coordinated approach to build digital skills capability

Assessing digital skills

36 Although the Health Board recognises the importance of digital skills, it does not yet have a structured way to assess the skills, capacity, or capability of its workforce. Only 289 staff have completed HEIW's Digital Capability Framework out of a workforce of around 15,994 in July 2025. Without a targeted development plan, the Health Board cannot see where digital skills are lacking or what action is needed. The tool measures only basic IT confidence and does not assess the wider skills needed for digital transformation. There is also no evidence that the Health Board has carried out its own assessment of these broader skills.

37 The Health Board is developing a Digital Workforce Plan that will support the new Digital Transformation Strategy. But without a clear picture of its digital capability, the Health Board risks slowing down its digital transformation because it cannot accurately target training needs, allocate resources, or plan service change.

Developing digital skills

38 Health Board staff currently have limited opportunities to develop their digital skills. Teams receive good training and support when the digital directorate roll out new software. However, this does not extend to routine digital skills support for day-to-day system use. Opportunities for training are limited by:

- competing statutory and mandatory training demands;
- limited collaboration with wider workforce planning at both operational and national levels; and
- funding constraints in the digital directorate to support wider digital training.

39 The Health Board recognises the need to address this gap. The Health Board views the refreshed Digital Transformation Strategy as an opportunity to improve digital skills. In January 2026, the Health Board appointed a Clinical Chief Information Officer to support digital skills development. The Health Board also needs to clarify who is responsible for this work and ensure it is fully linked with Workforce and Organisational Development plans.

Collaboration and involvement

While the Health Board engages well with staff and service users, it lacks a clear strategy for addressing digital exclusion

Staff and service user involvement

40 The Health Board works closely with staff, patients and service users on key digital transformation projects, such as the My Medical Record system within urology and the roll out of the hospital e-prescribing system¹. The My Medical Record system rollout had a patient group who were involved in development and roll out. The Health Board has also established monthly meetings with stakeholders from corporate and operational divisions to develop medium to long term digital plans. The aim is to support transformational programmes including planned care and the unscheduled care six goals work.

41 Clinical engagement in digital is strong. Clinicians are engaged in key digital projects with sufficient time to ensure:

- effective clinical input into system developments; and
- time to support wider clinical colleagues on digital developments.

42 The Health Board also has a clinical safety officer and a business continuity manager. They support the safe development and operation of clinical and other software applications.

Reducing digital exclusion

43 The Health Board arrangements to address digital exclusion are currently underdeveloped. Through its IMTP 2025-28 the Health Board acknowledges that digital exclusion is a challenge and commits to understand the digital needs of the workforce and patients. The IMTP also pledges the Health Board to seek accreditation towards the digital inclusion charter. But its progress is slow. It has not set measurable targets for addressing digital exclusion. It also has no plan to identify or engage with patients who may be excluded, and there is no designated lead for digital inclusion.

Using digital developments to support service transformation

The Health Board is seeking to gain value from its digital projects, but funding constraints may present an increasing challenge

Investment in digital transformation

44 The investment in digital services is 1% of the Health Board total annual budget, and it estimates it needs to be closer to 3%. **Exhibit 1** sets out the capital and revenue investment in digital over three years. Its recent revenue spend on digital is fairly stable. This may Health Board's ability to sustain digital services or support new digital transformation work. The Health Board's capital funding is also not insignificant, but it is difficult to tell whether this sufficiently reflects investment needed both to maintain its infrastructure and implement new technology.

Exhibit 1: Annual capital and revenue investment in digital (2021–22 to 2024–25)

Financial Year	Capital Investment £m	Revenue Investment £m
2021-22	7.9	35.5
2022-23	4.5	30.0
2023-24	3.4	29.6
2024-25	6.9	31.3

Source: Health Board supplied data

- 45 **Exhibit 2** identifies the planned level of investment between 2025 and 2028. Capital funding will rise from £4.8 million in 2025-26 to £7.5 million in 2027-28. This steady increase supports a more sustained programme of investment. However, the Health Board will need to assure itself that its use aligns with the new digital strategy’s priorities and is sufficient to deliver them. The Health Board also forecasts its digital revenue spend to increase from £32.3 million to £33.4 million over the same timeframe. This is likely to be below inflationary increase and suggests little room for major new digital commitments.
- 46 The Health Board will also need to plan for how its digital priorities affect the balance between revenue and capital funding. If its strategy moves further toward hosted, cloud, or service-based systems, the need for local capital investment may fall, but revenue costs are likely to rise to support this new approach.

Exhibit 2: Forecast levels of digital capital and revenue funding

Financial Year	Capital £m	Revenue £m
2025-26	4.8	32.4
2026-27	6.0	32.3
2027-28	7.5	33.4

Source: Health Board supplied data

Local and regional digital projects

- 47 The Health Board has a coordinated approach to oversee and monitor delivery of a wide range of local and national projects. At the time of our review, 45 projects were live, across seven programmes. These programmes and underpinning projects include acute, ICT, digital community, digital patient, clinical support services, digital ward, and electronic prescribing. Current work includes upgrading digital dictation systems, improving endoscopy imaging, digitising eye care, improving appointment-booking tools, and introducing digital letters. The DDaT directorate has also completed the replacement maternity system and introduced an AI tool to support chest X-ray reporting.
- 48 The Health Board is also starting to work more closely with other health boards on regional digital plans. A joint regional meeting has taken place, and a formal regional digital group has been created. Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards are at an early stage of exploring what a shared regional digital strategy could look like. They are also considering areas where working together could bring savings, such as through Microsoft 365. The Health Board already has a regional digital plan in place for rolling out the OpenEyes system.
- 49 The Board will need to strengthen its oversight of regional digital work. At the time of our work, there had been no formal oversight of the activity underway or the wider regional opportunities available.

Adopting national digital systems

- 50 The Health Board works closely with key partners on national systems. Their partners include DHCW, HEIW, Welsh Government, and the Clinical Networks within NHS Performance and Improvement. Board members receive regular updates on delivery of major national programmes through the Digital, Data and Technology report to Finance and Performance committee. These reports highlight the many initiatives and projects delivered in collaboration with partner organisations. They outline current progress, timelines and identify where issues are slowing down progress, and action the Health Board and partners are taking in response.

- 51 The Health Board is rolling out national solutions to improve service access, quality and efficiency and productivity. This includes the radiology informatics system procurement and the Laboratory Information Management system.
- 52 The Health Board reports that national programme delays are significant. These delays limit its ability to manage digital risks and deliver wider transformation. The strategic risk register highlights slippage in Laboratory Information Management system and Radiology Informatics System Procurement, which creates major risks to service continuity and project delivery. These delays have led the Health Board to strengthen escalation, including zero-tolerance thresholds and direct reporting to senior leadership and Welsh Government. The Health Board has improved its local governance and oversight, but these actions cannot offset delays outside its control. As a result, its ability to modernise digital services and achieve wider transformation remains constrained.

Evaluating digital solutions

- 53 The Health Board has good examples of evaluating its digital solutions. For example, it reviewed the electronic prescriptions system and the Welsh Intensive Care Information System. These evaluations looked at savings in nursing time and improvements in the quality of care.
- 54 The Health Board has a good approach for assessing benefits after it introduces new digital systems. A dedicated Business Change and Benefits Team within the DDaT Directorate oversees this work and support all projects. The team uses a comprehensive Benefits Management Framework that sets out when benefits should be delivered and how it will measure them. Business cases also describe the benefits expected, which helps the Health Board check that these have been achieved.
- 55 The DDaT directorate tracks benefits across each programme and category through the Digital Portfolio Progress subgroup. It also runs benefits workshops for individual projects. For 2025-26, the directorate has identified 211 benefits across efficiency, patient experience, safety and cash releasing areas.

56 The Board have received presentations on the benefits of digital programmes. In January 2025, it received an update on the My Medical Record system in Urology and patients shared the benefits they had experienced. The Finance and Performance committee also receives regular reports on whether digital business case benefits are being delivered. It recently reviewed the benefits of the Digital Maternity programme and noted improvements for services, staff and patients. The Value and Sustainability update also tracks financial opportunities linked to digital transformation.

Recommendations

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

- R1

The Health Board should update its Digital assurance report to Finance and Performance committee to include detail on financial reporting, including project level budgets, current and forecast expenditure and any variances **(Paragraph 17)**.
- R2

The Health Board should clarify whether the Digital Data and Technology directorate governance structure proposal will proceed **(Paragraph 20)**.
- R3

The Health Board should develop a clear standalone cyber security risk, including defined controls and assurance arrangements, to ensure that threats are properly understood and resources are directed to the right mitigations **(Paragraph 23)**.
- R4

The Health Board should ensure its digital strategy fully addresses cyber security risks and the arrangements to address them. **(Paragraph 30)**.

- R5 The Health Board should implement a coordinated programme to assess and build workforce digital capability, which should;
- 5.1 assess/review digital capability across staff groups (**Paragraph 36**);
 - 5.2 identify and implement actions to improve digital capability. In doing so, ensure that the approach aligns with Workforce and Organisational Development training plans (**Paragraphs 36 and 39**).

- R6 The Health Board should strengthen its approach to digital inclusion by;
- 6.1 assigning a strategic lead for digital inclusion (**Paragraph 43**);
 - 6.2 producing a measurable digital inclusion plan with clear targets (**Paragraph 43**); and
 - 6.3 assessing digital inclusion risks on new patient/public facing systems. Systems/care pathways should then be designed to enable accessibility and alternative access contact routes (**Paragraph 43**).

- R7 The Health Board should ensure formal oversight of regional working is in place, which includes regular reporting on regional digital initiatives, assessment of risks and benefits and alignment of regional strategies with the Health Boards own digital plans (**Paragraph 49**).

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Health Board is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a well-led and appropriately resourced approach to digital transformation?
- Is the Health Board developing the digital skills, capacity, and capability of its workforce?
- Does the Health Board have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Health Board engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Health Board actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.
- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked Aneurin Bevan University Health Board (the Health Board) to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Digital, Data and Technology directorate organisation change and terms of reference for key governance groups.

- Key strategies and plans, including Digital Strategy and Integrated Medium-Term plan.
- Key risk management documents, including the Strategic Risk Register.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Director of Digital.
- Assistant Director of Digital Programmes.
- Interim Assistant Director of Strategy, Planning and Design.
- Independent Member for Digital.

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

- Finance and Performance Committee.
- Digital Portfolio Progress Group.

2 Key terms in this report

Term	Description
Strategic Risk Register	The Strategic Risk Register sets out the risks linked to the organisation’s strategic objectives, and the controls and assurances in place to manage those risks.
Corporate Risk Register	A Corporate Risk Register sets out the organisation’s significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
A Healthier Wales	The Welsh Government’s long-term plan for health and social care, focused on prevention, wellbeing, and more care delivered closer to home
Clinical Futures	Aneurin Bevan University Health Board’s previous long-term plan for creating a sustainable, modern health and care system across Gwent.
Gwent 2035 – Better Health, Better Care, Better Lives	Gwent 2035 is the Health Board’s new long-term strategy, shaped through extensive engagement and the Joint Strategic Assessment.
HIMSS EMRAM	Eight-stage (0–7) international maturity model developed by HIMSS to measure how effectively a hospital has adopted and is using digital and electronic medical record systems. It assesses progress from basic digital recordkeeping to fully paperless, data-driven, interoperable care, supporting safer, more efficient clinical practice.
Laboratory Information Management System (LIMS)	National digital platform used to manage all pathology test requests, processing, tracking, and reporting across Wales.

Term	Description
Radiology Informatics System Procurement (RISP)	National NHS Wales programme to replace and modernise all radiology IT systems across Wales. It was procured by Digital Health and Care Wales (DHCW) on behalf of all Health Boards and Trusts, with a contract award published in November 2023
Shadow IT	Shadow IT refers to any software, hardware, or technology service used within an organisation without the knowledge, approval, or oversight of the IT department
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each Health Board creating its own version.
HEIW's Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development
Digital Inclusion Charter	The Digital Inclusion Charter for Wales is a national set of commitments that organisations sign up to in order to actively support and promote digital inclusion across Wales.
Electronic Prescribing and medicines administration (ePMA)	A system in its hospitals, designed to improve patient safety through better documentation, streamlined workflows, and more efficient access to medication records as part of NHS Wales' Digital Medicines Programme
OpenEyes	Electronic patient record (EPR) system designed specifically for ophthalmology services.
My Medical Record	System allows patients access to results quickly, as well as access to records and clinic appointments
Six Goals Programme	A national NHS Wales transformation framework for urgent and emergency care, structured around six goals covering admission avoidance (Goal 1), front-door assessment and flow (Goals 2–4), and effective discharge and recovery (Goals 5–6)

Term	Description
Planned Care Programme	The NHS Wales programme focused on reducing long waits, improving outpatient and theatre efficiency, and ensuring timely treatment—especially for cancer and the longest-waiting patients—through pathway optimisation, day-case expansion, and improved scheduling

About us

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

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

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



Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.

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

Management response form

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should update its Digital assurance report to Finance and Performance committee to include detail on financial reporting, including project level budgets, current and forecast expenditure and any variances (Paragraph 17) .	From the June 2026 meeting onwards, the Digital assurance report to the Finance & Performance Committee will include project-level financial reporting for both local and national digital programmes, including agreed budgets, current and forecast expenditure, and any material variances.	10 June 2026	Director of Digital
R2	The Health Board should clarify whether the Digital Data and Technology directorate governance structure proposal will proceed (Paragraph 20) .	The Health Board has agreed to proceed with the proposed Digital, Data & Technology governance structure. The final component of the structure is the Digital, Data & Technology Group, which will be chaired by Medical Director to ensure strong clinical leadership.	31 May 2026	Director of Digital

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		The revised terms of reference will be presented to the Executive Committee for approval in April 2026, with meetings scheduled for the next 12 months following approval.		
R3	The Health Board should develop a clear standalone cyber security risk, including defined controls and assurance arrangements, to ensure that threats are properly understood and resources are directed to the right mitigations (Paragraph 23).	The Health Board will develop a standalone cyber security risk, setting out key threats, controls and assurance arrangements. This will be added to the Corporate Risk Register, and will reported through established risk management processes to ensure appropriate oversight and prioritisation of mitigations	31 May 2026	Director of Digital Supported by: Head of Corporate Risk and Assurance
R4	The Health Board should ensure its digital strategy fully addresses cyber security risks	One of our goals within our strategic mission is to strengthen our cyber security resilience which will be delivered via a clear Infrastructure plan and a	30 June 2026	Director of Digital

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	and the arrangements to address them (Paragraph 30) .	roadmap for infrastructure replacements and upgrades.		
R5	The Health Board should implement a coordinated programme to assess and build workforce digital capability, which should;	A core mission of our refreshed digital plan is “Building the Organisational Capability for Digital Transformation.” Delivery of this mission will be coordinated with Workforce and Organisational Development colleagues to ensure a structured and consistent approach to assessing and developing digital capability.	31 March 2028	Director of Digital
	5.1 - assess/review digital capability across staff groups (Paragraph 36) ;	Our Chief X Information Officer will lead the assessment of digital capability across staff groups, using the HEIW Digital Capability Framework.	31 March 2028	Director of Digital

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		Initial assessments have been completed within Pharmacy, with a phased programme of assessments across the wider workforce to be completed by March 2028.		
	5.2 - identify and implement actions to improve digital capability. In doing so, ensure that the approach aligns with Workforce and Organisational Development training plans (Paragraphs 36 and 39) .	Based on the outcomes of digital capability assessments, the Health Board will identify and implement targeted actions to address gaps. This will include the development of digital communities of practice and tailored training plans, aligned to Workforce and Organisational Development provision and the Health Board's People Plan.	31 March 2028	Director of Digital
R6	The Health Board should strengthen its approach to digital inclusion by;	The Health Board's Digital Transformation Plan includes a principle that digital inclusion is non-negotiable. This principle will be embedded	N/A	Director of Digital

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		through leadership, planning and assurance arrangements set out in the actions below.		
	6.1- assigning a strategic lead for digital inclusion (Paragraph 43);	Following approval of the Digital Transformation Plan, a strategic lead for digital inclusion will be formally assigned to provide organisational oversight and accountability.	31 July 2026	Director of Digital
	6.2 - producing a measurable digital inclusion plan with clear targets (Paragraph 43); and	Following the appointment of a digital inclusion lead, a measurable digital inclusion plan with defined targets will be developed	31 March 2027	Director of Digital
	6.3 - assessing digital inclusion risks on new patient/public facing systems. Systems/care pathways should then be designed to enable accessibility and alternative access contact routes (Paragraph 43).	Digital inclusion principles will be applied to all new patient and public-facing digital developments. Digital governance arrangements will include explicit assessment of digital inclusion risks alongside existing assurance processes for	31 July 2026	Director of Digital

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		cyber security, information governance and patient safety		
R7	The Health Board should ensure formal oversight of regional working is in place, which includes regular reporting on regional digital initiatives, assessment of risks and benefits and alignment of regional strategies with the Health Boards own digital plans (Paragraph 49) .	Formal governance arrangements for regional digital initiatives are being developed with Directors of Digital across Southeast Wales and the Regional Collaborative. These arrangements will be presented to the Regional Executive Management Group in May 2026. Once agreed, regular reporting on regional digital initiatives, including risks, benefits and alignment with the Health Board's digital plans, will be provided through existing programme reporting to the Finance & Performance Committee and the Board.	30 June 2026	Director of Digital

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 April 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit, Risk and Assurance Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance.

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To support effective governance and oversight, the Audit, Risk and Assurance Committee requires a clear overview of its business, including completed items, changes, and forthcoming matters.

Cefndir / Background

Across the 2026/27 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 February 2026 and April 2026, there have been no amendments made to the committees forward work programme.

Argymhelliad / Recommendation

The Committee is asked to:

- **Note** the status of Committee business, including completed business, amendments/changes, and forthcoming business.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

Gwybodaeth Ychwanegol:

Further Information:

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

Effaith: (rhaid cwblhau)

Impact: (must be completed)

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

ANNUAL PROGRAMME OF BUSINESS 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
Preliminary Matters								
Attendance and Apologies	SI	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2025/26	An	Chair & DofCG						√
Review of Committee Programme of Business	SI	Chair	√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	An	Chair & DofCG	√					
Committee Annual Report 204/25	An	Chair & DofCG	√					
Corporate Governance, Risk & Assurance								
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	An	DofCG					√	
Receive full report of all offers of gifts and hospitality as declared	An	DofCG					√	
Compliance with Ministerial Directions 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	√		√	√	√	
Financial Governance and Control								
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	√		√	√	√	
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	An	DofCG						√
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	An	DofCG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	An	DofCG		√	√			
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	An	DofF&P		√	√			
Audit Enquiries to those charged with Governance and Management	An	DofF&P		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	An	AW			√			
Final Annual Accounts Memorandum	An	AW					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	An	HofIA			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	An	Chair			√			
Counter-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy (Feb 2028)	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			√	√		√
Post Payment Verification								
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					√	
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	An	HofIA	√					
Receive Internal Audit Progress Report	SI	HofIA	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	SI	HofIA	√	√	√	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	An	HofIA with Chair	√					
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	An	AW		√	√			
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						
Additional Papers/Actions								

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
Receive Deep Dive into all live digital audit recommendations	Ad hoc	DoCG		√				
Receive Deep Dive into Discharge Planning audit recommendations	Ad hoc	DoCG		√				
To Receive a targeted review of all pre 2023 audit recommendations	Ad hoc	DoCG		√				
Total Items Scheduled (excluding preliminary items) -to be updated prior to each meeting			13	16	17	14	16	8
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	BI	Chair	√			√		
Internal Audit Team	BI	Chair		√			√	
Local Counter Fraud Team	BI	Chair			√			√

Lead Officer Key	
DofCG	Director of Corporate Governance
DofF&P	Director of Finance and Procurement
HofCF	Head of Counter Fraud
PPV	Post Payment Verification
HofIA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

Schedule of Meetings Key	
√	Scheduled agenda item in FWP
√R	Received at the Scheduled meeting
D	Deferred from this agenda
√ D	Deferred Scheduled agenda item Received
W	Withdrawn from FWP

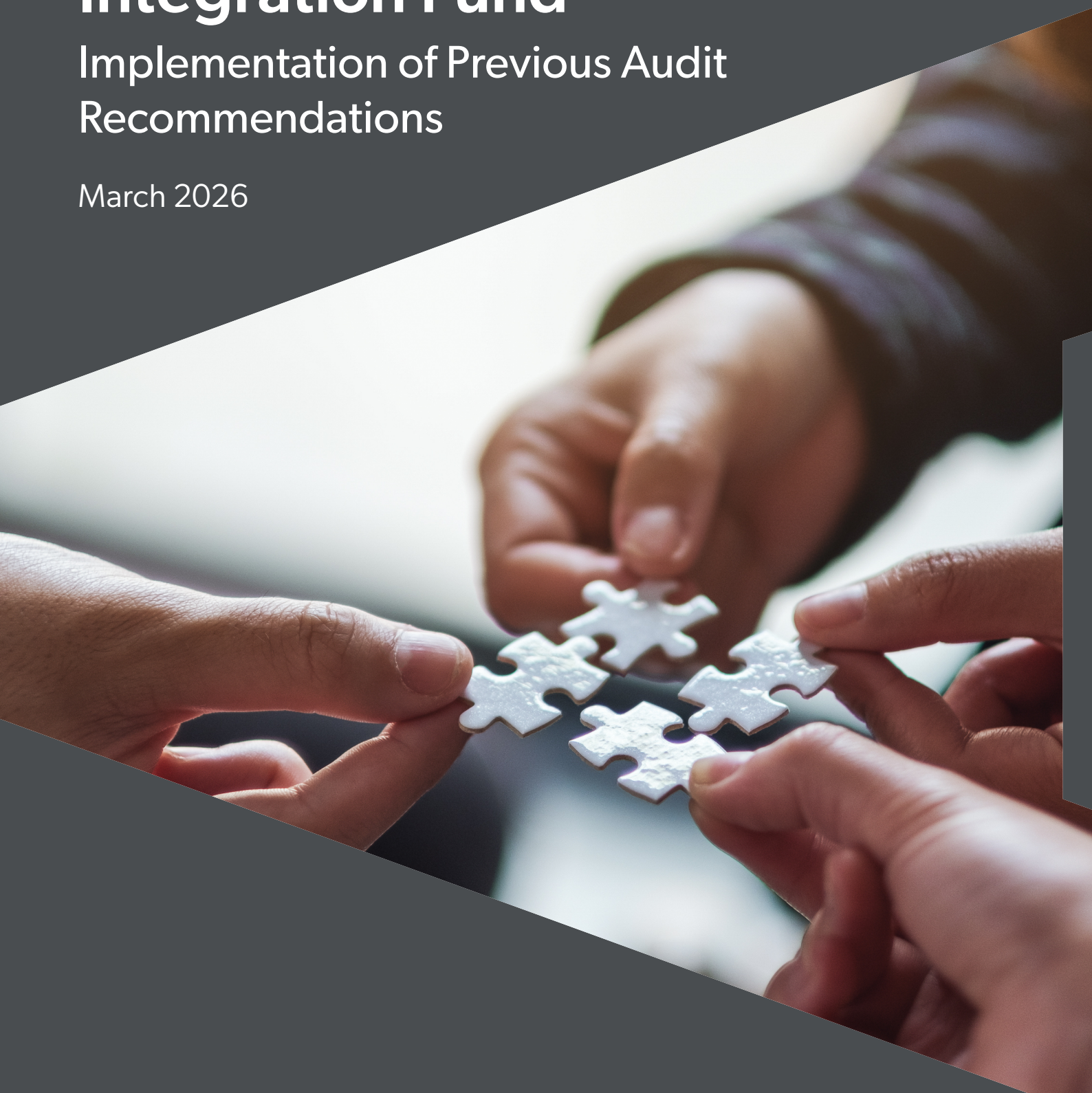
T	Transferred to another Committee
IC	Matter discussed In Committee

DRAFT

Managing the Regional Integration Fund

Implementation of Previous Audit
Recommendations

March 2026



We have prepared and published this report for presentation to the Senedd under section 145A of the Government of Wales Act (1998).

© Auditor General for Wales 2026

You may re-use this publication (not including logos) free of charge in any format or medium. If you re-use it, your re-use must be accurate and must not be in a misleading context. The material must be acknowledged as Auditor General for Wales copyright and you must give the title of this publication. Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned before re-use.

If you need any help with this document

If you would like more information, or you need any of our publications in an alternative format or language, please:

- call us on 029 2032 0500
- email us at info@audit.wales

You can use English or Welsh when you get in touch with us – we will respond to you in the language you use.

Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

Contents

Audit snapshot	4
Auditor General's view	6
Key facts and figures	7
Our findings	8
Recommendations	37

Appendices

1 About our work	40
2 Financial information	42
3 Key terms in this report	48



Audit snapshot

What we looked at

- 1 In 2019, we published a [Review of the Integrated Care Fund](#). The Welsh Government set up the Integrated Care Fund (ICF) in 2014 to enable regional partnerships to better integrate health, social care, and housing.
- 2 The review described the ICF's positive impact on improving integration and partnership working. However, it also identified weaknesses in the way the annual fund was managed. It made six recommendations for the Welsh Government which it [accepted in full](#).
- 3 In April 2022, the Welsh Government replaced the ICF along with its Transformation Fund with the Health and Social Care Regional Integration Fund (RIF). The capital elements were replaced with a new Housing with Care Fund.
- 4 This report examines the extent to which the Welsh Government has implemented our recommendations through the rollout of the RIF, and to a lesser extent through the Housing with Care Fund.

Why this is important

- 5 The RIF is a key part of the Welsh Government's approach to achieving its long-term vision of integrated health and social care, set out in its 2018 strategy, [A Healthier Wales](#). Through the RIF and Housing with Care Fund, along with the Integration and Rebalancing Capital Fund it aims to embed a preventative approach to population health and wellbeing, and delivery of seamless health and care support.
- 6 The RIF is the Welsh Government's main funding to support early intervention, integration, and partnership working through Regional Partnership Boards (RPBs). It is a five-year fund running from April 2022 to March 2027, with an annual budget of around £146 million.

What we have found

- 7 The Welsh Government's Regional Integration Fund is supporting regional working and developing seamless models of care. Now in its fourth year, the fund has had a positive impact on many people's lives. In 2024-25, it supported over 180,000 people to prevent their health and care needs escalating.
- 8 The Welsh Government has fully implemented five of our six previous recommendations and partly completed the remaining one. It has improved the timeliness of its decision-making and monitoring information, strengthened its oversight and supported RPBs to share learning. However, we found some minor gaps in the Welsh Government's oversight of RPB spending of the RIF. We also found that some shared learning networks are more effective than others.
- 9 Despite the Welsh Government's efforts to simplify RPB funding arrangements, those arrangements are still complex and could be better integrated. There are also concerns about longer-term funding to replace the RIF programme in 2027, particularly as RIF funding is being used to fund some services which are now embedded in the health and social care system.
- 10 We identified weaknesses in oversight by statutory organisations of RPB activities and how RIF funding is being used. Health boards and local authorities are responsible for ensuring appropriate oversight takes place. The Welsh Government could also do more to assure itself that those bodies comply with its guidance on oversight.

What we recommend

- 11 We are reissuing two of our previous recommendations, updated to reflect the current delivery context. These focus on further simplifying and aligning RPB funding streams and ensuring appropriate scrutiny of RPB decisions in the regional statutory organisations.
- 12 We are also making two new recommendations to improve the quality of the Welsh Government's oversight of RPB spending.

Auditor General's view



I am encouraged to see that the Welsh Government has taken the findings of my 2019 report on the ICF seriously and acted on my recommendations. The report has clearly driven improvements to the management of public money by the Welsh Government and RPBs.

The Welsh Government is increasingly allocating funds through RPBs, so it needs to continue working with partnership bodies to ensure they are overseeing spending that money wisely. The findings and further recommendations that I have set out in this follow up report will hopefully help shape that important work going forward.

Adrian Crompton

Auditor General for Wales



Key facts and figures



The Welsh Government has fully addressed **5 recommendations** from our 2019 review, and partly addressed the remaining one.



The RIF aims to create sustainable service change through **6 national integrated models of care.**



The Welsh Government has committed around **£146 million** annually for five years through the RIF.



From 2022-23 to 2024-25, RPBs have spent **£436.6 million** of RIF funding.



Partner organisations provided an additional **£174.2 million** of match funding over the first three years of the fund.



From 2022-23 to 2024-25, RPBs have spent **£125 million** of Housing with Care funding.



In 2024-25, **747,953** people used RIF funded projects*.



That support prevented levels of need escalating for **181,922** people.

Note * People may be counted more than once if they used more than one project.

Our findings

Allocating RIF funding

The Welsh Government has clearly designed the RIF to support longer-term planning and minimise late decision-making

- 13 In 2019, our report on the ICF found that changing Welsh Government expectations and issues with the timeliness of funding allocation processes hampered regional delivery. **Exhibit 1** shows that the Welsh Government has fully implemented our recommendation to improve the timeliness of guidance and decision-making.

Exhibit 1: the Welsh Government's implementation of recommendation 1 from our 2019 report

Recommendation 1

We recommended that the Welsh Government should:

- consider the impact of issuing guidance earlier on the timeliness of project funding decisions (**complete**); and
- consider whether any further improvements in the funding allocation process can be made (**complete**).

Source: Audit Wales

Development of the RIF

- 14 The Welsh Government has clearly learnt from our review and national evaluations of the [ICF](#) and [Transformation Fund](#) to develop its RIF programme. A key example of that learning is the Welsh Government’s design of the RIF as a five-year programme to support longer-term planning and provide more certainty for RPBs.¹ The Welsh Government also expanded the Housing with Care Fund timespan to match the five-year term of the RIF.
- 15 Most RPB members we spoke to welcome the RIF’s five-year timespan. However, one RPB member responding to our survey described it as restrictive, while others felt five years was not long enough:



5-year plans can of course bring a sense of continuation and stability but they also risk locking us into spending that is too hard to review and change, bringing a sense of inertia and complacency.

RPB member survey
respondent



It’s a positive development that we had a five year cycle. We hope that will be extended in order to make medium term decisions rather than short termism.

RPB member survey
respondent



To create a mature partnership that can effectively develop and deliver long-term strategic plans that support fundamental transformation needs long term guaranteed funding.

RPB member survey
respondent

1 RPBs were set up in response to the [Social Services and Well-being \(Wales\) Act 2014](#) and bring together health boards, local authorities, the third sector and independent providers to meet the care and support needs of their area.

- 16 The Welsh Government designed the RIF as a learning programme to inform the development of its Integrated Community Care System, and it is clear to see the evolution from the ICF to the RIF and then emerging care system plans. It continues to learn from delivery of the RIF through the communities of practice, and a series of national evaluations throughout the programme.² The Welsh Government aims to use the evaluations to develop 'blueprints' setting out revised national models of care by year five of the RIF (2026-27).
- 17 Welsh Government's RIF team (the RIF team) worked with RPB members over an 18-month period to develop the RIF. Some of those members criticised the Welsh Government for not implementing all their suggestions. However, most RPB members we spoke to said that early Welsh Government engagement laid the foundations for positive working relationships to deliver the programme.
- 18 The Welsh Government continues to engage RPB members as the programme evolves, adapting its arrangements in response to feedback. For instance, it removed its reduction or 'tapering' of RIF funding over time in recognition that the statutory partners within the RPBs were struggling to 'mainstream' successful RIF funded projects due to financial pressures. The RIF team's early and sustained engagement is an example of good practice in involving stakeholders in the design and delivery of Welsh Government programmes.

The timeliness of decision-making

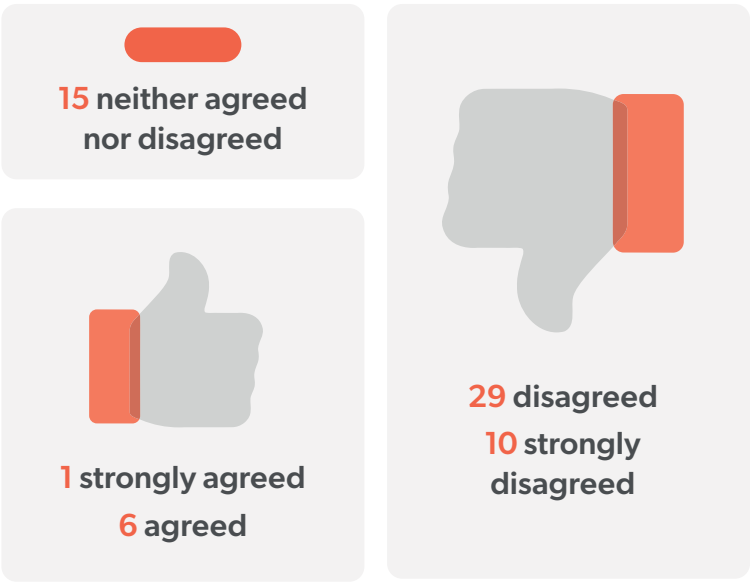
- 19 The Welsh Government published the final version of its RIF guidance in February 2022, shortly before the programme started in April. It asked RPBs to submit RIF investment proposals for 2022-23 by the end of March 2022. Despite the publication timeframe, the Welsh Government had engaged regularly with RPBs before the programme started and agreed which projects previously funded by ICF and met the RIF criteria could move over to the RIF. The Welsh Government also used 2021-22 as a transition year to allow RPBs to plan and make the necessary changes from the ICF to the RIF.

2 Communities of practice are networks of professionals designed to share learning and make links between relevant Welsh Government national programmes.

- 20 Although the Welsh Government did not publish its Housing with Care Fund guidance until May 2022, it worked with RPBs beforehand to support their planning. The RPBs had capital investment plans in place to manage forthcoming and ongoing ICF capital projects. The capital investment plan arrangements rolled forward with the introduction of the Housing with Care Fund to include new capital projects and existing ICF commitments. **Exhibits 21 and 22 in Appendix 2** set out Housing with Care Fund spending over time.
- 21 To date, the Welsh Government has looked to simplify arrangements for RPBs by avoiding making changes to its RIF guidance. Rather than revising the guidance, it wrote to RPBs about tapering changes in January 2024. Officials told us they are waiting for the outcome of our review to incorporate potential changes before updating the guidance.
- 22 Some RPB members responding to our survey felt that the Welsh Government did not issue its guidance early enough to support effective planning. Given the steps the Welsh Government took to develop and embed its RIF guidance (see **paragraph 19**), survey respondents may have been referring to Welsh Government guidance for funds allocated to the RPBs other than the RIF. Many RPB members described difficulties responding to the Welsh Government's requirements for other funds, in particular where it provided those funds at short notice (see **paragraph 39**).
- 23 The Welsh Government provides a clear five-year funding commitment through the RIF. It also sets out annual allocations each December in its NHS budget letters to health boards, which should leave RPBs in no doubt about their funding allocations. The Welsh Government also issues annual RIF funding allocation letters for the next financial year to RPBs as a formality between January and March. It agrees in-year transfers between projects in routine meetings with RPB finance leads.
- 24 Despite those longer-term arrangements, many RPB members perceive the Welsh Government's funding decisions as late. The majority (39) of RPB members responding to our survey either disagreed or strongly disagreed that the Welsh Government made funding decisions early enough to support effective regional planning (**Exhibit 2**).³

3 63 RPB Members completed our survey.

Exhibit 2: number of respondents to our survey who agree or disagree with the statement ‘the Welsh Government makes funding decisions early enough to support effective regional planning’



Source: Audit Wales Survey of RPB Members, 2025

25 Some RPB members described slow decision making from their regional partners rather than the Welsh Government. Several members of different RPBs told us that regardless of the Welsh Government’s five-year timeframe, RPB planning follows an annual cycle. Despite being a formality, some members said that their RPB did not want to confirm funding for projects until receiving the Welsh Government’s allocation letter.

The Welsh Government supports RPBs to use RIF funding flexibly to meet local need, but RPB funding is becoming increasingly complex

- 26 In 2019, we reported that RPBs were finding it difficult to align local population needs with the Welsh Government's indicative allocations for priority population groups within the ICF. At the time, RPB funding arrangements were complicated with multiple short-term Welsh Government funding streams focusing on the same priority population groups. Those funds often had different criteria which made it difficult for RPBs to combine them to address local need. **Exhibit 3** shows that the Welsh Government has fully implemented our recommendation to simplify RPB funding streams.

Exhibit 3: the Welsh Government's implementation of recommendation 2 from our 2019 report

Recommendation 2

We recommended that the Welsh Government review all short-term funding streams available to health, social care, and housing partners to ensure that funding streams:

- minimise duplication (**complete**);
- are complementary and that the collective allocations for specific groups of people align with local population needs as well as Welsh Government priority areas (**complete**); and
- can be combined to address local need (**complete**).

Source: Audit Wales

- 27 The Welsh Government has worked hard to simplify and align funding streams within the RIF. Nonetheless, funding arrangements are still over-complicated and some RPB members are confused about whether the Welsh Government still sets indicative allocations for priority population groups.
- 28 The Welsh Government developed the RIF programme to align to local population need and relevant policy areas. Its RIF guidance makes it clear that RPBs must demonstrate that RIF funded initiatives meet the needs of five target priority population groups through six national models of care (**Exhibit 4**).

Exhibit 4: RIF priority groups and models of care

Priority groups

- Older people including people with dementia
- Children and young people with complex needs
- People with emotional and mental health well-being needs
- Unpaid carers
- People with learning disabilities and neurodevelopmental conditions

Models of care



Community based care: **Prevention** and **community coordination**



Community based care: Complex care **closer to home**



Promoting good **emotional health** and **well-being**



Supporting families to **stay together safely**, and therapeutic support for **care experienced children**



Home from hospital

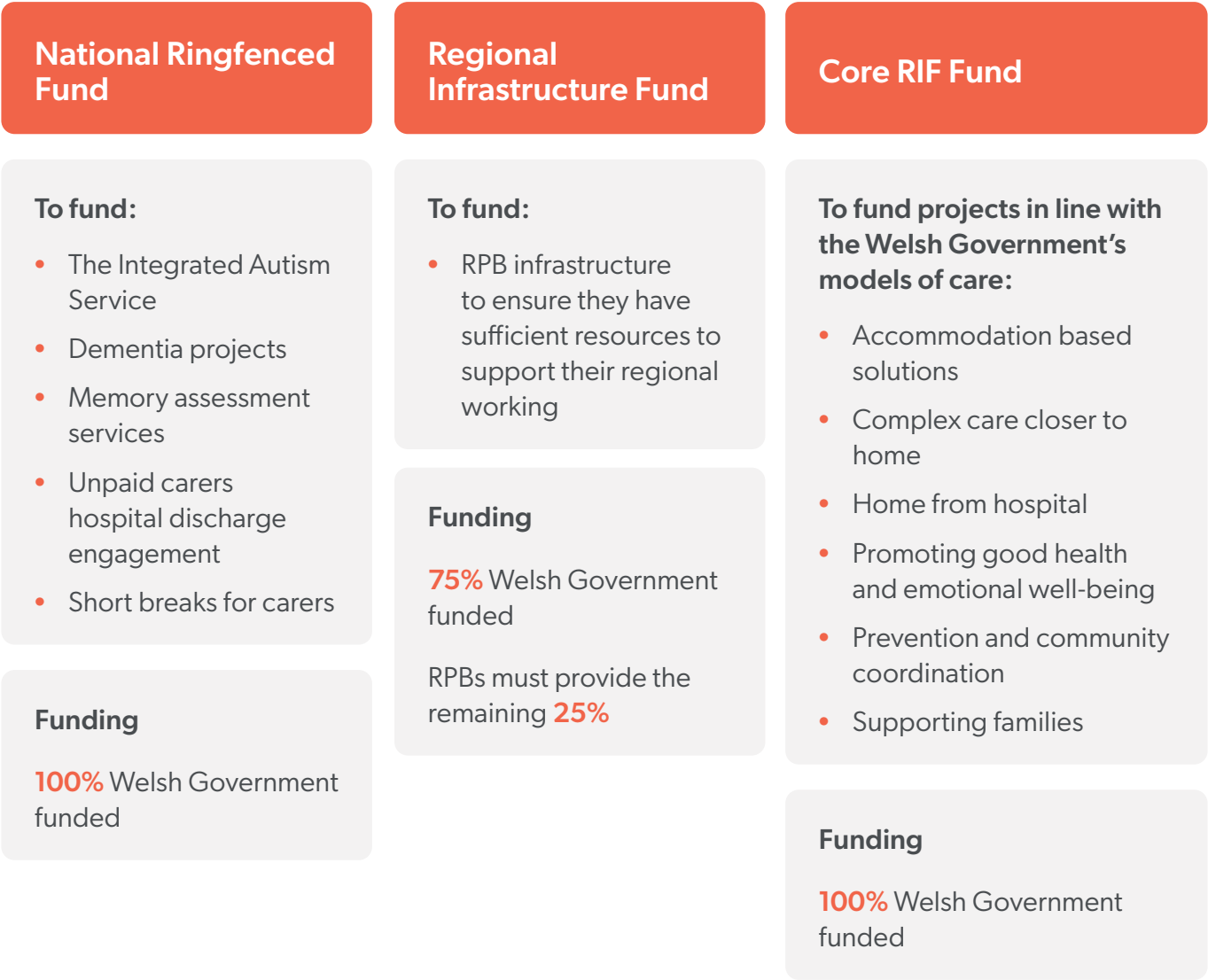


Accommodation based solutions

Source: Audit Wales analysis of Welsh Government information

29 The Welsh Government does not set indicative allocations for the priority population groups for the main RIF fund but sets aside specific ring-fenced funds within the RIF for key groups or services. RPBs can transfer funds from one priority population group to another in agreement with Welsh Government officials. The RIF also includes a ring-fenced annual £750,000 regional infrastructure fund for running costs (**Exhibit 5**).

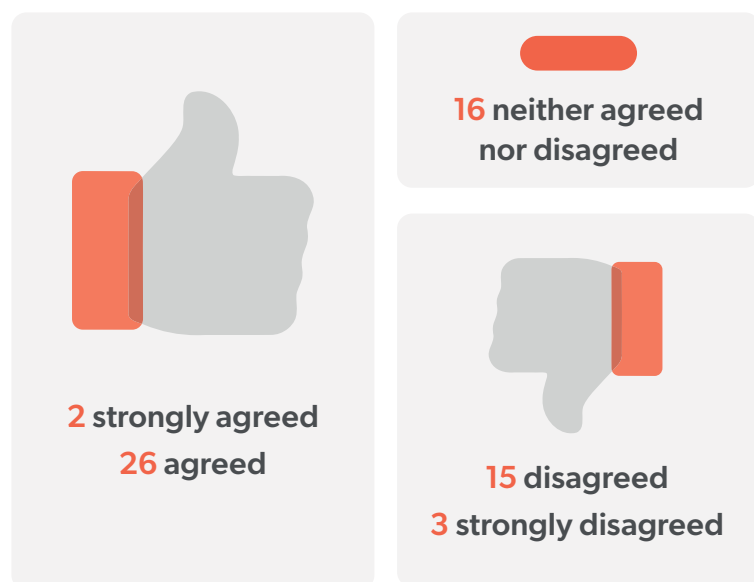
Exhibit 5: the structure of the RIF



Source: Audit Wales analysis of Welsh Government information

30 Just under half of the RPB members (28) responded positively to our survey question on the RIF's alignment to local need. However, over a quarter of respondents felt more negatively about that alignment, and a quarter gave a neutral response (**Exhibit 6**).

Exhibit 6: number of respondents to our survey who agree or disagree with the statement 'the RIF priority areas set by the Welsh Government are clearly aligned to local need'



Source: Audit Wales Survey of RPB Members, 2025

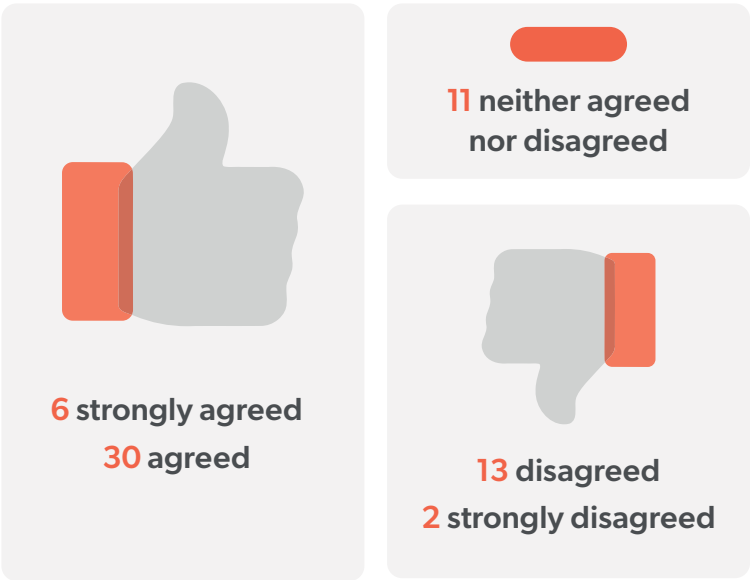
- 31 Some of the RPB members we spoke to misunderstand the Welsh Government's focus on priority population groups and asked for more flexibility to respond to local need. Some regional partners were already funding initiatives for some population groups with non-RIF funding. They mistakenly thought they are unable to move RIF funding for one population group to meet the needs of other groups.
- 32 Some of the misunderstanding about priority population allocation may stem from misinterpretation of information in Welsh Government allocation letters. For example, the 2022-23 letters set out its expectation that for the core RIF fund:
 - at least 5% would be used to support unpaid carers (in addition to the ringfenced fund);
 - at least 20% would be spent on delivery through partners delivering wider economic, social, or environmental benefits; and
 - at least £20 million would be spent across Wales in services to support children who are care experienced or at the edge of care.

Integration of relevant funding streams

- 33 The Welsh Government designed its RIF to better integrate processes for existing funding streams into a single system. It consolidated several individual funding streams, providing ring-fenced allocations within the RIF (see **Exhibit 5**). It designed the RIF, Housing with Care Fund and Integration and Rebalancing Capital Fund as complementary programmes to support its longer-term vision for an Integrated Community Care System.
- 34 Between 2021-22 and 2026-27, RPBs will have had access to £1.45 billion Welsh Government funding spanning nine programme areas (see **Exhibit 17, Appendix 2**). Most of these funds started at the same time as the RIF or predated it. The Welsh Government introduced other short term funding streams after the RIF including Allied Health Professional, Further Faster, and 50-day Challenge funding.
- 35 The year one national evaluation of the RIF described the ‘fast-changing policy context’ as a challenge to integrating the RIF with other relevant funding programmes. The Welsh Government’s RIF team recognised this challenge from the start and has taken steps to address it.
- 36 The RIF team hold regular meetings with policy leads for relevant programmes to improve integration and develop plans for the Integrated Community Care System.⁴ These officials also sit on the RIF Assurance Board where we saw positive examples of information sharing.
- 37 As the RIF programme has evolved, the Welsh Government has better integrated reporting of key funding streams. For instance, the RIF annual report for 2023-24 was a joint progress report or ‘position statement’ for its Housing with Care Fund, Integration and Rebalancing Care Fund and RIF funds. The position statement also describes progress towards creating the Integrated Community Care System.
- 38 Just over half of the RPB members (36) responding to our survey were positive about the flexibility of the RIF funding criteria (**Exhibit 7**) and 27 found it easy to combine the RIF with other funding streams (**Exhibit 8**). However, RPB members and the Welsh Government’s RIF team recognise that since the start of the RIF, funding allocated to RPBs has become increasingly complex.

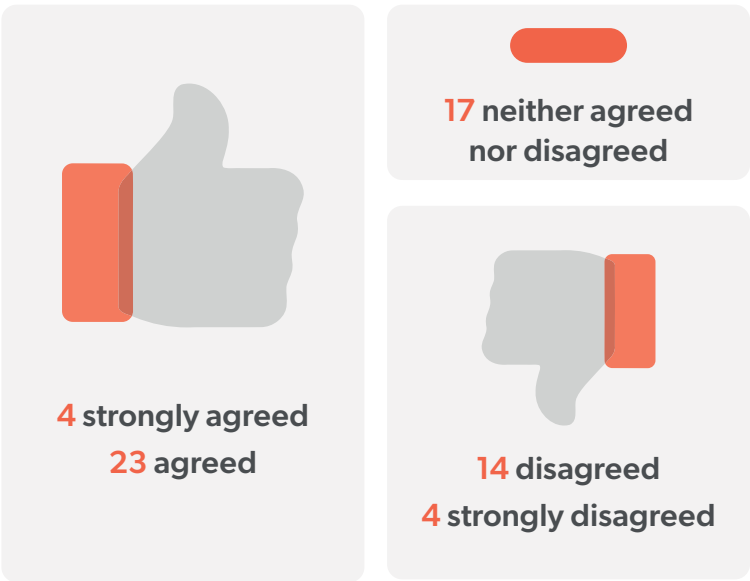
4 Including the Housing with Care Fund, the Six Goals Programme, and the Strategic Programme for Primary Care

Exhibit 7: number of respondents to our survey who agree or disagree with the statement ‘the RIF funding criteria is flexible enough to support local decision-making’



Source: Audit Wales Survey of RPB Members, 2025

Exhibit 8: number of respondents to our survey who agree or disagree with the statement ‘the Welsh Government has made it easy to combine the RIF with other funding streams’



Source: Audit Wales Survey of RPB Members, 2025

- 39 RPB members we spoke to were concerned about the complexity and sometimes short timeframes associated with new funding streams such as the 50-day Challenge and Further Faster funds. They told us that responding to the requirements of some initiatives (particularly the 50-day Challenge) puts pressure on RPB staff and members and diverts resources from other aspects of delivery.
- 40 The Welsh Government's 2024-25 RIF funding allocation letters list details of some other funds to provide an overview of funding to RPBs.⁵ However, the Welsh Government still sends separate letters for those programmes in addition to its RIF letters. Also, the RIF letters do not list all relevant RPB funds. The number of funding letters may be contributing to RPB's perception that funding arrangements are overly complex.
- 41 The RIF, Housing with Care Fund and Integration and Rebalancing Capital Fund all end in 2027, presenting an opportunity to reflect on future arrangements. The Welsh Government has already started this reflection and has set up a cross sector working group to explore ways of aligning investment and delivery in relevant areas. Moving forward, it wants to better integrate funding streams through its Integrated Community Care System, recognising that future investment decisions depend on political priorities after the May 2026 Senedd election.

5 The letters list allocations of Further Faster, Allied Health Professionals and Integration and Rebalancing Capital funds.

The Welsh Government is identifying and sharing good practice, but some RPB members are unclear about aspects of the approach

- 42 Our 2019 report found little evidence that ICF funded projects had been ‘mainstreamed’ as part of core service delivery within partner organisations. We recommended that the Welsh Government increases its support for shared learning across RPBs with a particular focus on approaches to managing the fund and overcoming challenges to mainstreaming. **Exhibit 9** shows that the Welsh Government has fully implemented our recommendation on supporting shared learning.

Exhibit 9: the Welsh Government’s implementation of recommendation 6 from our 2019 report

Recommendation 6

We recommended that the Welsh Government increases its support for shared learning across the RPBs with a particular focus on:

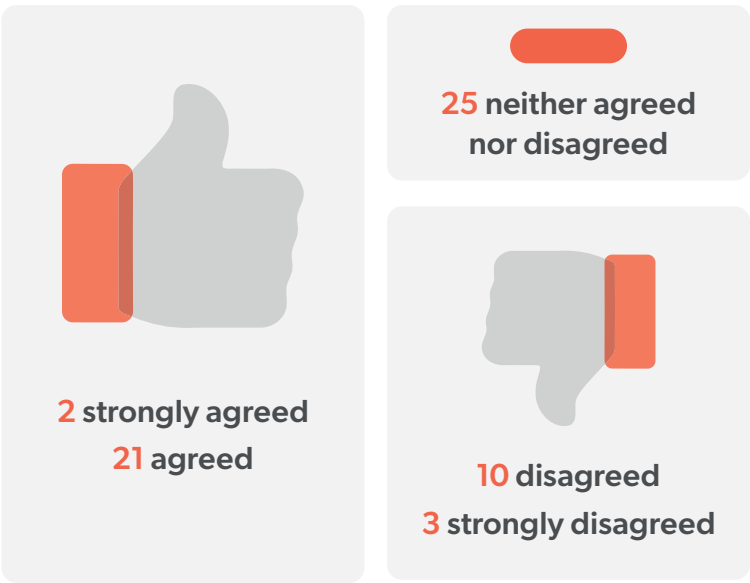
- approaches to managing the fund, in the context of the variation highlighted in this report (**complete**); and
- overcoming challenges to mainstreaming successful projects (**complete**).

Source: Audit Wales

- 43 The Welsh Government provides formal and informal opportunities to share learning. Its formal arrangements include:
- capturing and sharing learning during its routine monitoring arrangements (see **paragraph 59**);
 - highlighting good practice in its annual progress reports;
 - conferences for RPBs to share learning; and
 - ‘communities of practice’ to share learning on the national models of care to inform RIF projects and the development of the Integrated Community Care System. The communities, introduced in 2022, are networks of RPB members, Welsh Government officials and other stakeholders.

- 44 Welsh Government officials also share learning informally through the network of RPB leads. We found several examples where Welsh Government officials recognised strengths in one region and worked with that region to share examples amongst RPB leads.
- 45 Despite the positive examples we identified, RPB member responses to our survey were not clear about whether the opportunities provided by Welsh Government were supporting shared learning (**Exhibit 10**). One RPB member commented that the Welsh Government’s support for shared learning was a recent development. Another described limited time to learn from others.

Exhibit 10: number of respondents to our survey who agree or disagree with the statement ‘the Welsh Government provides opportunities for shared learning about other RIF funded projects’



Source: Audit Wales Survey of RPB Members, 2025

- 46 RPB members we spoke to explained that learning is shared regularly between regions, but that process is not always led by the Welsh Government. RPB leads have made their own arrangements to share learning through weekly meetings, which the Welsh Government has encouraged as a form of pro-active peer to peer sharing of good practice. In general, RPB members praised the RIF team's positive engagement and responsiveness.
- 47 The Welsh Government has established six communities of practice to support shared learning. These are sharing learning, policy developments and facilitating engagement with stakeholders in relevant sectors. Welsh Government officials acknowledged that some communities of practice are more effective than others in sharing good practice.
- 48 Some RPB members we spoke to were confused about the purpose of the communities of practice. Some RPB leads told us they had stopped attending meetings because they were time-consuming and unhelpful. The year three national evaluation of the RIF found that target membership is unclear and raised questions about the breadth of representation. It also recognised that the objectives of the communities of practice are not always clear to stakeholders. The Welsh Government is currently exploring ways to improve the effectiveness of the communities of practice, learning from those that are working well.

The RIF has supported partnership working and service improvement but there are concerns over long term funding arrangements

- 49 RPB members responding to our survey clearly value the RIF programme and responded positively to our survey questions about its contribution to regional partnership working and providing sustainable and improved services. Respondents also made comments about the impact of the RIF:



The RIF has become instrumental in the development of new ways of working, many of which are embedded in the way services are now delivered.

RPB member survey
respondent



Many councils and the NHS would strongly evidence that the fund has enabled a consistent added value to residents.

RPB member survey
respondent

- 50 However, due to broader financial challenges many RPBs also described a lack of progress mainstreaming successful projects. Several RPB members called for clarity about how the Welsh Government will replace RIF funding after 2026-27, saying it is currently being used to fund services which are now considered part of core provision.



Mainstreaming was introduced but doesn't appear to have happened in practice as individual organisations face significant financial challenge.

RPB member survey
respondent



RIF needs to be continued and consolidated as it is used to fund core services that have become essential elements of the health and care system. In the current financial climate, reducing or ceasing funding will result in the curtailing of services.

RPB member survey
respondent

- 51 There are considerable challenges associated with mainstreaming projects into core budgets. Nonetheless, partner organisations within RPBs have contributed their own funding to support the Welsh Government’s RIF allocations using a combination of cash and other resources.⁶
- 52 RPB partners provided an additional £174.2 million of match funding over the first three years of the RIF. **Exhibit 11** shows that the proportion of funding provided by partner organisations varies considerably by region.⁷ In particular, partner organisations within the North Wales Regional Partnership Board provided considerably higher levels of their own funding in 2022-23 and 2023-24 than other regions.

Exhibit 11: RPB RIF funding provided by partner organisations from 2022-23 to 2024-25, in £ millions and as a percentage of overall RPB income (shown in brackets)

RPB	2022-23	2023-24	2024-25
Cardiff and Vale	*	*	6.2 (24%)
Cwm Taf Morgannwg	6.1 (21%)	5.6 (20%)	5.0 (18%)
Gwent	7.3 (21%)	7.0 (20%)	5.5 (17%)
North Wales	23.5 (42%)	27.7 (46%)	55.0 (63%)
Powys	2.0 (24%)	0.4 (6%)	1.6 (19%)
West Glamorgan	*	*	6.2 (25%)
West Wales	2.5 (12%)	3.9 (17%)	8.7 (32%)

Source: Audit Wales analysis of Welsh Government information

Note: *Cardiff and Vale and West Glamorgan Regional Partnership Boards did not provide information on funding provided by their partners organisations in 2022-23 and 2023-24.

- 53 RPBs are also experiencing financial pressures associated with delivering RIF funded projects, particularly rising staff costs. The Welsh Government removed the tapering element of the RIF in recognition of mainstreaming challenges (see **paragraph 18**). It has not increased RIF funding to match inflation.

6 Such as staff, or premises not funded by the RIF.

7 Welsh Government officials told us that some of this variation could relate to differences in how RPBs capture match funding information. Officials are working with the RPBs to improve the quality and consistency of their data.

54 The Welsh Government’s overall RIF allocation has increased slightly from £144.7 million in 2022-23 to over £146 million in 2023-24 and 2024-25. However, in real terms the Welsh Government’s funding fell by 8% over the three years.⁸ **Exhibits 18 to 20 in Appendix 2** provide more analysis of RIF spending by type and RPB.

Welsh Government oversight

The Welsh Government has continued to work with RPBs to improve the quality and consistency of RIF monitoring information

55 In 2019, our ICF report described weaknesses in the Welsh Government’s arrangements to assess the overall impact of its programme. It explained that RPBs were using different tools and processes to measure performance and found it difficult to measure project outcomes. **Exhibit 12** shows that the Welsh Government has fully implemented our recommendation to improve project monitoring.

Exhibit 12: the Welsh Government’s implementation of recommendation 5 from our 2019 report

Recommendation 5

We recommended that the Welsh Government work with RPBs to:

- agree key outcome measures which are expected to be achieved, and monitored, for the different target groups in receipt of the fund. Where possible, these measures should align to wider outcome measures set out in national outcome frameworks already in place (**complete**);
- make clear how it is using the information gathered by RPBs (**complete**); and
- streamline the reporting requirements for revenue and capital projects, where practical to do so (**complete**).

Source: Audit Wales

8 Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money, June 2025.

Measuring outcomes and impact

- 56 The Welsh Government developed a RIF outcomes framework clearly setting out the outcomes and principles it wants to achieve for the wider health and social care system.⁹ The Welsh Government provided separate guidance to support RPBs to use the framework. The framework is a positive step towards measuring the fund's impact, focussing on both person-centred and system outcomes (**Exhibit 13**). The Welsh Government continues to refine the approach as the programme progresses including developing ways to measure social return on investment.

9 The Welsh Government published the framework on page 42 of its [RIF guidance](#).

Exhibit 13: key intended outcomes in the Welsh Government’s outcomes framework



Source: Audit Wales analysis of Welsh Government information

- 57 The Welsh Government has different arrangements to measure the impact of its Housing with Care Fund. RPBs set out intended outputs and outcomes for individual projects in their respective 10-year capital investment plans. The Welsh Government's Health and Housing Team monitors delivery against the plans every six months.

RIF monitoring arrangements

- 58 The Welsh Government has worked hard to develop monitoring arrangements that provide robust information for effective oversight of its investment. It also provides £750,000 annually to each RPB to support their management of the RIF including reporting arrangements (see **paragraph 29**).
- 59 The Welsh Government has developed a clear monitoring schedule for RPBs based on:
- quarterly finance returns setting out forecast and actual spend, and delivery of projects to date, setting out risks to project delivery at quarters two and four; and
 - six monthly impact reports demonstrating progress using the RIF outcomes framework, risks, and project learning.
- 60 The RIF team has good arrangements to scrutinise RPB finance and impact reports and discuss in quarterly meetings with the RPB leads. Officials consider RPB plans to manage project over or underspends and have clear arrangements to agree transferring funding between projects.
- 61 Officials told us that they initially planned to include routine 'spot-checks' on individual spending lines in the finance reports to check that funding allocated through RPBs is being spent appropriately. At the time of our review, the Welsh Government had not developed arrangements for those checks which are intended to be undertaken by its internal audit function.
- 62 For the Housing with Care Fund, the Welsh Government's Health and Housing Team discusses performance with RPBs in monthly meetings with RPB leads. Discussions focus on project delivery, finance, and risk, which feed into six-monthly progress reviews with the Welsh Government.
- 63 The Welsh Government worked with RPBs to develop monitoring tools in preparation for the introduction of the RIF and has continued to work with them to refine and develop new tools throughout the programme. We also found examples of the Welsh Government sharing good monitoring processes at one RPB to improve approaches elsewhere.

- 64 The RIF team has formally reported a risk associated with poor quality RPB monitoring information on the risk log it shares with its RIF Assurance Board. To mitigate the risk, the Welsh Government provides training for RPB leads, reporting templates and support through routine monitoring meetings. It also has a formal escalation process for late submissions. Those actions have reduced the residual score on the risk log, and the Welsh Government reviews the risk every six months.
- 65 We found the Welsh Government's monitoring requirements clear and proportionate. However, the majority of RPB members responding to our survey did not find it easy to provide the type of monitoring information the Welsh Government requests. Several RPB leads told us monitoring arrangements are an administrative burden, often requiring staff training. Some were using parallel monitoring processes where the Welsh Government's requirements differ from those of the RPB partner organisations. Some RPB leads were frustrated that the Welsh Government asked for information it already has, from previous RIF monitoring information or from other programmes.



The reporting requirements via the RIF templates are significant, and the timescales are not always realistic, especially when gathering information from organisations who are being commissioned by the RPB.

**RPB member survey
respondent**



Requests for data that Welsh Government already has access to is frustrating – especially as different agencies have different systems and we do not share data in a way that would support strategic planning and integration.

**RPB member survey
respondent**

- 66 Many of the RPB leads said that the Welsh Government's financial reporting template is difficult to use. Welsh Government officials recognised that there are opportunities to improve the template which they are working with RPBs to address.

- 67 Despite their concerns about responding to the Welsh Government's monitoring requirements, most RPB leads described significant improvements in monitoring requirements in 2024-25. One person explained that reporting requirements had reduced from about 500 pages in year one of the RIF to about 200. Welsh Government officials told us they had been confident to move to more 'light touch' monitoring from 2023-24 onwards because the strength of RPB performance information had improved considerably.
- 68 RPB members we spoke to had varying views on the level of feedback they get from the Welsh Government on their monitoring submissions. Some praised the clear and regular feedback whilst others felt that they would submit information to the Welsh Government but not receive any feedback from officials. Welsh Government officials told us that they provide robust feedback through the quarterly meetings with RPBs and in an annual 'score card' report. Not all RPB members are included in these meetings, so there is a possibility that not all members are sighted of feedback.

RIF reporting arrangements

- 69 The Welsh Government publishes annual reports on progress delivering the RIF on its website. The first report (2022-23) set out funding allocations, the number of projects and a description of outputs and outcomes for key projects for each region.
- 70 By its second year (2023-24), the Welsh Government's reporting of the RIF was more sophisticated, publishing some performance measures from the outcomes framework (see **paragraph 56**). The report set out information clearly and simply with output measures of 'how much we did' and outcomes measures of 'the difference we made for people'. The Welsh Government continued to use this approach for its third-year report (2024-25) (**Exhibit 14**).

Exhibit 14: outputs and outcomes from the Welsh Government’s RIF annual report 2024-25

Outputs



747,953 individuals have accessed RIF projects in 2024-25



249,455 were accessing the projects for the first time



1,620,654 contacts were made (count multiple contacts per individual)

Outcomes



213,091 individuals felt less isolated



231,547 individuals were maintaining or improving their emotional health and well-being



175,953 individuals felt they were able to influence decision-making that impacted them



161,797 individuals feel more confident in accessing services following project support



207,931 individuals whose independence has improved or remained the same after the support of a project



181,922 individuals have received support that has prevented their level of needs from escalating

Source: Audit Wales analysis of information in the Welsh Governments annual report 2024-25

The Welsh Government's RIF Assurance Board provides good scrutiny, including challenge from outside the RIF team

- 71 In 2019, our ICF report found that the Welsh Government needed to strengthen central oversight of the fund. It also described the impact of limited Welsh Government staff capacity to support regular and timely oversight. **Exhibit 15** shows that the Welsh Government has fully implemented our recommendation to strengthen its project board arrangements.

Exhibit 15: the Welsh Government's implementation of recommendation 3 from our 2019 report

Recommendation 3

We recommended that the Welsh Government further strengthen its governance arrangements for the fund by reviewing the membership of its project board to include representation from outside of the departments directly involved in the fund to provide some independent challenge (**complete**).

Source: Audit Wales

- 72 The Welsh Government has addressed our recommendation by incorporating independent challenge into its RIF Assurance Board. The Board has broad membership including Welsh Government officials representing health, social care, and housing, and from the Bevan Commission.
- 73 The Board's terms of reference are clear, and the RIF team effectively supports Board oversight with clear and regular information on relevant areas. The Board also holds helpful 'deep dive' sessions focused on specific topics supported by relevant information from the RIF team. For instance, in February 2025 it held a deep dive on progress towards developing the Integrated Community Care System.
- 74 We identified some minor areas for improvement in the information that the RIF team shares for Board oversight. The team provides verbal summaries of financial and impact reports but could provide more clarity in its finance reports on spending variance against year-end forecasts. It could also analyse the information submitted by RPBs in their quarterly finance returns to understand overall progress in 'mainstreaming' RIF funded projects.

- 75 There was a gap of 10 months in the frequency of Board meetings due to staff vacancies. Meetings resumed in August 2024 when the new Head of RIF started work. We saw good scrutiny of performance and financial information from Board members outside the RIF team. We also saw examples of the Board acting as a forum for officials to share information and ideas across different parts of the Welsh Government.
- 76 In June 2025, the Welsh Government set up internal audit arrangements to provide assurance to the RIF Board Chair and Director General of Health and Social Services on the effectiveness of processes to oversee the RIF. The Welsh Government's internal audit team share quarterly observations to the Welsh Government's Health, Social Care and Early Years Group Audit and Risk Committee, and more formally, in an annual report.¹⁰
- 77 The Welsh Government's Housing with Care Fund Board oversees delivery of its Housing with Care programme. The Board is supposed to meet quarterly but at the time of our review, had not met for a year due to staff vacancies. During this time, the Housing with Care Fund panel continued to meet to approve funding applications but did not provide overall programme oversight. The programme lead also met regularly with the Deputy Director of Homes and Places to manage the gap in oversight. The Board resumed meetings from October 2025.

There are still weaknesses in health board and local authority oversight of RPB activity and use of the RIF, and the Welsh Government's understanding of that oversight

The status of RPBs

- 78 Our 2019 ICF report found that there was little scrutiny of RPB activity by health boards and local authorities. There was also a general lack of awareness across these organisations about how the fund was being used. We recommended that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies. **Exhibit 16** shows that the Welsh Government has not gone far enough to implement our recommendation to improve RPB governance arrangements.

¹⁰ From July 2025 onwards, the Committee became the Health, Social Care and Early Years Assurance Board.

Exhibit 16: the Welsh Government's implementation of recommendation 4 from our 2019 report

Recommendation 4

We recommended that the Welsh Government works with NHS bodies and local authorities to ensure that appropriate scrutiny arrangements are in place for decisions made by the RPBs on behalf of those bodies (**partly complete**).

Source: Audit Wales

- 79 Health boards and local authorities established RPBs in response to the Partnership Arrangements (Wales) Regulations 2015.¹¹ RPBs are statutory governance bodies which limits their functions. In particular, they cannot employ staff or hold budgets.¹² They can only make recommendations but not decisions. Those decisions rest with the statutory partners and must be taken through each body's lawful decision-making procedures. Representatives of those partners sitting on RPBs may only take decisions within any delegated authority, and otherwise must seek Cabinet or Board approval.
- 80 In 2021, the Welsh Government consulted on its proposals to improve social care arrangements and strengthen partnership working in a White Paper on Rebalancing Care and Support. The paper set out its proposal to establish RPBs as legal entities. However, the Welsh Government chose not to change RPBs in this way in response to feedback from statutory partners including, local authorities, health boards and from RPB members. The Welsh Government revised its part 9 statutory guidance to clarify RPB membership and scrutiny arrangements (see **paragraph 83**).

11 Part 9 of the Social Services and Well-being (Wales) Act 2014 allowed Welsh Ministers to make regulations about partnership arrangements between health boards and local authorities.

12 RPB staff are employed by either health boards or local authorities depending on regional arrangements. RPBs can use the £750,000 annual RIF allocation for staff costs although some of those costs are met by partnership bodies.

Partner scrutiny

- 81 All funding allocated to RPBs is provided by Welsh Government funding streams. Health boards hold those funds on behalf of the RPBs.
- 82 The limitation of RPB functions (see **paragraph 79**) means it is essential that health boards and local authorities have robust oversight and governance arrangements. They must provide adequate scrutiny of RPB activity and the funds health boards hold on behalf of RPBs to ensure services and resources are used effectively and efficiently.
- 83 The Welsh Government's part 9 statutory guidance sets out its expectations that partnership bodies should be satisfied that RPBs have effective oversight and governance arrangements.¹³ In addition, its RIF guidance requires RPBs to 'put in place a memorandum of understanding that sets out the agreed governance, accountability and decision-making processes including appropriate arrangements to enable scrutiny of investment decisions by relevant sovereign bodies'. However, the Welsh Government has not checked whether RPBs have complied with its requirement.
- 84 All RPBs have some form of terms of reference setting out their purpose and responsibilities. However, only four of the seven RPBs had a memorandum of understanding. None of the documents were clear enough about how health boards and local authorities will scrutinise RPB activity, including which information they will receive and which forum it will go to.
- 85 Despite these apparent gaps, RPB members responding to our survey were generally confident that their organisation has appropriate scrutiny arrangements in place to oversee RPB decisions on their behalf. The majority (41 respondents) also agreed or strongly agreed that their organisation has the right information to understand the impact of RIF funded projects.
- 86 We used our focus groups with RPB members to understand those positive responses in the light of the governance weaknesses we had identified. On closer examination, many members were unclear about health board and local authority arrangements to scrutinise RPB activity. Some were able to cite individual examples of RPB documents being scrutinised at council or health boards meetings. However, none of the RPB members we spoke to were clear about which information goes to those bodies and which forums it goes to.

13 Under part 9 of the Social Services and Well-being (Wales) Act 2014, health boards and local authorities must have regard to the Welsh Government's part 9 statutory guidance. The Welsh Government published an updated version of the guidance in April 2025.

- 87 Some RPB members told us that there is considerable variation in scrutiny arrangements at local authorities in their region. They said the variation makes it even harder to understand the regularity and focus of scrutiny at those organisations.
- 88 Some RPB members we spoke to raised broader questions about RPB governance arrangements. They recognised that RPB members had responded to the Welsh Government's 2021 consultation to say they did not want to become legal entities. However, we heard examples where RPB chairs were uncomfortable making decisions on behalf of partnership bodies.

Welsh Government oversight of partnership scrutiny

- 89 Partner bodies are responsible for providing effective oversight and governance arrangements (see **paragraph 83**). The Welsh Government requires RPBs to set out those arrangements in their annual reports. Officials also discuss compliance with the part 9 requirements with RPBs in quarterly meetings. The Welsh Government also requires RPBs to complete self-assessments of their performance every two years from 1 April 2025.¹⁴ RPBs must also consider the effectiveness of their governance arrangements.
- 90 The Welsh Government ran a series of pilots with RPBs, Care Inspectorate Wales (CIW) and Healthcare Inspectorate Wales (HIW) from 2021 to 2024 to develop the self-assessment approach. For the pilot, all RPB members were invited to complete a self-assessment survey designed by the Welsh Government. The survey includes a specific question on whether RPB partner organisations have arrangements in place for organisations to be held to account for delivery of the RPB priorities. RPBs then took part in workshops to discuss the findings and develop improvement actions.
- 91 The Welsh Government asked RPBs to set out their actions to address issues from the pilot self-assessments in their 2024-25 annual reports. But it has not used the self-assessment results from the pilot or the improvement actions identified to understand the strengths and weaknesses of RPB arrangements. The Welsh Government recognises it could do more to oversee the effectiveness of RPB partner scrutiny including checking that memoranda of understanding are in place.

14 A requirement of the Welsh Government's amended Partnership Arrangements (Wales) Regulations in 2024.



Recommendations

92 We are re-issuing two of our previous recommendations, updated to reflect the current delivery context. We are also making three new recommendations.

Updated recommendations from our 2019 ICF review

R1 The Welsh Government should make further changes to simplify RPB funding arrangements and ensure they are aligned to local population needs. It should:

- 1.1** Work with RPBs to make sure they understand the flexibility of the RIF and their ability to transfer non-ring-fenced funds between projects where they clearly align to local need (**paragraphs 27 to 32**);
- 1.2** Work with RPBs to combine monitoring and reporting arrangements for different funds where possible (**paragraphs 33 to 41**); and
- 1.3** Build arrangements into its Integrated Community Care System to incorporate new funding streams that may emerge after it is established (**paragraphs 33 to 41**).

R2 The Welsh Government should work with health boards and local authorities to ensure they have appropriate scrutiny arrangements in place for delegated decisions made by the RPBs on behalf of those bodies. This should include ensuring RPBs have a memorandum of understanding in place (**paragraphs 81 to 91**).

New recommendations

R3 The Welsh Government should improve the finance reports it provides to the RIF Assurance Board to include information on:

- RPB spending variance against year-end forecasts; and
- RPB progress towards mainstreaming successful projects (**paragraph 74**).

R4 The Welsh Government should introduce spot-checks on RPB spending to ensure that RIF funding is spent appropriately (**paragraph 61**).



Appendices

- 1 About our work
- 2 Financial information
- 3 Key terms in this report

1 About our work

Scope of the audit

We have looked at how well the Welsh Government has addressed the recommendations in our 2019 review through the rollout of its RIF, and to a lesser extent the Housing with Care Fund. We have not reviewed the Welsh Government's management of the Integration and Rebalancing Care Fund.¹⁵ We did not set out to evaluate the impact of the RIF or consider wider points beyond our 2019 recommendations.

Audit questions and criteria

Questions

Our audit focused on four specific questions:

- Does the Welsh Government have a coherent strategic approach to providing integrated health, social care, and housing funding via the Regional Integration Fund?
- Does the Welsh Government have appropriate arrangements to oversee delivery of its Regional Integration Fund?
- Has the Welsh Government worked with NHS bodies and local authorities to ensure that there are appropriate scrutiny arrangements of decisions made by RPBs?
- Does the Welsh Government ensure the sharing of good practice across regions?

¹⁵ We reviewed aspects of the Fund as one of our five case studies to inform our May 2025 report on the [Wales Infrastructure Investment Strategy](#).

Criteria

In gathering evidence against the above questions, we were looking for the Welsh Government to demonstrate that it had made the expected progress in implementing our 2019 audit recommendations to address the issues and concerns identified in the original audit.

Methods

We undertook our field work during April and July 2025.

We used the following methods:

- Review of Welsh Government documents which shows the timeliness of decision making; guidance for the RIF and related funding streams; monitoring information on delivery of the RIF including progress reports on delivery outputs and outcomes; RIF project board papers; and information demonstrating how good practice is identified and shared.
- Review of some RPB documents including the terms of reference, memorandum of understanding and their scrutiny arrangements.
- High-level financial analysis of Welsh Government spending to date through the ICF, Transformation Fund and RIF.
- Interviews with Welsh Government officials responsible for managing and overseeing the RIF and similar funds associated with Welsh Government's national programmes on Planned Care, Urgent and Emergency Care and Primary Care.
- Focus groups involving all RPB leads and chairs in Wales.
- An online survey of all 196 RPB members which received a total of 63 responses. The survey was open for responses between the 2 May 2025 and 14 July 2025.
- An observation of a meeting of the Welsh Government's RIF Assurance Board which includes Welsh Government officials from various backgrounds to provide oversight of the RIF.

2 Financial information

Exhibit 17 shows all RPB funding streams available from 2021-22 to 2026-27. **Exhibits 18 to 20** set out RIF spending by type and from 2022-23 to 2024-25 by RPB. The Welsh Government publishes detailed analysis of RPB spending across population groups in its annual reports. **Exhibits 21 and 22** show Housing with Care Fund spending from 2022-23 to 2024-25 and by RPB.

Exhibit 17: RPB funding streams available during the period 2021-22 to 2026-27

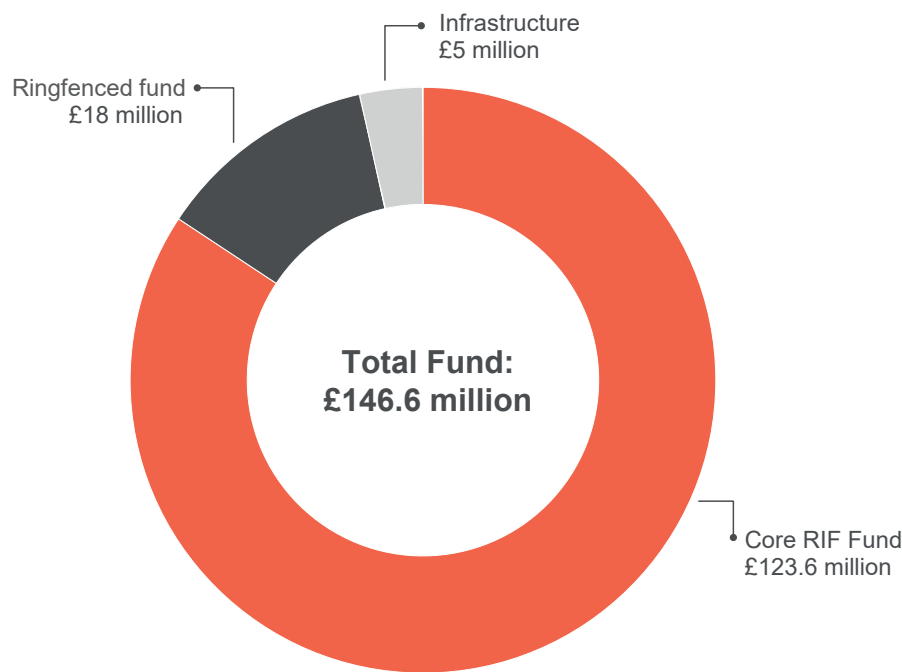
Funding programme	Value	Duration	Focus
Integration and Rebalancing Capital Fund	£320 million	2022-23 to 2026-27	Develop local community care hubs to co-locate frontline health and social care services
Integration and Rebalancing Capital Fund – revenue budget	£20 million	2022-23 to 2026-27	To resource RPBs for the strategic planning and coordination of the Integration and Rebalancing Capital Fund
Housing with Care Fund	£242 million	2022-23 to 2026-27	Provide supported housing and accommodation for vulnerable people with care and support needs
Regional Integration Fund (RIF)	£731 million	2022-23 to 2026-27	Create sustainable system change by developing six integrated models of care
Six Goals for Urgent and Emergency Care Programme	£100 million	2021-22 to 2025-26	Provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration
Strategic Programme for Primary Care	£7.6 million	2022-23 to 2023-24	Deliver national primary care priorities

Funding programme	Value	Duration	Focus
Allied Health Professionals Funding	£5 million	2023-24	Increase access to community-based care by increasing the number of NHS Allied Health Professionals and support workers
Further Faster Funding	£12 million	2023-24	Go ‘further, faster’ to strengthen community care capacity by developing an integrated community care system for Wales
50-day Challenge Funding	£19 million	2024-25	Help more people safely return from hospital and ease winter pressures on the health and social care system

Source: Audit Wales analysis of Welsh Government information

Note: The Six Goals Urgent and Emergency Care Programme is administered by NHS Wales Performance and Improvement. All other funds in the table are administered by the Welsh Government.

Exhibit 18: RIF spending by type, 2024-25



Source: Audit Wales analysis of Welsh Government information

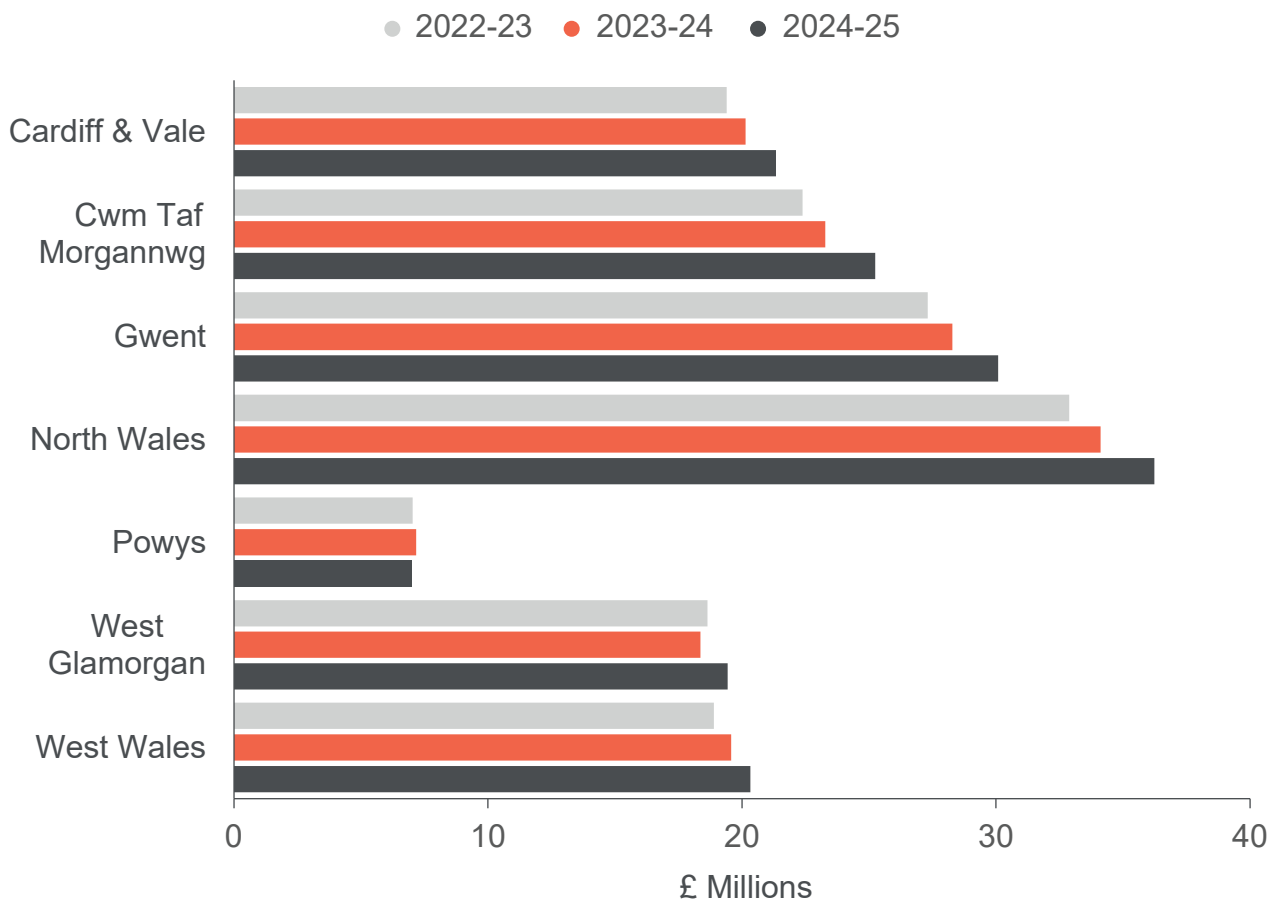
Note: Cwm Taf Morgannwg and Gwent RPBs did not spend their full allocation of £750,000 infrastructure funding in 2024-25.

Exhibit 19: core RIF spending by model of care, 2024-25

Model of care	£ millions
Home from hospital	35.6
Prevention and community coordination	30.8
Supporting families	22.7
Complex care closer to home	20.6
Promoting good health and emotional well-being	8.4
Accommodation based solutions	2.1
Project management costs	3.4

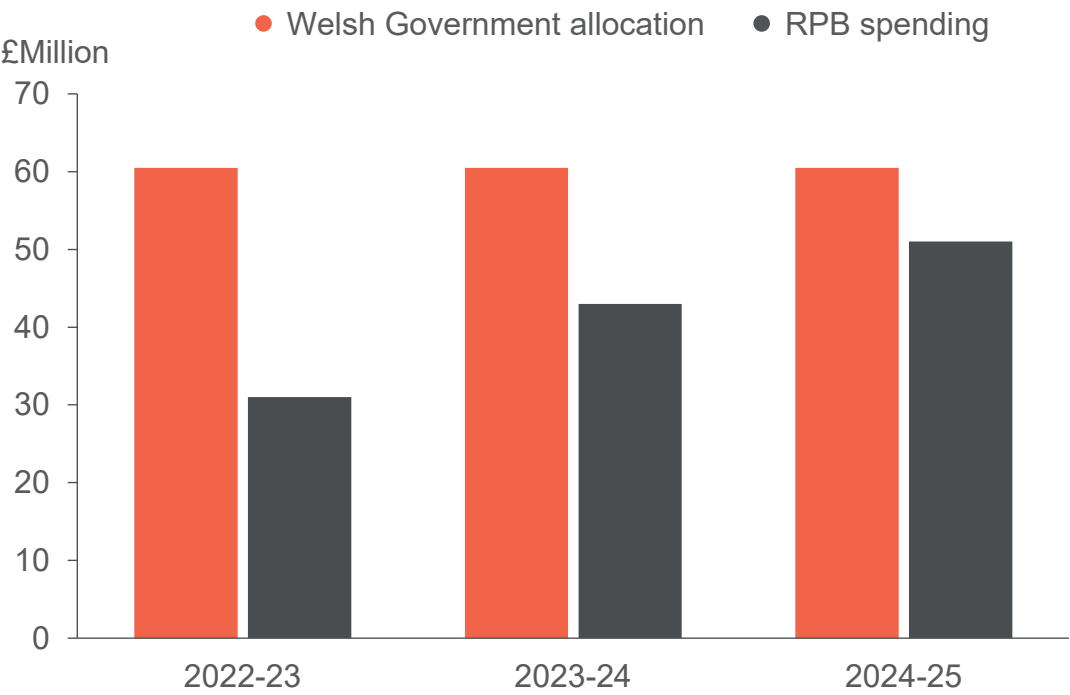
Source: Audit Wales analysis of Welsh Government information

Exhibit 20: total (core and non-core) RIF spending by RPB, 2022-23 to 2024-25



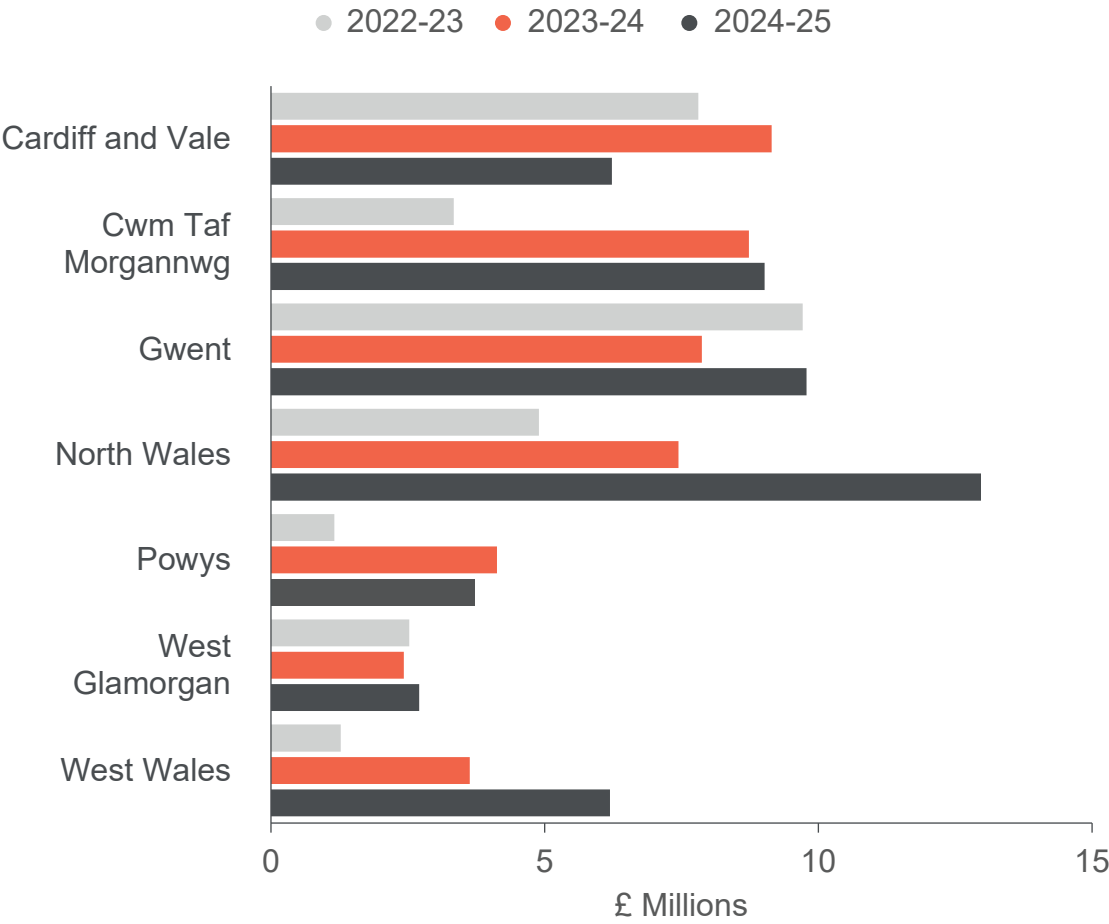
Source: Audit Wales analysis of Welsh Government information

Exhibit 21: Housing with Care Fund Welsh Government allocations and RPB spending, 2022-23 to 2024-25



Source: Audit Wales analysis of Welsh Government information

Exhibit 22: Housing with Care Fund spending by RPB, 2022-23 to 2024-25



Source: Audit Wales analysis of Welsh Government information

3 Key terms in this report

Term	Description
Allied Health Professionals funding	A Welsh Government fund for RPBs in 2023-24. The fund was aimed at increasing the number of community-based healthcare professionals and support workers.
Further Faster funding	A Welsh Government fund for RPBs in 2023-24. The fund was aimed at bringing together existing health and social care initiatives to start developing an integrated community care system.
Housing with Care Fund	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at providing supported housing accommodation for vulnerable people with care and support needs.
Integrated Community Care System	The Welsh Government’s vision for providing seamless health and social care at or as close to home as possible through six models of care.
Integrated Care Fund (ICF)	A Welsh Government fund for RPBs from 2014-15 to 2021-22. The fund was aimed at encouraging collaboration between social services, health, housing, and the third and independent sector to improve the lives of the most vulnerable people in Wales. The Welsh Government introduced the fund in 2014 as the Intermediate Care Fund and renamed it the Integrated Care Fund in 2017.
Integration and Rebalancing Capital Fund	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at developing local community hubs to co-locate frontline health and social care and other services.

Term	Description
Mainstreaming	Mainstreaming refers to the process of embedding successful, innovative, or pilot initiatives into standard practice across health and social care systems.
NHS Wales Performance and Improvement	The Welsh Government set up the NHS Wales Executive in April 2023. The Executive changed its name in 2025 to NHS Wales Performance and Improvement. It aims to drive improvements in the quality and safety of care.
Regional Integration Fund (RIF)	A Welsh Government fund for RPBs from 2022-23 to 2026-27. The fund is aimed at supporting integrated health and social care initiatives at a regional level.
Tapering	A method used in social care funding where financial support gradually reduces over time. It allows projects to support themselves financially gradually, avoiding sudden loss of support and encouraging financial independence.
Transformation Fund	A Welsh Government fund for RPBs from 2019-20 to 2021-22. The fund was aimed at improving health and social care services by scaling up models that are successful and replacing less successful or outdated ones.
Six Goals for Urgent and Emergency Care Programme	An NHS Wales Performance and Improvement fund from 2021-22 to 2025-26. The fund is aimed at providing healthcare as close to home as possible and to improve service access and integration.
Social Services and Well-being (Wales) Act 2014	The Act came into force in 2016 in Wales. It promotes voice, control, prevention, co-production, and collaboration, giving individuals and carers more say in the support they receive.
50-day Challenge funding	A non-recurrent Welsh Government fund for RPBs in winter 2024-25. The fund was aimed at helping people safely return from hospital to ease winter pressures on hospitals.
Strategic Programme for Primary Care	The Welsh Government set up the Strategic Primary Care Programme in 2018 to implement its vision for primary care. The programme is now led by NHS Wales Performance and Improvement and no longer has a dedicated funding stream.

About us

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

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

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



Audit Wales

1 Capital Quarter

Tyndall Street

Cardiff CF10 4BZ

Tel: 029 2032 0500

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.

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

Benefits Realisation

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

This audit forms part of the 2025/26 internal audit plan for Aneurin Bevan University Health Board (the 'Health Board') and focuses on the arrangements for benefits realisation within non-digital initiatives. Benefits realisation is a critical component of programme and project management, ensuring that planned improvements such as enhanced patient outcomes, service efficiency, and financial sustainability are achieved.

The Health Board undertakes a range of transformation and service redesign programmes aligned to its strategic objectives. Effective benefits realisation supports accountability and demonstrates value for money in the use of public resources.

The purpose of this audit is to provide assurance on the adequacy and effectiveness of processes for identifying, monitoring, and reporting benefits regardless of the route taken for approval.

Scope, Risks & Approach

Scope	To ensure appropriate processes are embedded for the management and achievement of anticipated benefits arising from change programmes within the Health Board, regardless of the approval route taken. Objectives of the area under review: 1. Appropriate governance arrangements exist to co-ordinate and oversee the identification/monitoring of benefits at non-digital programmes and projects; 2. For all change/ investment programmes, regardless of the route taken for approval, anticipated benefits are clearly defined, measurable, and linked to organisational objectives at the planning stage of initiatives; and 3. Processes are in place to track, validate, and report all realised benefits against planned outcomes, including escalation of variances.
Associated risks	• Roles and responsibilities in relation to benefits realisation have not been clearly defined. • Benefits for programmes and projects are not clearly articulated or linked to strategic objectives. • Monitoring of benefits is inconsistent and reporting arrangements are inadequate.
Limitations to scope	This audit will not cover digital projects and initiatives.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:

	Quality Domains	Quality Enablers
	Effective Efficient	Leadership Information Learning, Research and Improvement Whole Systems Approach

Contacts & Timings

Client contacts	Rob Holcombe Hannah Evans	Director of Finance, Procurement & Value Director of Strategy, Planning & Partnerships
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	February 2026 March 2026 TBD
Brief agreement	Executive Director of Finance & Procurement 12 th February 2026	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

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

Overseas Recruitment

Final Internal Audit Brief

Aneurin Bevan University Health Board



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



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

Aneurin Bevan University Health Board (the 'Health Board') employs overseas staff who are required to maintain valid and current visa documentation as a condition of employment in the United Kingdom. Immigration rules, sponsorship obligations and Home Office requirements are subject to frequent change. Failure to comply can result in financial penalties, reputational damage and restrictions on the Health Board's ability to sponsor future staff. This audit will assess whether the Health Board has effective processes to monitor, update and act upon visa requirements within appropriate timeframes.

Scope, Risks & Approach

Scope	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.	
Associated risks	Failure to comply with Home Office visa and sponsorship requirements, leading to fines, sanctions, or loss of sponsorship	
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings	
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:	
	Quality Domains	Quality Enablers
	Safe Person Centred Efficient	Workforce Culture

Contacts & Timings

Client contacts	Sarah Simmonds Shelly Williams Sian Bigmore	Director of Workforce & OD Deputy Director of Workforce & OD Head of Recruitment
Audit & Assurance contacts	Stephen Chaney Eifion Jones Rhian Gard	Head of Internal Audit Deputy Head of Internal Audit Audit Manager
Indicative timings	Fieldwork Debrief meeting Audit Committee	February 2026 March 2026 April 2026
Brief agreement	Sarah Simmonds, Director of Workforce & OD 05.02.2026	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

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

Professional Staff Registration

Final Internal Audit Brief

Aneurin Bevan University Health Board



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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

The purpose of this audit is to provide assurance on the adequacy and effectiveness of the processes in place at Aneurin Bevan Health Board for verifying and maintaining professional staff registrations. Registration with the appropriate professional body is a fundamental requirement for many clinical and professional roles. Ensuring that staff hold valid, up-to-date registrations is essential for safeguarding patient safety, maintaining service quality, and complying with statutory and regulatory obligations.

Scope, Risks & Approach

Scope	To ensure appropriate arrangements are in place to demonstrate that medical staff requiring professional registration are appropriately registered throughout their employment. Objectives of the area under review: - To assess the adequacy and effectiveness of the control framework in place to ensure that professional staff hold valid and up-to-date registrations with the relevant regulatory bodies – including the responsibility of individuals and management. - To evaluate whether processes for monitoring, recording, and verifying registration status (including renewals and alerts for lapses) are consistently applied and accurately reflected within ESR and local management systems.	
Associated risks	- Staff do not hold the required/ relevant professional registration. - Registrations lapse or are terminated without the knowledge of the Health Board.	
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings	
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:	
	Quality Domains	Quality Enablers
	Safe Care	Governance
	Effective Care	Leadership
	Dignified Care	Workforce
	Timely Care	Information
	Individual Care	Engagement

Contacts & Timings

Client contacts	Jennifer Winslade Dr. Seema Srivastava Peter Carr	Executive Director of Nursing Medical Director Executive Director of Allied Health Professions (AHPs) & Health Science
Audit & Assurance contacts	Stephen Chaney Eifion Jones	Head of Internal Audit Deputy Head of Internal Audit
Indicative timings	Fieldwork Debrief meeting Audit Committee	April 2026 TBC TBC
Brief agreement	Executive Director of Nursing – 20 th February 2026 Medical Director – 19 th February 2026 Executive Director of AHPs & Health Science – 20 th February 2026	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

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

Cancer Referral Rates

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

Background

This audit will be completed in accordance with Aneurin Bevan University Health Board’s (the ‘Health Board’) 2025 / 2026 Internal Audit Plan. The audit will seek to determine if the controls in place monitor the referral of patients for cancer treatment in a timely and appropriate manner and identify any data anomalies, whilst adhering to NICE guidance.

Scope, Risks & Approach

Scope	The overall objective of the audit is to determine if the referral and application processes within the Health Board are consistent with the rest of NHS Wales. Objectives of the area under review are to evaluate the following aspects: - the Health Board follows the national suspected cancer pathway model used across NHS Wales for identifying and treating cancer cases; and - referral rates seen in the Health Board are in line with expectations considering determining factors e.g. population size, age profile, deprivation levels, environment category etc.	
Associated risks	- The Health Board’s cancer referral rates are higher than expected. - Patients needing cancer referral do not receive it and suffer harm as a result. - Over-referral of cases results in increased system pressure which negatively impacts timely cancer detection and treatment.	
Limitations to scope	We will not assess the clinical appropriateness of individual cancer referrals.	
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings	
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:	
	Quality Domains	Quality Enablers
	Safe Care Timely Care Effective Care Efficient Care Equitable Care Person-centred Care	Information Learning, Improvement and Research Whole Systems Approach

Contacts & Timings

Client contacts	Leanne Watkins Rebecca Goode Arvind Kumar Margaret Parrott Ian Williamson Mary Craig	Chief Operating Officer Head of Operational Transformation Interim Divisional Director Cancer Services Manager Consultant GP Cancer Lead
Audit & Assurance contacts	Stephen Chaney Eifion Jones	Head of Internal Audit Deputy Head of Internal Audit
Indicative timings	Fieldwork Debrief meeting Audit Committee	March/ April 2026 April 2026 TBD
Brief agreement	[Title] [Date]	



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

Disclaimer notice

This audit brief has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit, Risk and Assurance Committee.

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

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