

Audit, Risk and Assurance Committee (Final Accounts)

Tue 23 June 2026, 09:30 - 12:00

MS Teams

Agenda

09:30 - 09:30 1. PRELIMINARY MATTERS
0 min

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

1.3. Declarations of Interest

Chair

1.4. Draft Minutes of the last Meeting held on 19th May 2026

Chair

 ARAC 20260623 1.4 20260519 Minutes.pdf (13 pages)

1.5. Committee Action Log and Matters Arising

Chair

 ARAC 20260623 1.5 Action Log.pdf (3 pages)

1.5.1. To Receive clear numerical implementation dates against recommendations in the Capital Projects Report.

Head of Internal Audit

 ARAC 20260623 1.5.1 Capital Projects Service Readiness Report -.pdf (12 pages)

1.5.2. Management actions and implementation dates within the GUH Extension report be updated to enable effective tracking

Head of Internal Audit

09:30 - 09:30 2. Items for APPROVAL/RATIFICATION/DECISION
0 min

2.1. To Approve Reviewed and Updated Financial Control Procedures

Director of Finance and Procurement

 ARAC 20260623 2.1 Updated Financial Control Procedures .pdf (6 pages)

09:30 - 09:30 3. ITEMS FOR DISCUSSION
0 min

3.1. To Review the Health Board’s Annual Report (Overview & Performance Section) (Part 1)

Director of Corporate Governance

-  ARAC 20260623 3.1 Annual Report.pdf (8 pages)
-  ARAC 20260623 3.1 Annual Performance Report Appendix A.pdf (64 pages)

3.2. To Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)

Director of Corporate Governance

-  ARAC 20260623 3.2 Final Accountability Report.pdf (118 pages)

3.3. To Review Draft/Final Annual Accounts and Financial Statements (Part 3)

Director of Finance and Procurement

-  ARAC 20260623 3.3 Final Annual Accounts and Financial Statements.pdf (4 pages)
-  ARAC 20260623 3.3 Final Annual Accounts and Financial Statements - Appendix 1 - Adjustments Action during Audit Period.pdf (3 pages)
-  ARAC 20260623 3.3 Final Annual Accounts and Financial Statements - Appendix 2 - ABUHB Final 2025-26 Annual Accounts.pdf (80 pages)
-  ARAC 20260623 3.3 Final Annual Accounts and Financial Statements - Appendix 3 - ABUHB Letter of Representation 2025-26.pdf (3 pages)

3.4. Receive the Annual Head of Internal Audit Opinion (including Specialised)

Head of Internal Audit

-  ARAC 20260623 3.4 Annual Head of Internal Audit Opinion.pdf (29 pages)

3.5. To Review Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation

Audit Wales

-  ARAC 20260623 3.5 Review Audit Wales.pdf (33 pages)

3.6. Agree a recommendation to the Board in respect of the audited annual report and accounts

Chair

3.7. Annual Review of Risk Management Framework

Director of Corporate Governance

-  ARAC 20260623 3.7 Annual Review of Risk Management Framework.pdf (7 pages)
-  ARAC 20260623 3.7 Annual Review of Risk Management Framework - Appendix A_DRAFT Risk Management and Assurance Framework.pdf (17 pages)
-  ARAC 20260623 3.7 Annual Review of Risk Management Framework - Appendix B_DRAFT Risk Management Procedure.pdf (24 pages)
-  ARAC 20260623 3.7 Annual Review of Risk Management Framework - Appendix C_Risk Appetite Statement.pdf (8 pages)
-  ARAC 20260623 3.7 Annual Review of Risk Management Framework - Appendix D_DRAFT Strategic Risk Assessment Template.pdf (2 pages)

3.8. To Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26

Post Payment Verification Manager

-  ARAC 20260623 3.8 Post Payment Verification Annual Report.pdf (4 pages)
-  ARAC 20260623 3.8 Post Payment Verification Annual Report - Appendix 1 - Slide 1 - End of year PPV Report 2025-2026.pdf (1 pages)
-  ARAC 20260623 3.8 Post Payment Verification Annual Report -Appendix 1 - Slide 2 End of year PPV Report 2025-2026.pdf (3 pages)

3.9. To Receive the Clinical Audit Activity Annual Report 2024 – 2025 and Agree the Clinical Audit Plan 2026 - 2027

Medical Director

-  ARAC 20260623 3.9 Clinical Audit Activity Annual Report 2024 – 2025 and Clinical Audit Plan 2026 - 2027 .pdf (7 pages)
-  ARAC 20260623 3.9 Clinical Audit Activity Annual Report 2024 – 2025 and Clinical Audit Plan 2026 - 2027 - Appendix 1 - National Clinical Activity Report.pdf (129 pages)
-  ARAC 20260623 3.9 Clinical Audit Activity Annual Report 2024 – 2025 and Clinical Audit Plan 2026 - 2027 - Appendix 2 - National Clinical Audit Plan 2026.2027.pdf (16 pages)

3.10. To Receive Internal Audit Progress Report

Head Of Internal Audit

-  ARAC 20260623 3.10 Internal Audit Progress Report.pdf (8 pages)

3.11. To Receive Internal Audit Reports

Head of Internal Audit

-  ARAC 20260623 3.11 Overseas Recruitment.pdf (9 pages)
-  ARAC 20260623 3.11 Cancer Referral Rates.pdf (7 pages)

3.12. Receive External Audit Progress Report 2025-26

Audit Wales

-  ARAC 20260623 3.12 External Audit Progress Report.pdf (10 pages)

09:30 - 09:30 4. ITEMS FOR INFORMATION 0 min

4.1. Review of Committee Programme of Business 2026/27

Director of Corporate Governance

-  ARAC 20260623 4.1 Committee Programme of Business.pdf (3 pages)
-  ARAC 20260623 4.1 Committee Programme of Business Appendix A.pdf (7 pages)

4.2. Internal Audit Brief

Head of Internal Audit

-  ARAC 20260623 4.2 Charitable Funds Audit Brief.pdf (3 pages)
-  ARAC 20260623 4.2 Job Evaluation Final Audit Brief_.pdf (3 pages)

09:30 - 09:30 5. OTHER MATTERS 0 min

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

Chair

5.2. Any Other Urgent Business

Chair

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**BWRDD IECHYD PRIFYSGOLN ANEURIN
BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH
BOARD**

**MINUTES OF THE AUDIT, RISK AND ASSURANCE
COMMITTEE**

DATE OF MEETING	19 th May 2026 09.30-12.00
VENUE	Microsoft Teams

PRESENT	Iwan Jones, Chair
	Dafydd Vaughan, Vice Chair
	Neil Patrick, Independent Member
	Helen Cunningham, Independent Member
IN ATTENDANCE	Rani Dash, Director of Corporate Governance
	Rob Holcombe, Director of Finance and Procurement
	Robert Jones, Assistant Director of Finance
	Gareth Lavington, Head of Counter Fraud
	Paul Solloway, Director of Digital (Item 3.1)
	Murry Guard, Auditor, Internal Audit
	Naomi Murtagh, Board Business Manager
	Stephen Chaney, Head of Internal Audit
	Efion Jones, Deputy Head of Internal Audit
	Julie Rees, Finance Audit Manager, Audit Wales
	Bryony Codd, Head of Corporate Governance
APOLOGIES	Gareth Iewis, Head of Financial Services & Accounting
	Harry Morris, Committee Secreteriat
APOLOGIES	Helen Sweetland, Independent Member
	Lucy Windsor, Head of Corporate Risk and Assurance

Preliminary Matters





ARAC 0519/01	Welcome and Introductions Iwan Jones (IW), Chair, welcomed everyone to the Committee.
ARAC 0519/02	Apologies for Absence Iwan Jones (IW), Chair, NOTED the apologies received for this meeting.
ARAC 0519/03	Declarations of Interest Helen Cunningham (HC), Independent Member, declared an interest in relation to the Audit Wales General Medical Services (GMS) Contract Challenges report, noting her role as a Councillor and that one of the affected surgeries was within her ward. The Committee NOTED the declaration of interest.
ARAC 0519/04	Minutes of the previous meeting The minutes of the meeting held on the 28th April 2026 were agreed as a true and accurate record.
ARAC 0519/05	Committee Action Log The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due.
ITEMS FOR APPROVAL / RATIFICATION / DECISION	
	There were no items for discussion during this section.
ITEMS FOR DISCUSSION	
ARAC 0519/06	To Receive Deep Dive of Audit Recommendations Rani Dash (RD), Director of Corporate Governance, presented a deep dive into audit recommendations, covering digital, discharge planning and pre-2024/25 actions, in line with a previous request from the Committee. Discharge Planning Recommendations: RD reported that two recommendations from 2022/23 remained





outstanding. It was noted that subject matter leads were not present to provide detailed updates. Iwan Jones (IW), Chair, raised concerns regarding previous inconsistencies between external audit reporting and the audit tracker, particularly in relation to discharge planning actions. RD advised that the current tracker had been validated and reflected the most accurate position. SC confirmed that recent internal audit review had identified only minor discrepancies and overall accuracy could be relied upon.

Digital Audit Recommendations:

RD outlined the current position of digital audit recommendations, noting that a number of recommendations remained live. It was highlighted that some actions had not yet reached their implementation date, while others were overdue but progressing.

Paul Solloway (PS), Director of Digital, acknowledged that the delivery of some recommendations had been challenging due to resource constraints and dependencies on external organisations. PS confirmed that all recommendations remained achievable and were being actively progressed, with the position showing improvement compared to previous years.

Members noted that some delays were outside of organisational control. Dafydd Vaughan (DV), Independent Member, suggested that reporting could more clearly distinguish between internally controlled actions and those dependent on external factors. RD agreed to incorporate this into future reporting.

The Committee **NOTED** the improved position in relation to historic audit recommendations and the assurance provided regarding the accuracy of the tracker, whilst emphasising the need for continued focus on delivery and clearer presentation of dependencies.

ARAC 0519/07

To Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)





Rani Dash (RD), Director of Corporate Governance, presented the draft Annual Report (Overview & Performance), noting that it had been submitted to Welsh Government and Audit Wales as part of the annual reporting process. RD advised that the report remained in draft form and was presented to the Committee for comment ahead of finalisation and Board approval.

RD outlined that the purpose of the report was to demonstrate how the Health Board had delivered against its strategic priorities and objectives over the previous year. It was noted that further updates would be made following feedback from Welsh Government and Audit Wales, with no formal feedback received from Welsh Government at the time of the meeting.

Iwan Jones (IW), Chair, sought clarification on how the figures within the report were validated. RD advised that processes were in place to ensure consistency across different sections of the report, with data checked against source systems and aligned where appropriate with financial information.

The Committee also discussed the narrative within the report and members noted opportunities to strengthen how performance and achievements were presented, including ensuring a balanced reflection of both progress made and ongoing challenges. It was agreed that minor editorial comments and suggested improvements would be shared with officers outside of the meeting.

The Committee **NOTED** the draft Performance Report and the ongoing work to refine the document ahead of final submission.

ARAC 0519/08

To Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)

Rani Dash (RD), Director of Corporate Governance, presented the draft Accountability Report, including the Annual Governance Statement. RD advised that the report formed part of the





was confirmed that some targets, including cash management and payment of creditors, had been achieved, while others had not been met due to ongoing system pressures.

RH informed the Committee that a small number of minor, non-material amendments had been identified following submission of the accounts. These had been shared with Audit Wales and did not affect the overall financial position.

Julie Rees (JR), Audit Wales, provided an update on the audit of the accounts, confirming that work was progressing in line with the agreed timetable. JR advised that no significant issues had been identified to date and that the audit remained on track for completion.

Members sought assurance regarding the robustness of the accounts and alignment with supporting narrative within the Annual Report. RH confirmed that appropriate validation and reconciliation processes were in place to ensure consistency across all reporting documents.

The Committee **NOTED** the draft Annual Accounts and Financial Statements and the progress of the external audit.

ARAC 0519/10

To Review Audit Enquiries to those charged with Governance and Management

Rob Holcombe (RH), Director of Finance and Procurement, presented the Audit Enquiries to those charged with governance and management. RH advised that this was a standard annual requirement as part of the external audit process and supported Audit Wales in completing their review of the annual accounts.

RH confirmed that the responses reflected the Health Board's governance, risk management and internal control arrangements, and had been completed in line with expected requirements.

Members sought assurance that the responses were robust and accurately reflected the organisation's position. RH confirmed





	that appropriate internal processes and senior oversight were in place to ensure the accuracy and completeness of the submission. Julie Rees (JR), Audit Wales, noted the return and confirmed that it forms part of the overall audit evidence base. The Committee NOTED the Audit Enquiries.
ARAC 0519/11	To Receive Report of Losses and Special Payment Rob Holcombe (RH), Director of Finance and Procurement, presented the report on losses and special payments. RH advised that the report set out the year-end position, including bad debt write-offs and other financial losses in line with Welsh Government reporting requirements. RH highlighted that the majority of losses related to bad debt, reflecting the routine year-end process of reviewing and writing off unrecoverable balances. It was also noted that one abandoned capital scheme had been included within the report. Members discussed the arrangements in place for managing debt recovery. RH confirmed that there are established processes to pursue outstanding debts, including the use of external agencies where appropriate, and that provisions were made within the accounts to reflect the level of risk associated with non-recovery. The Committee NOTED the report on losses and special payments.
ARAC 0519/12	To Receive the Counter Fraud Annual Report and Agree the Counter Fraud Functional Standard Return Declaration Gareth Lavington (GL), Head of Counter Fraud, presented the Counter Fraud Annual Report and Functional Standard Declaration. GL advised that the report summarised counter fraud





activity for the year and confirmed compliance with the NHS Wales Counter Fraud Functional Standards.

GL reported that the Health Board had achieved a “green” rating against all standards, reflecting full compliance. It was noted that there had been an increased focus on proactive work during the year, resulting in a more balanced approach between preventative and reactive activity.

GL highlighted a reduction in overpayment referrals compared to previous years. This was attributed to improvements in payroll processes, alongside enhanced training, awareness and communication across the organisation.

Members discussed emerging fraud risks, including those relating to procurement and the increasing use of digital technologies. GL confirmed that these risks were being considered within ongoing counter fraud work and that national guidance was being utilised where appropriate.

The Committee **APPROVED** the Counter Fraud Functional Standard Declaration and **NOTED** the Counter Fraud Annual Report.

ARAC 0519/13

Strategic Risk and Assurance Report

Rani Dash (RD), Director of Corporate Governance, presented the Strategic Risk and Assurance Report. RD advised that the report provided an overview of the Health Board’s strategic risk profile and associated assurance arrangements.

RD confirmed that there had been no changes to the overall risk profile since the previous reporting period. It was noted that a number of strategic risks remained outside of the Health Board’s risk appetite, reflecting the scale and complexity of the organisation’s operating environment.

Members discussed the status of these risks and the progress of mitigating actions. RD advised that many of the risks were



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long-term in nature and required sustained action over time, with controls and mitigating measures continuing to be developed and strengthened.

The Committee emphasised the importance of ensuring that mitigating actions are sufficiently robust and that progress is clearly demonstrated over time, particularly where risks remain above appetite.

The Committee **NOTED** the Strategic Risk and Assurance Report.

ARAC 0519/14

**Internal Audit Progress Report Including the 2026/27
Internal Audit Plan**

Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report. SC advised that the majority of planned audit work for 2025–26 had been completed, with only a small number of reviews outstanding and these not expected to impact the overall annual audit opinion.

SC confirmed that the draft annual opinion remained at **reasonable assurance**, reflecting generally sound systems of governance, risk management and internal control across the organisation.

SC also presented the Internal Audit Plan for 2026–27, noting that it had been developed using a risk-based approach informed by organisational priorities and engagement with Executive leads. It was highlighted that the plan retained flexibility to respond to emerging risks during the year.

Members considered the progress reported and the proposed plan, noting assurance regarding the delivery of the current year's programme and the alignment of the future plan with key organisational risks.





	The Committee NOTED the Internal Audit Progress Report, the anticipated annual opinion, and the Internal Audit Plan for 2026–27.
ARAC 0519/15	Internal Audit Reports Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit reports, including the Space Utilisation Advisory Review and the Follow-Up of Agreed Actions Report. Space Utilisation Advisory Review SC outlined the findings of the advisory review, noting that the audit had identified low utilisation rates across a number of office spaces. While established estate management arrangements and utilisation studies were in place, the review highlighted opportunities to strengthen the use of data to support decision-making and improve strategic oversight of the estate. Members discussed the findings in detail, recognising the potential to improve efficiency and maximise value from existing estate resources. It was noted that better visibility and analysis of space usage could support more informed planning and alignment with wider organisational priorities. The Committee also considered the practical constraints impacting utilisation, including operational requirements, service needs and the potential financial implications of reconfiguring or reducing estate footprint. Members acknowledged that improvements in this area would require a balanced approach, linked to broader estates, workforce and financial planning. Given the cross-cutting nature of the findings, it was agreed that the report should be shared with other relevant Committees to support wider organisational discussion and oversight. Follow-Up of Agreed Actions SC presented the annual follow-up review of previously agreed audit actions. It was reported that arrangements for tracking and



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	managing audit recommendations were generally effective, with evidence supporting the closure of completed actions and improved overall accuracy of the audit tracker. The Committee Recognised that, while good progress had been made, some actions continued to be delayed, with implementation dates extended on multiple occasions. SC highlighted that there was an opportunity to strengthen scrutiny in these instances, including ensuring that extensions are supported by clear justification and that initial timescales are realistic. ACTION: Director of Corporate Governance Members acknowledged the findings and emphasised the importance of maintaining focus on the timely delivery of agreed actions. The Committee NOTED the Internal Audit reports.
ARAC 0519/16	External Audit Annual Audit Report Julie Rees (JR), Audit Wales, presented the External Audit Annual Audit Report, summarising the findings from audit work undertaken during 2025–26. JR advised that the report largely reflected work and findings that had previously been reported to the Committee throughout the year. It was noted that the report brought together conclusions from both financial and performance audit activity, providing an overall summary of Audit Wales' work across the Health Board. JR highlighted that further work remained in progress, including reports relating to cancer services and estates, which would be presented to the Committee in due course. No new significant issues or concerns were raised within the Annual Audit Report.



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	Members noted the report and the assurance it provided regarding the audit work completed to date, and acknowledged the ongoing programme of external audit activity. The Committee NOTED the External Audit Annual Audit Report.
ITEMS FOR INFORMATION	
ARAC 0519/17	To receive Committee Programme of Business 2026/27 The Committee received the Programme of Business for 2026–27 for information. The Committee NOTED the Programme of Business.
ARAC 0519/18	Audit Wales GMS Challenges Contract Challenges Report The Committee received the Audit Wales General Medical Services (GMS) Contract Challenges report for information, noting that it had previously been considered in-committee. The Committee NOTED the report.
OTHER MATTERS	
ARAC 0519/19	Items to be Brought to the Attention of the Board and Other Committees The Chair invited members to identify any items requiring escalation to the Board or referral to other Committees. It was agreed that the Space Utilisation Advisory Review should be brought to the attention of relevant Committees, recognising its wider implications across estates, workforce and financial planning. The Committee NOTED the items to be escalated.
ARAC 0519/20	Any Other Urgent Business There were no further items raised for discussion.



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ARAC 0520/21

Date of the Next Meeting:

Tuesday 23rd June 2026 09:30



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Aneurin Bevan
University Health Board

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

Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
April 2026	ARAC 0428/13	Internal Audit Reports Input clear numerical implementation dates against recommendations in the Capital Projects Report.	Head of Internal Audit and Director of Strategy, Planning and Partnerships.	June 2026	Completed <u>June update</u> An updated audit report has been issued with numerical dates entered, they have all now been amended to 30 th November 2026. However, one of the key finding (#1) had a previously reported date of 30 th June 2026. As this has been brought in line with the work to address the other

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					key findings, for the 30 th November, the Audit Committee will need to be aware of this update and approve the revised date.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
May 2026	ARAC 0519/15	Report Process for Managing and Approving Extensions Develop and present a formal process outlining how extension requests will be managed, including the criteria and evidence required for committee approval.	Director of Corporate Governance	September 2026	In progress

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

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

Capital Projects: Service Readiness

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference

ABU-2526-07

Fieldwork

November 25 – January 2026

Executive Sign Off

April 2026

Updated Issue

June 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:

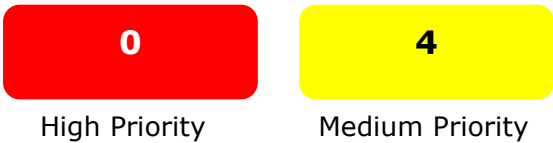
- The Capital Procedures and Notes document would benefit from a refresh to ensure there is a detailed focus on the importance of Commissioning and Pre-Commissioning Plans, including examples, as they are a crucial aspect for service delivery.
- Pre-Commissioning plans need to be tracked, monitored and 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.

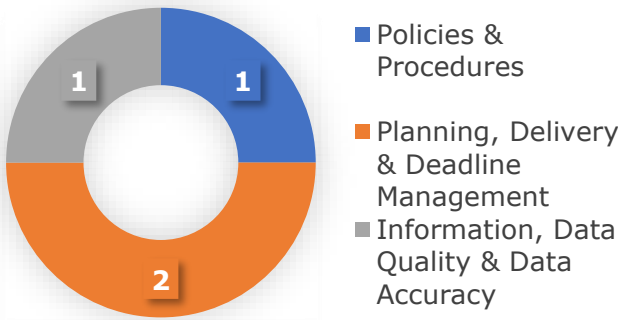
Scope & Assurance Summary

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



Themes



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

			- o 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	Officer: Assistant Director of Strategic Capital Target Implementation Date: 30 November 2026
	Theme: Policies & Procedures	Control Design	
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	Agreed Action: • Develop a standardised commissioning plan template covering milestones, dependencies, resource requirements, risks, operational readiness criteria and key decision points. Expected Evidence of Implementation:

		subsequently putting the project at risk of being completely correctly.	• Standardised commissioning plan template approved by PMO.
		Medium Priority	Officer: Assistant Director of Strategic Capital
	Theme: Planning, Delivery & Deadline Management	Control Operation	Target Implementation Date: 30 November 2026

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
	Medium Priority	Officer: Head of Operational Transformation Target Implementation Date: 30 November 2026
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). • 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.

		Medium Priority	Officer: Head of Operational Transformation Assistant Director of Strategic Capital Target Implementation Date: 30 November 2026
	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.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 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.



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

There are no FCPs to be reviewed at this Committee.

Summary Position on Financial Control Procedures

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



FCP	Year Due	Approved	Committee Approved	Review Date	Notes
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	
General Ledger	29/30	Y	Apr-26	28-Apr-29	
Commissioning Non NHS Clinical Services	29/30	Y	Apr-26	28-Apr-29	

2. Technical Accounting Issues

Technical updates

Since the last committee meeting in April 2026, there has been one technical accounting update issued by Welsh Government.

Update Note 9 for 2025/26 covered the following area:

- **NHS Pensions Note for Template**

Welsh Government provided updated wording for Organisations to include as a narrative disclosure in Note 9.7 of the Annual Accounts.

This is standard wording which all organisations are to include in the notes to their accounts and provided by the NHS Business Services Authority – Pensions Division in relation to the Accounting and Actuarial Valuations of the pension scheme.

The current valuation is based on actuarial data as at 31 March 2024. The Update Note confirmed that the next “annual cycle” will take place on 31 March 2026, for inclusion in the 2026/27 accounts.



• **Chair and Non-Executive Director Pay Increase**

Confirmation that Chief Executive Officers had received notification of the pay increase for Chair and Non-Executive Directors. The pay circular stipulated that the increase was agreed by the Cabinet Secretary on the 1 December 2025, with an implementation date of the 1 January 2026.

Consequently, Welsh Government confirmed that they expect Organisations to account for the pay increase in 2025/26 accounts. The Health Board included the pay increase for the Chair and Non-Executive directors in its 2025/26 position.

• **Arrangements for Amendments to Accounts Templates**

Details provided for how Organisations should submit requests for any amendments required to the standard Accounts template, including expected response timeline for actioning amendments.

The Health Board required minor adjustments to the template, as part of the completion of the accounts, to allow for additional reporting lines on some Notes to the Accounts. These were all actioned promptly by Welsh Government, prior to submission of the account on the 1 May 2026.

3. Public Sector Payment Policy (PSPP)

The following table shows the Public Sector Payment Policy performance for the month of May 2026 and on a cumulative basis for the 2026/27 Financial Year.

Category	Invoices	In Mth %	YTD %
NHS	Value	99.8	99.9
	Number	95.4	95.8
Non-NHS	Value	95.2	96.3
	Number	96.9	97.1

The Health Board has achieved the target to pay 95% of the number of Non-NHS and NHS creditor invoices within 30 days of delivery of goods/services in May and cumulatively for the 2026/27 financial year.

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.

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 PSP – 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:	



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

Resource Assessment:

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

Is EIA Required and included with this paper?

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

Not Applicable

Yes, outlined within the paper

Yes, outlined within the paper

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

No does not meet requirements

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

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

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

Choose an item.

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Report and Accounts 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In respect of the Annual Report and Accounts 2025/26, this paper presents to the Board the final draft audited versions of:

- 1) The Performance Report (Part 1)
- 2) The Accountability Report (Part 2), including:
 - a) A Corporate Governance Report
 - b) A Remuneration and Staff Report
 - c) A Parliamentary Accountability and Audit Report.

for consideration and approval prior to being submitted to Welsh Government on 30th June 2026, in-line with HM Treasury Requirements.

Following presentation of the draft documents to the Audit, Risk and Assurance Committee on 19th May 2026, the final draft versions incorporate comments and feedback received from Welsh Government; Audit Wales; and Board Members, including those comments made by the Audit, Risk and Assurance Committee when reviewing the drafts.

Page numbers contained in the documents will be added once the 3 reports have been combined in to one consolidated document for submission.

Part 3 of the Annual Report and Accounts 2025/26 are the Financial Statements 202, and these are provided to the Audit, Risk and Assurance Committee under separate cover.

Cefndir / Background

NHS Bodies are statutorily obliged to prepare their annual report and accounts in compliance with the determination and directions given by Welsh Ministers and the approval of the Treasury.

The Manual for Accounts, issued by Welsh Government, has been prepared to ensure that those determinations and directions are consistent with the 2025-26 Government Financial Reporting Manual (FReM) which sets out the accounting guidance applicable to bodies within the Resource Accounting Boundary. In setting the requirements of the FReM the government is advised by an independent body, the Financial Reporting Advisory Board (FRAB). NHS bodies are required to follow FReM guidance except where a divergence has been formally agreed with the Treasury.

The Manual provides principles-based guidance to NHS bodies on how to prepare and complete their annual report and accounts and financial returns. Application of the principles to the individual circumstances of a NHS body is a matter between the body and its external auditors.

The Annual Report and Accounts as a whole must be fair, balanced and understandable and the Accountable Officer takes personal responsibility for it and the judgments required for determining that it is fair, balanced and understandable.

Asesiad / Assessment

Annual Report and Accounts – Requirements for 2025/26

As set out in the Manual for Accounts, NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes:

- The Performance Report, which must include:
 - An overview.
 - Delivery and Performance analysis
- The Accountability Report, which must include:
 - A Corporate Governance Report.
 - A Remuneration and Staff Report.
 - Senedd Cymru/Welsh Parliament Accountability and Audit Report.
- The Financial Statements, including:
 - The Audited Annual Accounts 2025/26.

The detailed structure of the Annual Report and Accounts 2024/25, is set out at Annex A.

For the 2025-26 reporting period the deadlines for submission are:

Annual Reports 2025/26 - Key Dates	2026	
Draft Accounts to WG	Fri	1-May
Draft Performance Report Overview, Accountability Report and Remuneration Report to WG	Fri	8-May
Draft Reports to ARA Committee Members	Tues	12-May
ARA Committee meeting to Consider Draft Accounts and Draft Accountability Report	Tues	19-May
Final Accounts & Accountability Report to Audit Committee Members	Fri	19 June
ARA Committee meeting to Consider Final Accounts, and Accountability Report	Tues	23-June
Board meeting to approve Final Accounts and Accountability Report	Wed	24-June
Certification by Auditor General		
Final Annual Report Deadline for Submission to WG – Annual Report and Accounts as a single unified document	Tues	30 June
Annual General Meeting – to receive the Annual Report and Accounts	Wed	15 July

Part One – The Performance Report 2025/26

The purpose of the performance section of the annual report is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. The requirements of the performance report are based on the matters required to be dealt with in a Strategic Report as set out in Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013, No. 1970. The main features of the performance report should flow from the organisation's agreed plan and demonstrate how the Health Board has delivered against that plan in the year of reporting.

The performance report must provide a fair, balanced and understandable analysis of the Health Board's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable.

The performance report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer).

The Draft Performance Report was considered by the Audit, Risk and Assurance Committee on 19th May 2026, where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft performance report for consistency with other information in the financial statements (Part 3). Feedback and amendments received from Audit Wales have been factored into the Final Draft.

The following comments were received and have been included in the final draft:

- ARAC: Include significant progress made in a number of areas, such as mental health. Section on the internal performance management framework has been included in the Control Framework section of the Accountability Report
- Audit Wales: Inclusion of information regarding the sustainability report providing information in relation to aspects on the MFA chapter 3.39 onwards, relating to greenhouse gas emissions, waste, use of resources as well as a TCFD compliance statement, net zero carbon baselining. Performance report updated to include link to the Decarbonisation Programme Annual Report 2024/25.
- Audit Wales: Wellbeing of Future generations aspect could have been stronger as it would be useful to provide commentary on performance against delivery of the objectives – this is a potential for improvement and not a requirement.

Part 2 – The Annual Accountability Report 2025/26

The purpose of the accountability section of the annual report is to meet key accountability requirements to the Welsh Government. The requirements of the accountability report are based on the matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2008 No 410.

The Accountability Report is required to have three sections:

❖ Corporate Governance Report

The purpose of the Corporate Governance Report is to explain the composition and organisation of the Health Board's governance structures and how they support the achievement of the entity's objectives.

As a minimum, the corporate governance report must include:

- The Directors' Report;
- The Statement of Accounting Officer's responsibilities; and
- A Governance Statement.

The Governance Statement is a key feature of the organisation's Annual Report and Accounts. It demonstrates publicly the management and control of resources and the extent to which the body complies with its own governance requirements, including how they have monitored and evaluated the effectiveness of their governance arrangements. It is intended to bring together in one place in the annual report all disclosures relating to governance, risk and control.

❖ Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers and where relevant the link between performance and remuneration.

❖ Senedd Cymru/Welsh Parliament Accountability and Audit Report

The Parliamentary Accountability Report contains disclosure on the following:

- Regularity of expenditure
- Fees and charges
- Public Sector Information Holders only - a statement is required if the entity has not complied with the cost allocation and charging requirements set out in HM Treasury guidance
- A brief description of the nature of each of the organisation's material remote contingent liabilities (that is, those that are disclosed under Parliamentary reporting requirements and not under IAS 37) and, where practical, an estimate of its financial effect. (This is included in the Annual Accounts [Part 3]).

The Accountability Report, once approved by the Board, shall be signed and dated by the Accountable Officer (the Chief Executive Officer), the Chair and the Director of Finance.

The Draft Accountability Report was considered by the Audit, Risk and Assurance Committee on 19th May 2026 where comments and feedback were provided to inform the Final Draft version, as attached. In addition, Audit Wales (External Audit), has reviewed the draft Accountability report for consistency with other information in the financial statements (Part 3). Audit Wales and Welsh Government has also reviewed the draft accountability report and were content that the Health Board had made the appropriate level of disclosure against the requirements in Chapter 3 of the Manual for Accounts, with no material changes identified.

The following comments were received by members of the ARAC Committee and have been included within the report:

- 6 risks outside of tolerance – include a list of what they are and why they are outside tolerance
- Clinical Audit Plan – the narrative sounds like there is a local plan which is not the case – clarify national plan with a local approach

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to CONSIDER and REVIEW the Final Draft versions presented prior to being submitted for formal approval by the Board on 24th June 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

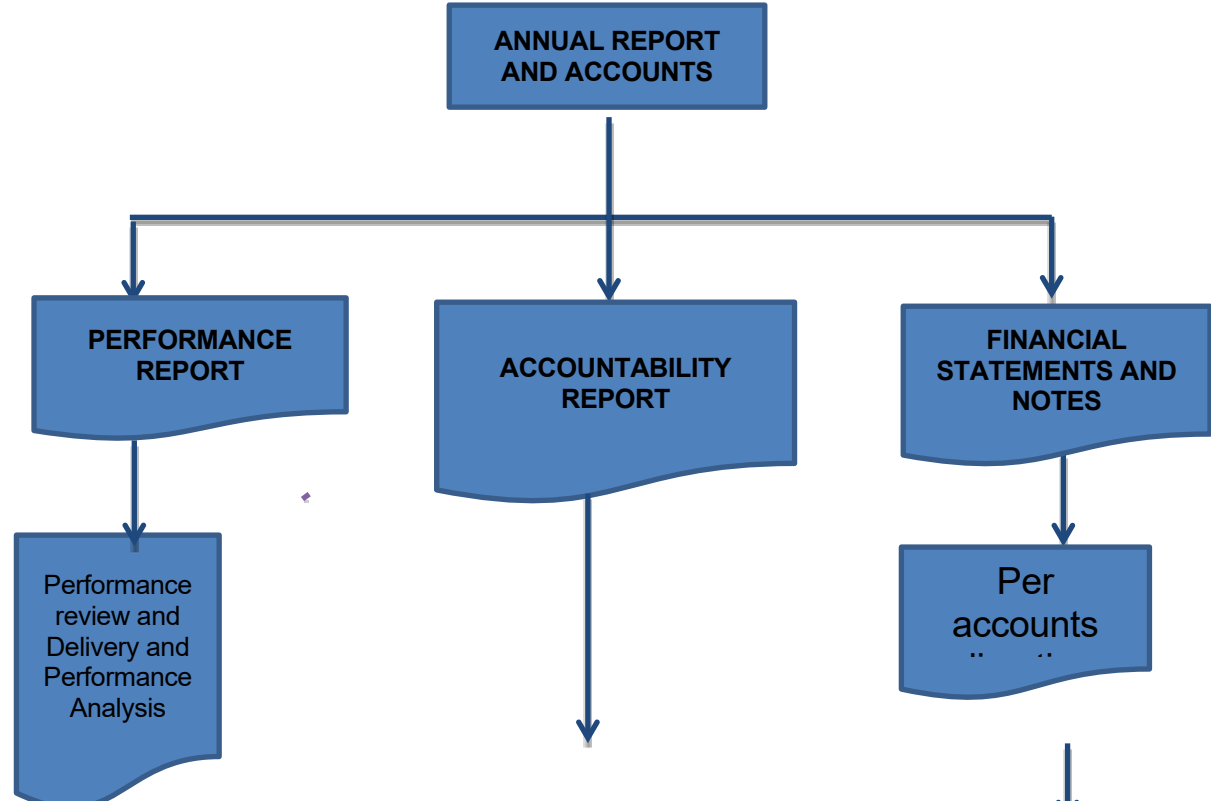
Cyfeirnod Cofrestr Risg
Corfforaethol a Sgôr Cyfredol:
Corporate Risk Register
Reference and Score:

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	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

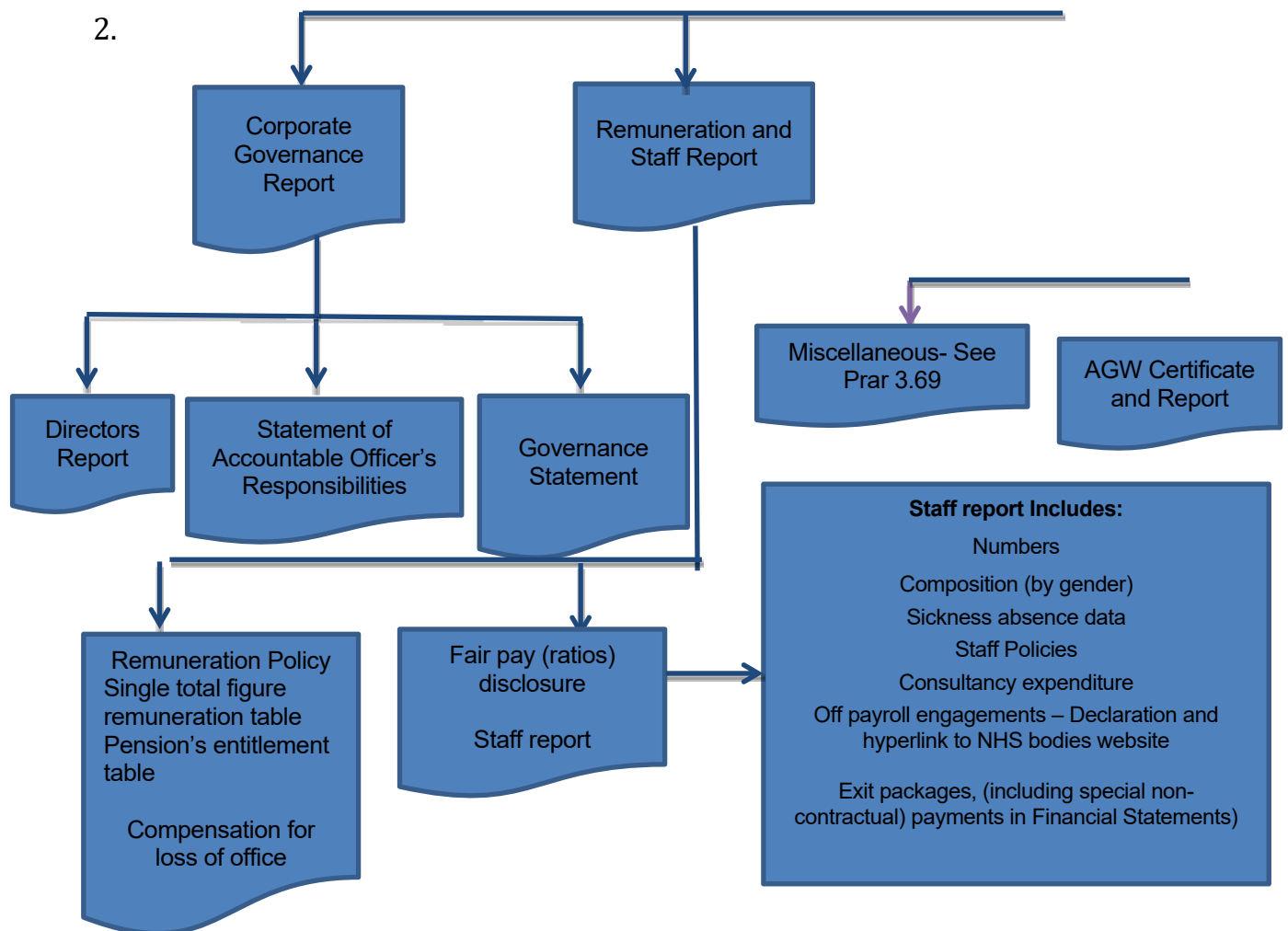
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. 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	Not Applicable Choose an item.

Annex A



1.

2.



Attachment One



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

2025 - 2026 Annual Report

Aneurin Bevan University Health Board

Introduction

Our Annual Report is a suite of documents that tell you about our organisation, the services and care we provide and what we do to plan, deliver and improve healthcare for you. It provides information about how we performed in 2025/26, what we have achieved, how we plan to continue to improve next year and what our plans are.

This report also explains how important it is for us to work with you and listen to your views, to better deliver services that meet your needs, as close to your home as possible.

Our Annual Report for the period 1st April 2025 to 31st March 2026 includes:

- Our Performance Report which details how we have performed against our targets and the actions planned to maintain or improve our performance.
- Our Accountability Report which details our key accountability requirements and provides information about how we manage and control our resources, identify and respond to our risks, and comply with our own governance arrangements.
- Our Financial Statements and Annual Accounts which detail how we have spent our money and met our obligations.

Contact Us

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<http://x.com/aneurinbevanUHB>

<https://www.facebook.com/AneurinBevanHealthBoard>

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Part 1:

Performance Report

1st April 2025 –
31st March 2026

1. Reporting Requirements

The purpose of the performance section of this Annual Report 2025/26, as set out in the guidance provided in the NHS Wales 2025/26 Manual for Accounts, is to provide information on Aneurin Bevan University Health Board, its main objectives, Strategy and plans and the principal risks that it faces. The requirements are based on the matters required to be dealt with as set out in Chapter 4A of Part 15 of the Companies Act 2006, as adapted in the Financial Reporting Manual and NHS Wales Guidance Manual.

The main features of the performance report flow from the organisation's agreed plans and demonstrate how the Health Board has delivered against these.

It should be noted that the Health and Social Care (Quality and Engagement) (Wales) Act 2020 legally requires Health Boards to publish an annual report regarding the Duty of Quality. This report will be prepared and published separately to this performance report. Further information is available in the Annual Accountability Report, Page **XX**.

2. Overview from the Chief Executive

In 2025/26, Aneurin Bevan University Health Board made important progress while operating within a challenging NHS Wales context of sustained operational, financial and workforce pressure. The year saw a clearer strategic direction, strengthened organisational planning and improvements in several priority areas of service delivery.

A key milestone was the publication of Gwent 35: Better Health, Better Care, Better Lives, the Health Board's ten-year strategy. This sets a clear ambition to improve healthy life expectancy, reduce inequalities and shift focus towards prevention, population health, care closer to home and sustainable services. It has been supported by the launch of the People Plan 2025-2030 and further work to strengthen place-based care, governance and accountability arrangements.

Operational delivery also improved in a number of important areas, supported by staff commitment, targeted improvement programmes and additional capacity. Key achievements included:

- **Improved access to planned and diagnostic care**, including major reductions in long outpatient, treatment and diagnostic waits.
- **Progress in care closer to home**, with strong delivery in pharmacy, optometry, enhanced community care and palliative care pathways.
- **Strengthened urgent and emergency care**, with improved ambulance handover performance, patient flow and discharge improvement work.
- **Development of specialist and regional services**, including regional ophthalmology delivery and the opening of the satellite radiotherapy centre at Nevill Hall Hospital.
- **Continued focus on quality, safety and outcomes**, with positive mortality outcomes, lower infection rates and strong performance against core mental health access standards.

The report also recognises where performance remains challenged. The Health Board was re-escalated by Welsh Government to Level 4 Targeted Intervention for Finance, Strategy and Planning, and for urgent and emergency care performance and outcomes. Financial balance was not achieved, and further improvement is required in urgent care, cancer

pathways, psychological therapies, neurodevelopmental services and some community capacity measures. These areas are being addressed through strengthened governance, recovery planning and focused operational delivery.

Overall, 2025/26 has established a stronger strategic platform while delivering tangible improvements for patients and communities. The focus for 2026/27 will be to sustain progress, accelerate recovery in challenged areas, improve financial performance and continue embedding Gwent 35 across the way services are planned and delivered.

3. The Health Board

Aneurin Bevan University Health Board (ABUHB) was established in October 2009 and achieved University status in December 2013.

The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our Partners and Stakeholders in the best interests of the population we serve.

As a Health Board, the organisation serves the population of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the South Wales valleys.

[The Gwent Joint Strategic Assessment 2025/26 Edition - Aneurin Bevan University Health Board](#) provides a comprehensive overview of the health and well-being of the people of Gwent in an accessible way for anyone to view. The majority of the data is sourced from publicly available national data sources such as Stats Wales, Wales Public Health Outcomes Framework and the Office of National Statistics. The Assessment provides partners across Gwent with a shared intelligence source about the current, future and influences of health and well-being of the population of Gwent. An evidence-base to inform planning for local service delivery, that provides us with a picture of health for Gwent and provides us with a framework for building a fairer, safer and healthier Gwent.

3.1 Gwent 35 Strategy

In July 2025, the Board approved *Gwent 35: Better Health, Better Care, Better Lives*, the Health Board's ten-year strategy ([Gwent 35: Our Ten Year Strategy](#)). The strategy sets a clear long-term direction for improving healthy life expectancy, reducing inequalities and shifting the organisation's focus towards prevention, population health, equity and care closer to home. It also fulfils the Health Board's statutory duty to publish well-being objectives under the Well-being of Future Generations (Wales) Act 2015.



Developed through engagement with communities and informed by evidence, Gwent 35 is built around three ambitions: better health, better care and better lives. These ambitions describe the conditions needed for people across Gwent to live healthier lives, access high-quality care when needed, and benefit from stronger communities, environments and services.

The strategy represents a significant step change for the Health Board, requiring a sustained rebalancing of resources, services and ways of working towards prevention, community resilience and sustainable models of care. It is underpinned by the organisation's values of Kindness, Integrity and Respect, which will guide the culture, behaviours and relationships needed to deliver the strategy.

Delivery is being supported through *Making it Happen*, the strategy delivery and deployment plan. This provides the framework for translating Gwent 35 into action through the Annual Plan and future IMTPs, supported by an outcomes framework and strategic plans aligned to the organisation's key areas for success. The detailed action plan can be found in [Making it Happen, our strategy deployment & delivery plan](#).

Delivery describes what the Health Board will do to achieve the ambitions of Gwent 35; deployment describes how the organisation will work

differently to make this happen. This includes strengthening the operating model so that culture and ways of working, organisational design, technology and infrastructure, governance and accountability, processes and partnerships are aligned to the strategy.

Work has commenced to review, test and strengthen the Health Board's operating model, with the action plan maintained as a live document to reflect the evolving work programme. An annual report on strategy delivery and deployment will be developed in September 2026 to provide assurance on progress and demonstrate how the Health Board is delivering against its well-being objectives.

3.2 Workforce

The Health Board has seen a significant growth in headcount over the last five years and currently employs 13,724 Whole Time Equivalents (WTE) (17,297 people; March 2025) and is the largest employer in Gwent. This is an increase of 264 WTE from last year, mainly in Nursing and Midwifery (146.24 WTE), and Medical & Dental (37.67wte).

The workforce demographic remains stable, with 20% of staff over 55 years old and 32% over 50 years old. From March 2025 to March 2026, turnover increased from 8.67% to 9.02% and sickness absence has increased from 6.44% to 6.55% with stress, anxiety, and depression accounting for a third of absences. All sectors, including the NHS have seen increases in sickness absence and the health and wellbeing of our staff remains a key priority of our People Plan.

The Health Board has significantly reduced Registered Nurse vacancies, and we are forecasting a zero vacancy position through student streamlining processes in 26/27. Medical and Dental vacancies have also reduced, although hard to fill posts in some medical specialties (e.g., Ophthalmology, General and Acute Medicine, Psychiatry, Public Health) remain. We will continue with dedicated recruitment and retention campaigns, as well as working with educational and national partners to address these issues. Long-term vacancies remain in non-clinical roles like Mechanical and Craftsperson positions, and we have designed career pathways to attract and future-proof these roles.

The priority is recruiting, developing, and retaining directly employed staff to build effective teams and provide a positive and qualitative staff and patient experience.

Our most recent records indicate that there are 1,329 WTE staff (2,094 headcount) working independently as GP practice staff, with 11% of GP staffing covered by Locums. In addition, 25% of GP partners are over the age of 55 years old, alongside 35% of the nursing workforce matching this age profile.

People Plan 2025 – 2030: The new 5-year plan People Plan was launched this year and is a core enabler of our 10-year Health Board Strategy: 'Gwent 2035'. The plan was developed with engagement from staff, Trade Unions and partners, and supports our purpose and ambition by putting people at the heart of everything we do; creating the conditions for them to thrive, and enabling us to deliver outstanding, compassionate care while tackling health inequalities and building healthier futures for all.

The Plan sets three clear pillars of action for the next five years:

Better Health and Wellbeing: Our approach will be proactive, preventative and focused on resilience, valuing care for our people as much as care for our patients.

Better Future Workforce: By building digital skills, creating flexible roles and opening routes into NHS careers, we will ensure we have the right people, in the right roles, with the right skills for years to come.

Better Working Lives: We will invest in modern, flexible working arrangements, career development and recognition so that our people are motivated, engaged and able to reach their potential.

The Plan provides a strategic delivery programme set over the next 5-years. This includes further developing our achievements of the last People Plan (2022-2025), our key workforce performance indicators, and building on the achievements to date, which include:

- Ensuring all staff have a meaningful Performance Appraisal (PADR), with a target compliance of at least 85% (currently at 76.95%).
- Promotion of our staff survey, acknowledging the increased participation rate of 32.5% for 25/26 (previously 13.3%).
- Evaluation of a pilot staff recognition platform 'Share Given', that was implemented to provide an opportunity for patients (or their

relatives) to say thank you and recognise the staff that made a difference to their care.

- Agreeing and implementing the recently refreshed Values and Behaviours Framework, following extensive staff engagement.
- Delivery and evaluation of a pilot strategic culture transformation project with consideration to how this approach can be applied across other teams and divisions.
- Continuation and development of our Leadership Development Programmes. Over the last year, 357 staff participated in a Leadership Development Programme and a further 339 managers attended masterclasses on subjects such as coaching, recognition and retention.
- Expanding retention initiatives across the Health Board following the success of the Nurse Retention plan including new starter surveys, a retention hub, talent and succession planning workshops.
- Further reducing time to hire, recognising this has consistently remained below the target of 71 days every month with lowest recorded average being 56.8 days.
- Reviewing our Nursing & Midwifery Workforce Strategy 2023-26, with a particular focus on Healthcare Support Worker development.
- Further roll out of innovative recruitment initiatives such as talent pools, lateral moves and rotational posts to support career development and promote retention across the Health Board. Through our talent pool approach, we have recruited to vacancies more efficiently, saving 25 days per vacancy in comparison to a traditional recruitment process.
- Further reduction of M&D vacancies by recruiting strategically to anticipated training gaps across a number of specialties where possible instead of recruiting to shorter gaps per specialty. We achieved our lowest vacancies in December 2025 (59.6 WTE, compared to 203.72 WTE at its highest in August 2022).
- Delivering sustained reductions in variable pay through improved workforce planning, strengthened roster management and continued focus on recruiting substantively to key posts, supporting better financial control and workforce sustainability.
- Improving our Occupational Health performance to support timely access and working towards achieving industry standard for Occupational Health Services.
- Integrating the ABUHB Post Incident Support Network and Clinical Pathway which was launched via our Employee Wellbeing Service.

Our People Plan provides a strong platform to horizon scan and recognises the changing demands on healthcare and the demographics of our staff and population. This strategy, along with other national changes and priorities will take us forward to 26/27 and beyond.

3.3 Finance

For financial year 2025/26 the Health Board received a £2 billion annual revenue resource limit (budget) from Welsh Government and a capital resource limit of £46m. These resources are used to deliver the Board's Annual Plan, including statutory requirements and working jointly with partners to provide and commission services for the population of Gwent.

Detail on how the Health Board is governed is set out within the Accountability Report (Section 2 of the Annual Report and Accounts 2025/26).

The Annual Plan for 2025/26 had the ambition to deliver financial balance, unfortunately this was not achieved for revenue spending and an £18m deficit was recorded despite savings of £43m being achieved (£3m more than expected). The deficit was driven by nationally agreed workforce costs, urgent care demand and investments in cancer and mental health services beyond the original plan, in order to meet increasing demand and safety priorities.

The Board did achieve its capital resource limit, its public sector payment targets and cash holding guidelines.

The Board established strengthened financial governance arrangements through its Value and Sustainability Board to drive improved financial performance and future sustainability.

Financial year 2026/27 is presenting similar financial challenges and improving financial performance is a priority for the Board going forward including refreshing its 'route map to sustainability'.

4. Three year Plan 2025/26: Performance against trajectories

The Health Board's performance reporting is aligned to the commitments made in the Integrated Medium-Term Plan (IMTP) 2025-28 which are framed around the following two components:

Ministerial Delivery Expectations

The Cabinet Secretary for Health and Social Services set out sixteen delivery expectations under five themes:

- Timely access to care
- Population Health & Prevention
- Building Community Capacity
- Mental Health Access (Adult and CAMHS)
- Women's Health

System Change Themes

Additional performance measures were set out against system change themes in the Integrated Medium-Term Plan (IMTP) 2025-28, drawn from the NHS Performance Framework, the Enabling Actions from the NHS Planning Framework and de-escalation conditions related to the Health Board's escalation status of Enhanced Monitoring for Urgent and Emergency Care.

The performance measures are grouped against the following IMTP system change themes:

- Embedding Prevention and Population Health in all that we do
- Progressing Place Based Models of Care and sustainability in Primary and Community Services
- Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways
- Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care
- Improving our Mental Health Services

A summary of the Health Board's Annual Performance is detailed below by System Change theme noting the relevant, corresponding Ministerial Priorities of Ministerial Delivery expectation (MD), Targeted Intervention (TI) or Enabling Action (EA).

5.1 Embedding Prevention and Population Health in all that we do

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
% uptake of the COVID-19 vaccination for those eligible Spring Booster	75% (Jun-26)	56.5% (Jun-25)	MD
% uptake of the COVID-19 vaccination for those eligible Autumn Booster	75% (Mar-26)	60.4% (Mar-26)	MD
% uptake of the influenza vaccination amongst adults aged 65 years and over	75% (Mar-26)	73.9% (Mar-26)	MD
% children up to date with vaccinations by age 5	95% (Mar-26)	83.8% (Q3)	MD
% of children receiving HPV vaccination 1 dose by the age of 15	90% (Mar-26)	70.6% (Q3)	MD
Percentage of adult smokers who make a quit attempt via smoking cessation services	5% (Mar-26)	3.9% (Q3)	
Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	32% (Mar-26)	22.2% (Q3)	
Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90% (Mar-26)	93.2% (Feb-26)	
Maintain physical examination at 6 weeks rates (Healthy Child Wales)	90% (Mar-26)	94.5% (Jan-26)	
Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	80% (Mar-26)	92.7% (Q3)	
Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	47% (Mar-26)	47.3% (Mar-26)	MD
Establishment of one Women's Health Hub in each health board area by March 2026	Yes (Mar-26)	Established (Mar-26)	MD

5.1.1 Vaccinations

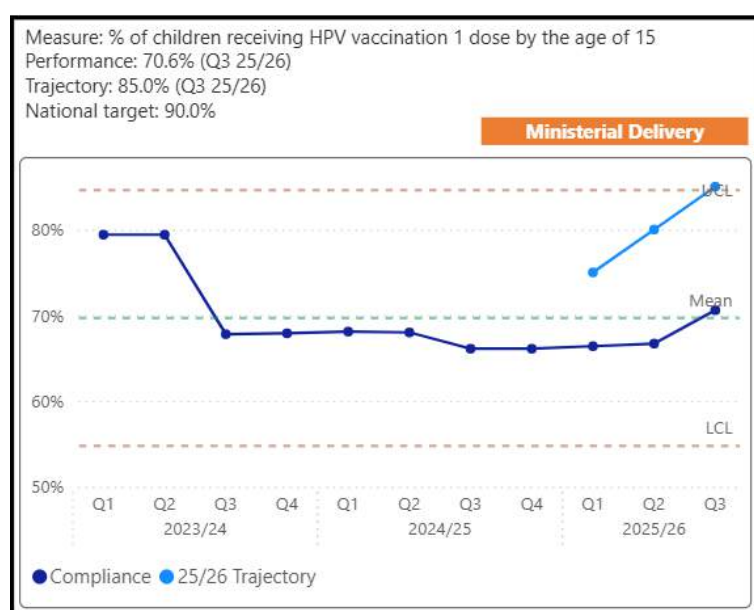
Vaccination rates are important because they directly determine how well a population is protected from infectious diseases both at an individual and system level and the Welsh Government Framework sets out expectations across the key vaccinations programmes of COVID, influenza and HPV.

COVID vaccination activity centred on both the spring and autumn campaigns and whilst the Health Board's performance was higher than the 'all Wales' average, rates fell short of the national expectation in both the campaigns, a trend reflected nationally.

Influenza vaccination rates in residents over 65 years old however was more positive, with performance at the end of the campaign achieving 73.9% coverage, which was an improvement from 72.9% in 2024/25. The

Health Board undertook several actions through the course of the year to improve uptake in seasonal vaccinations, including a review of booking processes and involvement in a PhD project to enhance uptake by exploring how to best remove barriers to uptake which will support further campaigns (e.g. use of text messaging services, improvement in letter wording to enhance engagement).

The number of children up to date with vaccinations by age 5 as well as those receiving HPV dose 1 by age 15 also did not meet the national targets (as of latest data available, Q3 2025/26). Vaccinations by age 5 had remained relatively stable at ~85% although there was a small decrease in the latest data to 83.8%. To support improved vaccination uptake by age five, a task and finish group has been established led by the Public Health Team and working in partnership with Health Visitors, the Vaccination Service and the Health Intelligence Team. The group will focus on targeted interventions in areas with lower uptake. A key initiative is the development of a 'live' dashboard to monitor uptake and assess the impact of interventions in real time. The initial pilot will prioritise MMRV vaccination



and the Director of Public Health's Annual Report findings. Progress has also been made in relation to HPV vaccination, with Q3 performance showing the first significant increase of the year, reaching 70.6%. Digital consent for school-aged vaccinations is being piloted with a small number of schools to support improved accessibility and uptake. Learning from the pilot will be used to inform further refinements prior to wider rollout, with the aim of increasing HPV vaccination coverage across Gwent. In addition, the Nye BeVAN mobile vaccination service has been deployed in areas with

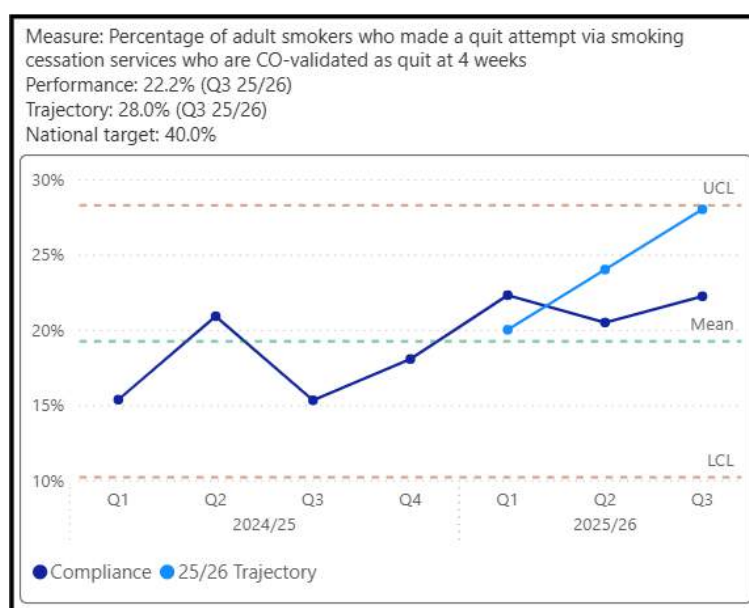
sub-optimal uptake, providing parents and young people with additional opportunities to access vaccination.

5.1.2 Smoking cessation

Smoking cessation measures have shown steady improvement over the last year as shown in the chart below.,

As part of the Public Health commitment to delivering place-based care, behaviour change practitioners responsible for the Health Board’s smoking cessation service have been aligned to localities and will form a core component of integrated neighbourhood teams. A comprehensive improvement programme is ongoing to optimise the service by reviewing and updating processes and placing greater emphasis on supporting individuals and groups to achieve carbon monoxide-validated quits at four weeks rather than just self-reported quits. This is being achieved by increasing community-based clinic capacity and ensuring that team members are given the opportunity to become embedded within their respective places and place-based teams.

Work is also ongoing to ensure proportionate capacity is given to vulnerable populations at higher risk of tobacco related harm, e.g., those with mental health conditions, people with chronic conditions, pregnant women, and people at socio-economic disadvantage.

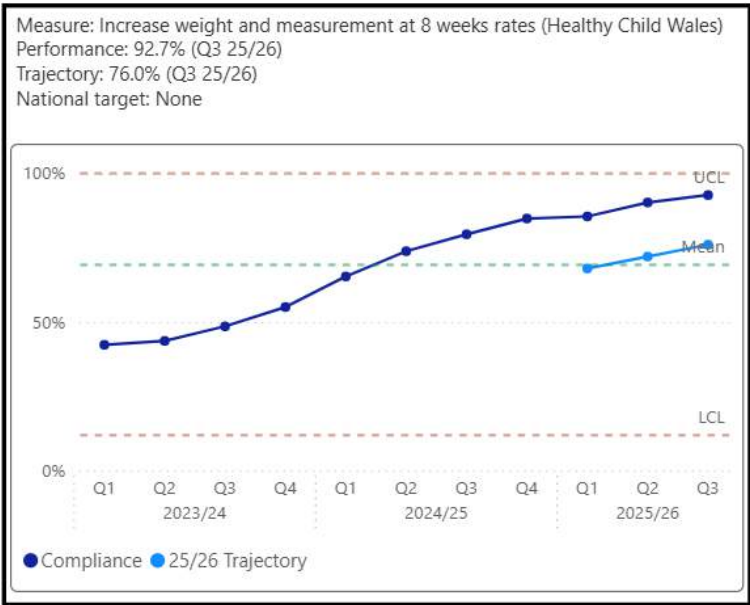


5.1.3 Newborn Babies

The three main measures for newborn babies:

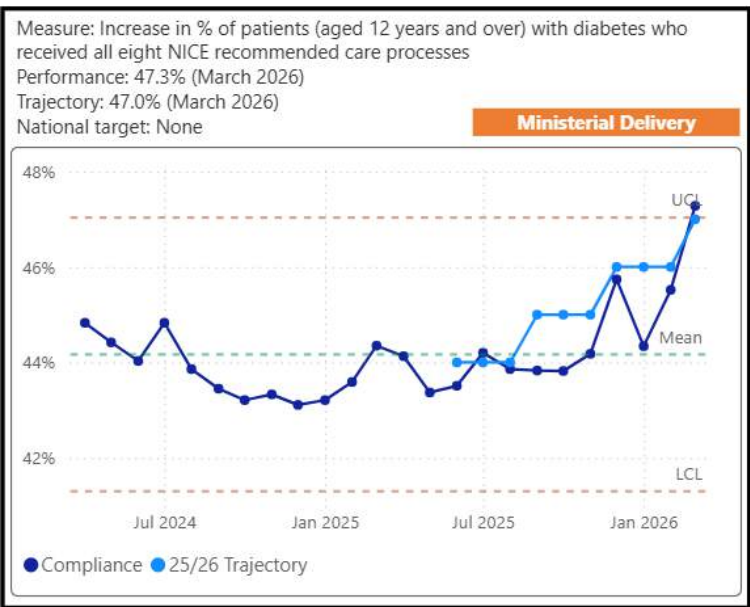
- hearing screening via the dedicated programme who complete screening within 4 weeks
- physical examination at 6 weeks rates
- weight and measurement at 8 weeks rates

have all performed strongly through the course of 2025/26 up to the latest available data and exceeding the IMTP trajectory. Increase in the weight and measurement at 8 week rates are most notable, having quarterly improvement from the beginning on 23/24, with performance having reached 92.7% as of Q3 2025/26.



5.1.4 Diabetes

The ministerial delivery expectation to increase the percentage of patients (aged 12 years and over) with diabetes who received all eight NICE (National Institute of Clinical Excellence) recommended care processes also



showed progress throughout the year, closing the year at 47.3% and meeting the improvement trajectory set out in the IMTP. Significant progress has been delivered through the High Value Impact Pathway programme led by the Public Health Team, with a strong focus on improving quality and outcomes across diabetes

care. Engagement materials supporting Urine ACR testing (which checks for early kidney damage) have been rolled out across all GP practices in

Gwent and extended to wider community and hospital settings, reaching primary care teams, community pharmacies and the public. This has supported improved clinical practice, with pilot sites achieving a 10% increase in compliance.

5.1.5 Women's Health Hub

The Health Board delivered its commitment to establish a Women's Health Hub. Launched in March 26, the online hub provides a trusted, accessible source of information, advice and support to help women and those accessing women's health services in making informed decisions about their health and wellbeing at every stage of life. The hub brings together guidance on maintaining a healthy lifestyle, information on local community groups and events, and clear signposting to further support from healthcare professionals when needed. This initiative forms part of a wider Welsh Government programme, including a national women's health website and directly supports delivery of the NHS Wales Women's Health Plan, a ten-year commitment to improving services and addressing health inequalities for women and girls across Wales.

5.2 Progressing place-based models of care and sustainability in primary and community services

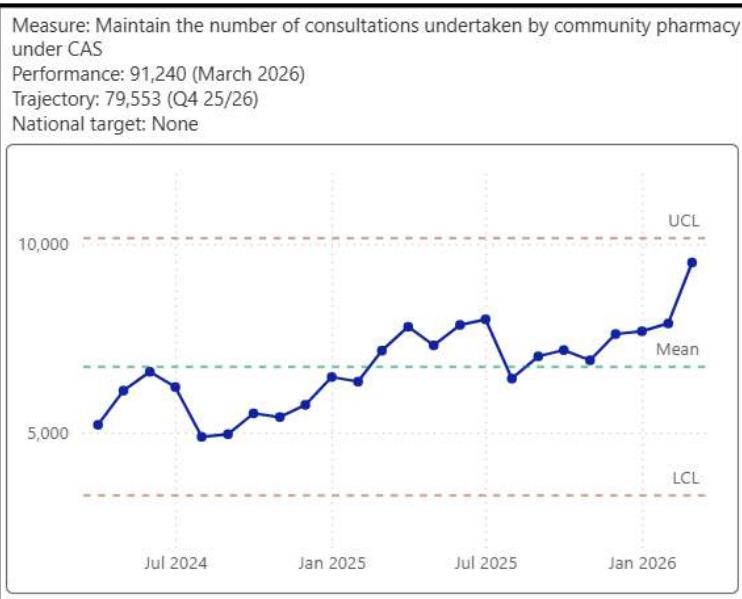
Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
100% of GP practices achieving all National Access Standards for In hours GMS	100% (Mar-26)	Due Jun-26	MD
Increase in people accessing PIPs where they would have visited their GP	24,065 (Mar-26)	37,789 (Mar-26)	MD
Maintain the number of consultations undertaken by community pharmacy under CAS	79,553 (Mar-26)	91,240 (Mar-26)	
Maintain the number of patients accessing NHS Optometry Services	246,133 (Mar-26)	266,125 (Mar-26)	
Number of patients accessing urgent emergency services - Dental	43,153 (Mar-26)	39,999 (Mar-26)	
Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25	128,347 (Mar-26)	92,343 (Mar-26)	MD
Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25	5,277 (Mar-26)	6,545 (Mar-26)	MD
Maintain 95% of Palliative Care referrals assessed within 2 days	95% (Mar-26)	94.0% (Mar-26)	
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments) for over 65s	8.5% (Mar-26)	7.0% (Mar-26)	

Increasing the offer and access to advice and service in the community and primary care is a key component of the Health Board's strategy of care closer to home. Throughout 2025/26 activity has increased across a number of primary care professional groups and therefore increasing the offer to patients and communities.

5.2.1 Pharmacy

Contacts and associated activity in the Pharmacy Independent Prescribing Scheme (PIPS) and Common Ailment Scheme (CAS) services have continued to increase, reflecting both the expansion of clinical conditions managed by the service and the impact of a successful public awareness

campaign. PIPs consultations finished the year at 157% of the annualised target, supported by the continued expansion of the service and an increase in participating community pharmacies from 49 to 67 over the year. CAS activity also exceeded the IMTP trajectory, with March recording the highest



monthly level of consultations to date at 9,510. Uptake continues to grow across newer clinical pathways, with UTI (Urinary Tract Infections) consultations almost doubling in the second half of the year to an average of just under 600 per month, and Sore Throat Test consultations showing both clear seasonal demand and a near-doubling year-on-year during the winter period, now exceeding 1,000 consultations per month. While further growth is anticipated, activity is expected to begin to moderate in future years as the service approaches capacity limits, particularly within CAS.

5.2.2 Optometry

Optometry activity exceeded the IMTP trajectory by 8%, supporting almost 20,000 additional patients compared to plan, driven by implementation of the new Wales General Ophthalmic Service (WGOS) pathways and increased access to community-based care. Overall utilisation surpassed the total number of patients seen in 2024/25, despite some seasonal variability, with activity ranging from a low in January to a record high in October.

5.2.3 Dental Care

Emergency Dental activity was slightly below trajectory, delivering 93% of planned activity, alongside a reduction in overall demand compared to the previous year. Performance was more variable across the year, with notable seasonal lows and a peak demand in January, reflecting ongoing pressures and changing patterns of urgent dental need.

5.2.4 Community Nursing

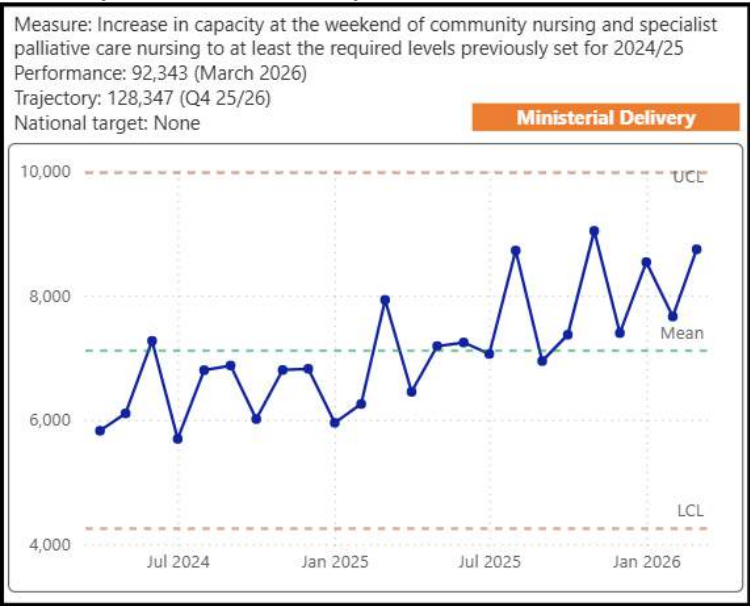
The Ministerial Delivery Expectation for weekend Community Nursing activity finished the year below the IMTP trajectory, delivering 72% of planned activity. However, a clear upward trend has been sustained, with average monthly contacts increasing by around 1,200 compared to 2024/25. While weekend activity continues to increase proportionally, meeting the ministerial ambition for weekend delivery of 80% of that of an average weekday, would require a significant

rebalancing of service delivery.

In contrast, Enhanced Community Care (ECC) performance, another Ministerial delivery expectation, exceeded forecast, with accepted referrals almost 25% above the IMTP trajectory, reflecting strong system utilisation of Rapid Response, Ready to Go Ward and Emergency Care at Home services.

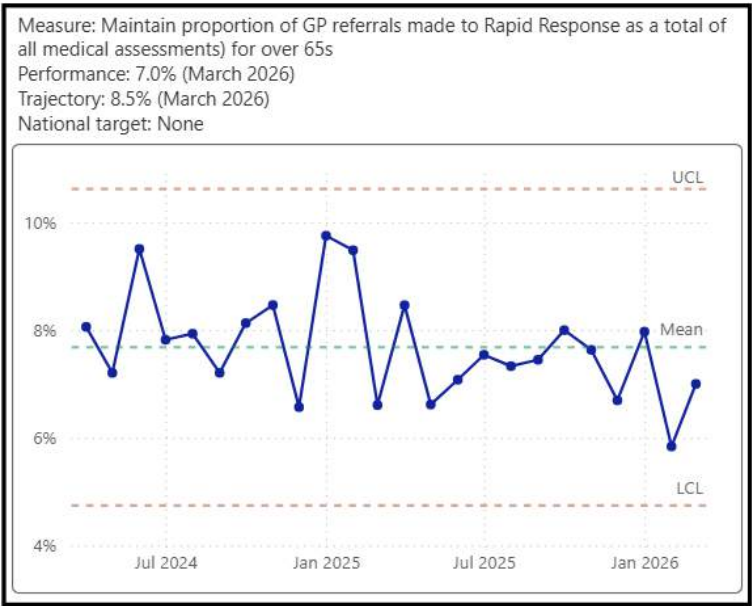
5.2.5 Palliative Care

Palliative Care performance was marginally lower than the previous year, remaining consistently around 91% for much of the year and below the IMTP trajectory, primarily due to increased demand and periodic workforce capacity constraints. However, recovery in the final two months resulted in an end-of-year position of 94%, demonstrating improving resilience.



5.2.6 General Practice

GP referrals to Rapid Response services as a proportion of all medical assessments remained relatively stable throughout the year but were lower overall than in 2024/25 and largely below the IMTP trajectory, with seasonal variation and a more pronounced reduction in late winter.



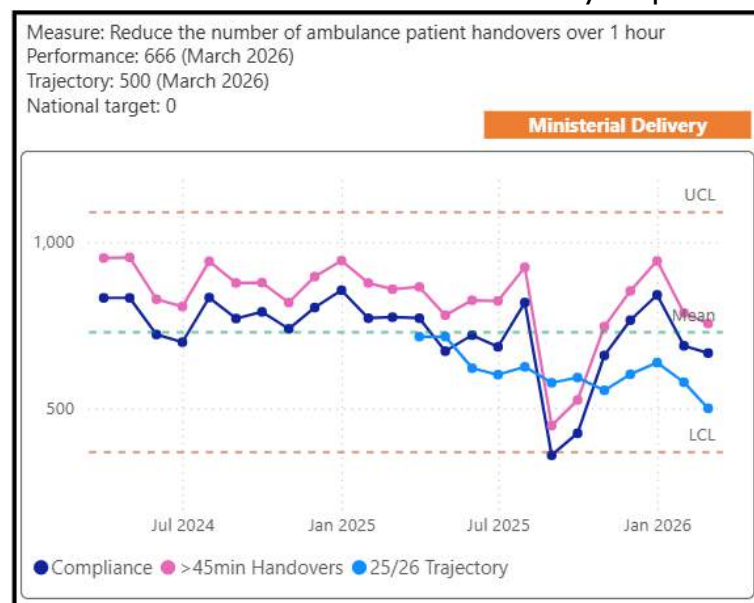
As part of the Urgent and Emergency Care transformation programme, the development of the Navigation Hub and Single Point of Access will seek to address access barriers and support improved utilisation of Rapid Response services, particularly for older people.

5.3 Improving our Urgent and emergency care system focusing on experience, access and discharge pathways

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
Reduce the number of ambulance patient handovers over 1 hour	500 (Mar-26)	666 (Mar-26)	MD
Reduce the number of ambulance crew hours lost at GUH ED (per month)	2,500 (Mar-26)	2,195 (Mar-26)	
Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	750 (Mar-26)	1,184 (Mar-26)	MD
Increase and maintain national target of the percentage of patients waiting <4 hours in ED/MIU	80% (Mar-26)	73.8% (Mar-26)	
Reduction in time from arrival to ED triage - no waits over 60 minutes	200 (Mar-26)	528 (Mar-26)	
Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.	60 (Mar-26)	152 (Mar-26)	TI
Maintain the number of Urgent Primary Care contacts (inc. virtual)	95,147 (Mar-26)	95,304 (Mar-26)	
% of patients directly admitted to an acute stroke ward <4hrs of clock start	20% (Mar-26)	15.9% (Mar-26)	
% of unique stroke patients given thrombectomy (all stroke types)	6% (Mar-26)	4.1% (Mar-26)	
% Assessed by OT within 24 hours	-	45.6% (Mar-26)	
% Assessed by PT within 24 hours	-	51.5% (Mar-26)	
% Assessed by SaLT within 72 hours	-	78.3% (Mar-26)	
Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	160 (Mar-26)	178 (Mar-26)	MD
Deliver a 12-month reduction trend in the number of total days delayed in hospital as measured by the Delayed Pathways of Care dashboard	6,437 (Mar-26)	4,543 (Mar-26)	
Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment	12 (Mar-26)	19 (Mar-26)	TI
Continuous reduction in the number of people admitted as an emergency who remain in hospital over 21 days since admission	370 (Mar-26)	385 (Feb-26)	TI

5.3.1 Ambulance handovers

A key priority for the organisation and a component of national escalation status the data demonstrates steady improvement in Ambulance handover

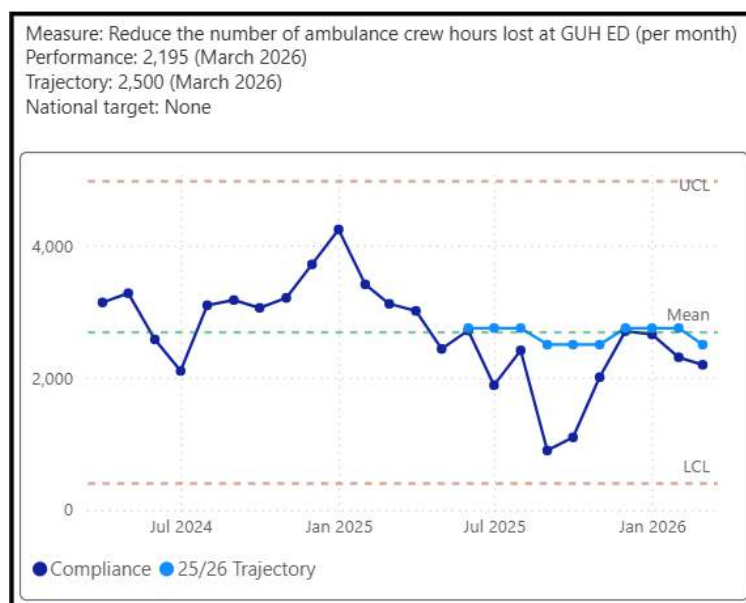


performance at the Grange University Hospital Emergency Department during 2025/26 with sustained reductions in both handover delays and associated lost hours.

Notwithstanding improvement the levels required to achieve de-escalation were not met. The total number of lost hours remained below trajectory and, whilst not

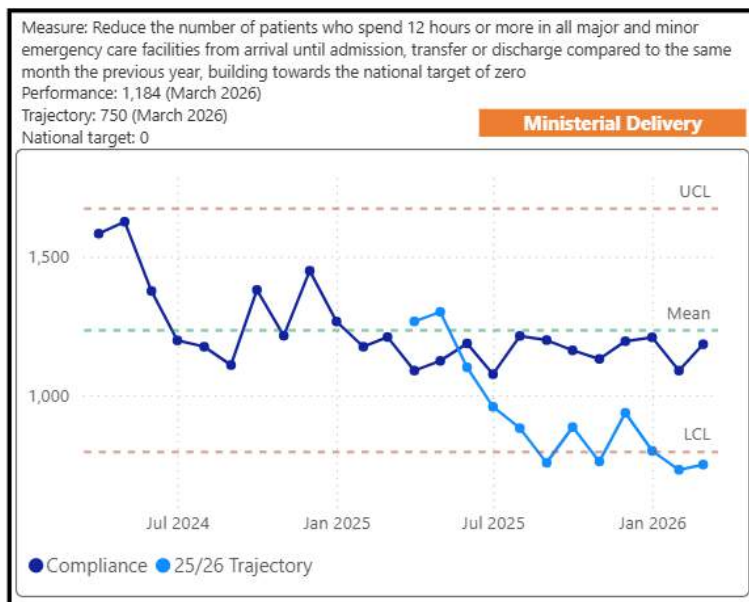
meeting the improvement trajectory set out on the IMTP, ambulance handovers over one hour showed marked improvement compared with the previous year, with around 100 fewer handover breaches and approximately 1,000 fewer lost hours over the same period.

The March, year-end position delivered the strongest performance of the year outside of the initial Our Next Patient (ONP) launch period (September to November, record lows for all handover measures).. A further step change in Ambulance handovers in line with Handover-45 expectations is required and is being underpinned by a refreshed improvement plan with strengthened oversight and governance at Executive and Board level.



5.3.2 12 and 4 hour targets

Delivery against the 12-hour EDMIU and 4-hour standards remained consistent during 2025/26, despite ongoing system pressures. While the 12-hour IMTP trajectory was not fully achieved, performance represented a



clear improvement on previous years, with breach volumes remaining within a narrow range throughout the year and significantly reduced volatility compared to historical patterns. 12-hour compliance was consistently strong, typically above 92%, with a post-Grange opening record high in July and year-end performance of 92.8%, narrowly below the

targeted intervention de-escalation threshold of 93%. These improvements reflect greater operational stability, although weekly variation persists, driven by delayed specialty responses, high bed occupancy and constrained patient flow across the wider system.

4-hour performance was more challenged during the winter period, reflecting demand-led pressures across the urgent and emergency care system. Sustained improvement will continue to focus on earlier specialty decision-making, improved inpatient throughput and maintaining continuous flow through the Emergency Department and downstream assessment units and wards, supported by the relaunch of the Our Next Patient initiative and in line with the Urgent and Emergency Care (UEC) Improvement and Stabilisation plan.

5.3.3 Triage and Wait to be Seen

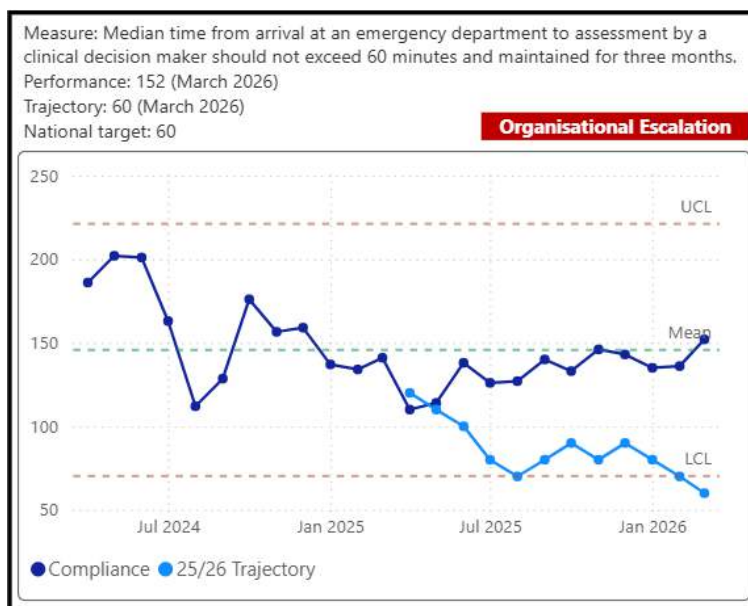
Triage and Wait to Be Seen (WTBS) performance during 2025/26 demonstrated improved control and stability compared with earlier years, while remaining sensitive to seasonal and operational pressures. Although triage performance tracked above trajectory following a winter peak, overall breach volumes remain significantly reduced, with 60-minute breaches

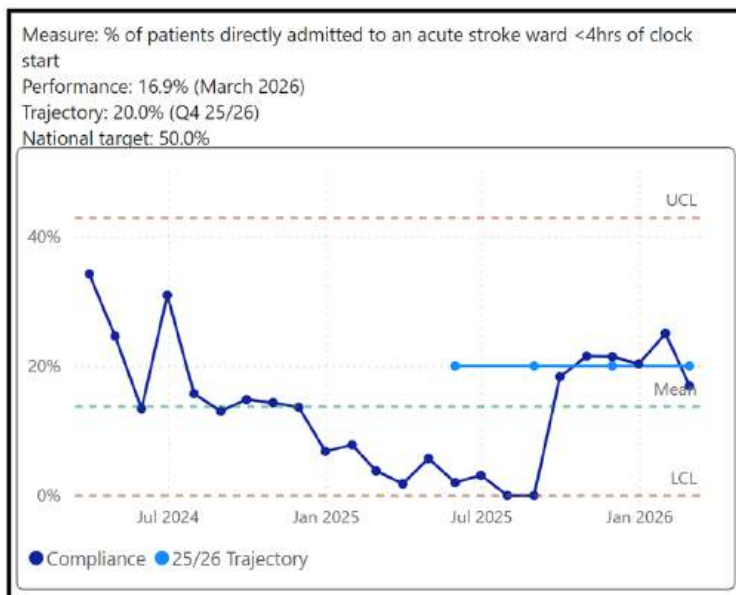
approximately one-third of those seen during the early years of the Grange University Hospital. Triage improvement remains a core focus within the relaunch of the ONP initiative. Clinical Median Wait/WTBS performance has also improved year-on-year and shown greater consistency, although it has trended upwards through the

course of the year and remains some way off achieving the IMTP trajectory which is aligned to the Health Board's targeted intervention de-escalation criteria. Sustained improvement actions are focused on strengthening daily operational huddles, enhancing early patient movement, optimising daytime assessment capacity through clinician role redesign and Senior Rapid Assessment and Treatment (SRAT) rostering, and protecting overnight cubicle capacity through robust escalation and boarding protocols to maintain flow and minimise delays.

5.3.4 Stroke services

Stroke services demonstrated strong performance improvement during the year underpinned by corrected data processing, focused improvement actions and strengthened regional oversight. Following the resolution of a data processing error which severely impacted performance in the first half of the year, Q3 Sentinel Stroke National Audit Programme (SSNAP) results confirmed that performance against the stroke 4-hour standard exceeded the IMTP trajectory, with a dip in Q4 due to increased demand.



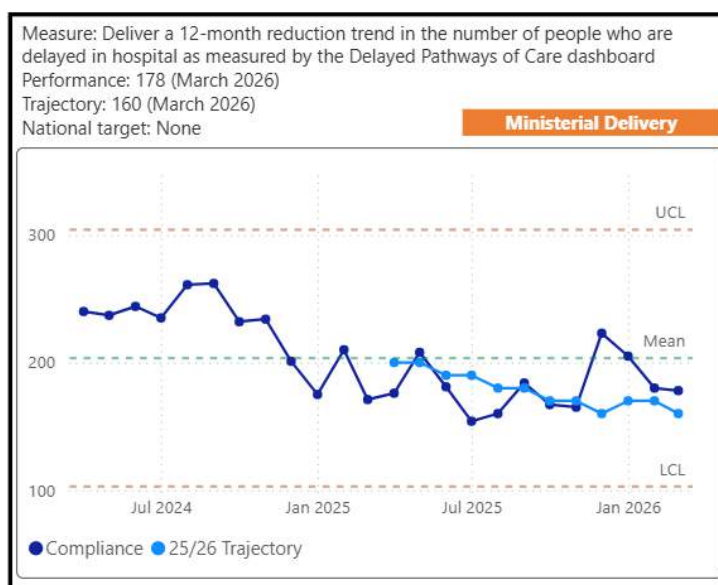
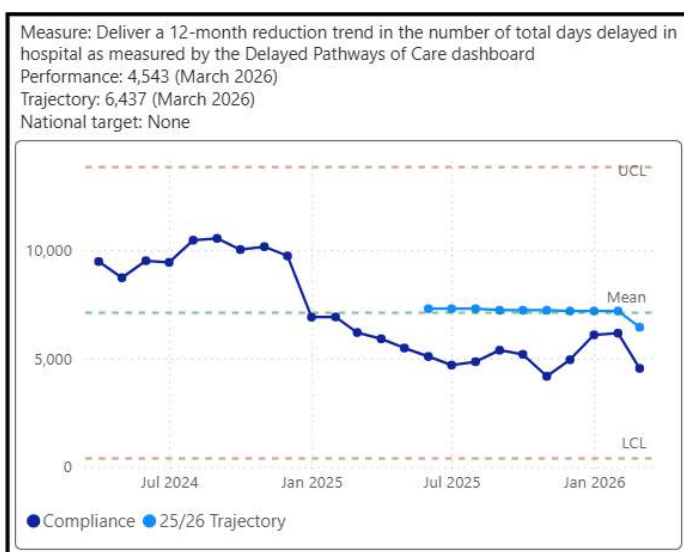


Progress has continued across the wider stroke pathway, with improved timeliness of physiotherapy and occupational therapy assessments and sustained improvements in speech and language therapy provision. An updated stroke improvement plan is in place to address

outstanding GIRFT (Get it Right First Time National Programme) actions and align delivery with the NHS Wales Stroke Quality Statement, with performance oversight strengthening through the Urgent and Emergency Care Improvement Programme and enhanced regional governance arrangements, including Llais participation on the Stroke Regional Network Board.

5.3.5 Pathway of Care Delays

Pathway of Care Delays (POCDs) showed signs of sustained improvement towards the end of 2025/26 following a peak in system pressure during the winter. After reaching a high point in December of 223, total POCDs reduced for



three consecutive months with the March, year-end position having reduced to 178. This was slightly above the planned trajectory of 160 and 4% higher than the equivalent position in the previous year (171), however the impact of delays has

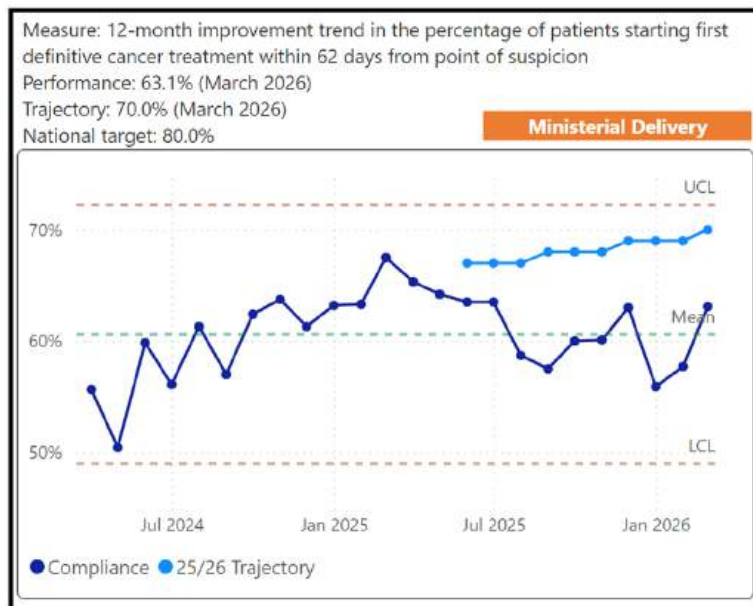
reduced more significantly, with total days delayed falling sharply to 4,543 in March which represents a 27% reduction compared with March 2025 and indicative of improved progression through discharge pathways, particularly for long-staying patients. Length of Stay for patients exceeding 21 days followed expected seasonal trends, peaking over winter before improving in February, supported by a renewed organisational focus through the Our Next Patient initiative. Continued improvement is being driven by a sustained focus on intensive review of the longest delays, alongside the introduction of strengthened divisional processes to improve the accuracy of Estimated Discharge Dates (EDDs) and clearer recording of the specific barriers preventing patients from moving to the next stage of discharge planning.

5.4. Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care

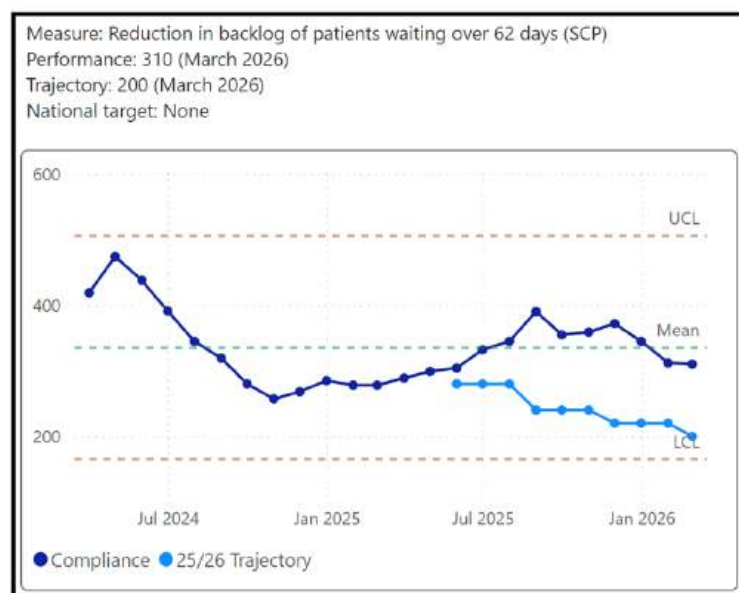
Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	70% (Mar-26)	63.1% (Mar-26)	MD
Reduction in backlog of patients waiting over 62 days (SCP)	200 (Mar-26)	310 (Mar-26)	
Reduction in backlog of patients waiting over 104 days (SCP)	50 (Mar-26)	92 (Mar-26)	
Increase in rate of treatments starting within 28 days of decision to treat	75% (Mar-26)	90.8% (FMar-26)	
Numbers of patients waiting over 104 weeks (all stages)	0* (Mar-26)	23 (Mar-26)	MD
Number of patients waiting over 52 weeks for Outpatients	1,834* (Mar-26)	1,228 (Mar-26)	
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	27,275 (Mar-26)	30,850 (Mar-26)	
Increase in the rate of See On Symptom and Patient Initiated Follow-ups	13.5% (Mar-26)	12.6% (Mar-26)	
Monitoring DNA/CNA for every Outpatient clinic. When DNA >5%, overbooking to be implemented & monitored and reduction of CNA	5% (Mar-26)	5.2% (Mar-26)	EA
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	166* (Mar-26)	233 (Mar-26)	MD
Number of adults waiting more than 14 weeks for all audiology pathways	5,440 (Mar-26)	5,766 (Mar-26)	
Number of children waiting more than 6 weeks for all audiology pathways	3,630 (Mar-26)	780 (Mar-26)	
No patient waiting more than 14 weeks for a therapeutic assessment	105 (Mar-26)	350 (Mar-26)	
On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from pressures and outliers	90% (Mar-26)	95.4% (Mar-26)	EA
Theatre Utilisation late starts to less than 20%	25% (Mar-26)	38.2% (Mar-26)	EA
Theatre Utilisation early finishes to less than 10%	25% (Mar-26)	40.8% (Mar-26)	EA
Theatre Utilisation session utilisation to 85%	85% (Mar-26)	83.7% (Mar-26)	EA
Deliver improvements in day surgery rates, achieving a BADS daycase rate	55% (Mar-26)	77.9% (Feb-26)	EA

5.4.1 Single Cancer Pathway

Delivery against the Single Cancer Pathway (SCP) standard during 2025/26 has been mixed as set out in the chart. Performance against SCP is impacted by demand fluctuations and sensitive to any changes in capacity in tumour site MDTs. Following a period of deterioration in quarters 1 and 2, performance improved at the end of the year, recovering to 63.1%



Notable improvements are observed in gynaecological oncology, where SCP compliance increased from 37.5% in November to 73.3% in February, while Head and Neck pathways have seen backlog reduction following the resumption of weekly review meetings. Colorectal services remain a key focus, with a detailed recovery action plan now in place to address challenges at the initial diagnostic stage, including the ongoing impact of high DNA and short-notice cancellation rates within endoscopy. The 62-day



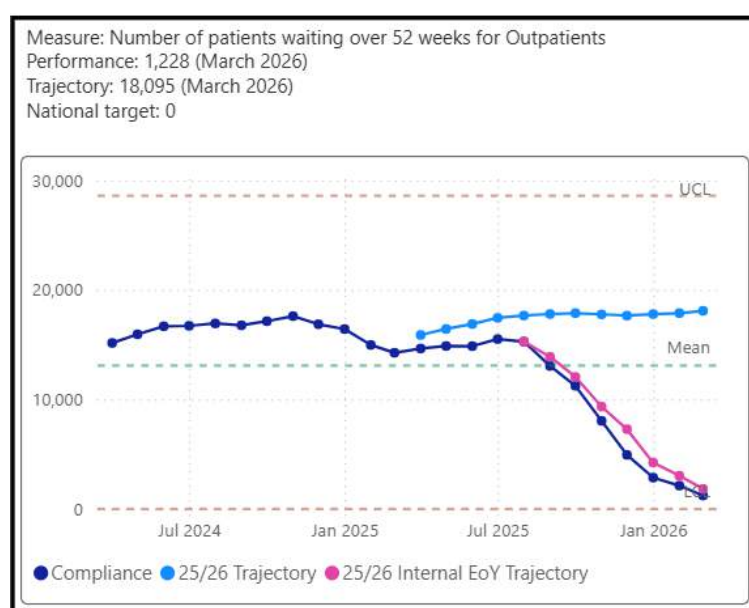
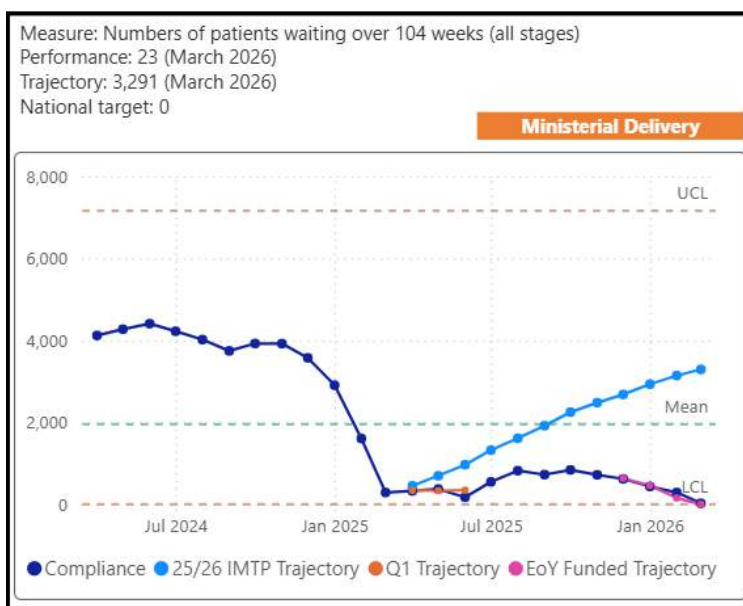
backlog reduced steadily from a peak of around 390 in September down to 310 at year end, equating to 9.5% of the total Patient Tracking List (PTL) and within the intended ~10% tolerance. The 104-day backlog has remained broadly stable over the last two quarters of the year and delivery against the 28-day treatment start standard from decision to

treat remained consistent throughout the year, ranging between 86.9% and 92.8%, and consistently above the mean, demonstrating sustained performance despite pathway pressures.

5.4.2 Planned Care

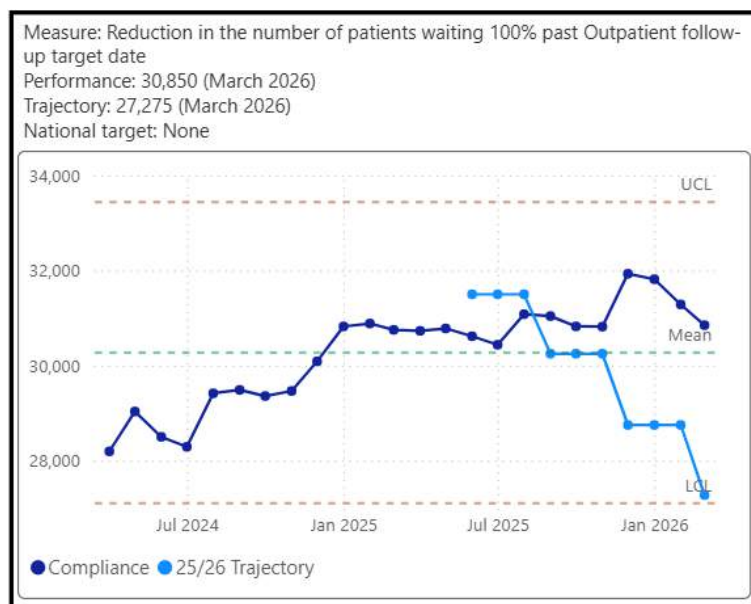
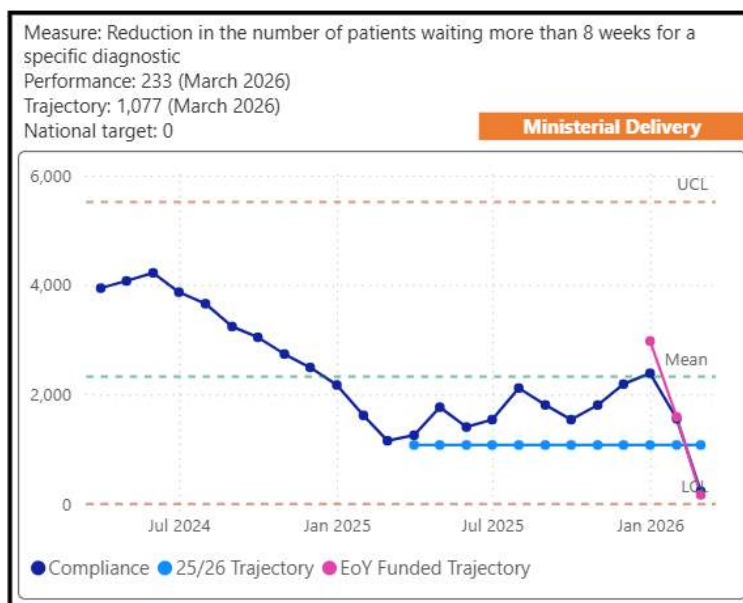
Planned care performance delivered a significant improvement during 2025/26, underpinned by strong organisational focus and targeted investment following national non-recurrent funding for both treatments (104 week waits) and outpatients (national insourcing programme). The Health Board reduced the number

of patients waiting over 104 weeks to 23 patients by March year end, the lowest position since April 2020. This represented a substantial achievement against a challenging trajectory that aimed for zero, with an acknowledged delivery risk of 30–40 patients in Orthopaedics. This



outcome was enabled a substantial, cross divisional effort across multiple teams. Performance against the 52-week new outpatient standard also improved, driven by the national outpatient insourcing programme, which contributed to a sustained reduction from August and delivered a year-end position of 1,228 patients over 52 weeks (down from 14,265 12 months previous). This was lower than the end of year forecast figure of 1,834 and represents the Health Board's lowest 52-week outpatient position since August 2020. Strong delivery as part of the national outpatient insourcing programme was central to this reduction, with 33,203 appointments achieved against a planned total of 33,612, equating to 98.8% contract delivery and demonstrating effective management of what was a hugely resource intensive programme to deliver within the Health Board.

Diagnostic performance against the 8-week standard improved markedly during the final quarter of 2025/26, following an intensive programme of recovery work supported by additional, non-recurrent funding. This resulted in a reduction in the numbers of patients waiting more than 8-weeks, falling from 1,557 in February to just 233 at year end. The year-end position saw zero breaches across several modalities, including endoscopy, neurophysiology and urodynamics, and a global 8-week compliance rate of 98.9%. The outcome reflects sustained organisational focus and the collective efforts of a wide range of clinical, operational and support teams, whose contribution has been instrumental in delivering this milestone improvement in performance.



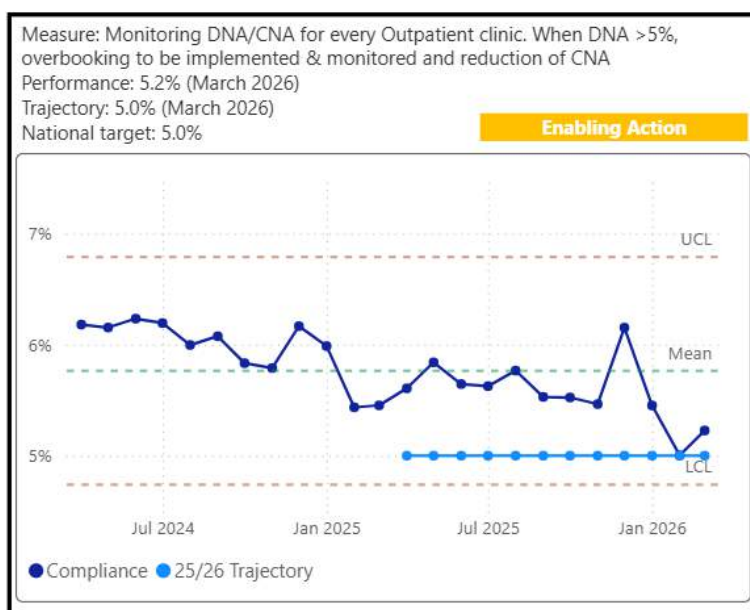
The number of patients on the follow up list delaying has remained fairly stable through the year and not achieved the reduction intended. Similarly, whilst comparatively achieving a good rate, the rates of See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) also did not fulfil the trajectory although improvements were demonstrated in the final

quarter of the year.

The Outpatient Transformation Programme continues to maintain a strong focus on managing patients with the longest follow-up waits, working closely with clinical leads and Directorates to ensure patients are

appropriately booked, clerically validated or clinically reviewed. Local SOS and PIFU pathways were established across services, with further work underway to ensure consistent utilisation and identify additional opportunities. Retrospective application of SOS and PIFU pathways is planned for 2026/27 as part of the wider validation strategy. Targeted clinical validation has already begun, including within ENT services, resulting in patients being discharged or appropriately transitioned to SOS or PIFU pathways where clinically suitable.

A key indicator of efficiency, Outpatient clinic 'Did Not Attend' (DNA) rates

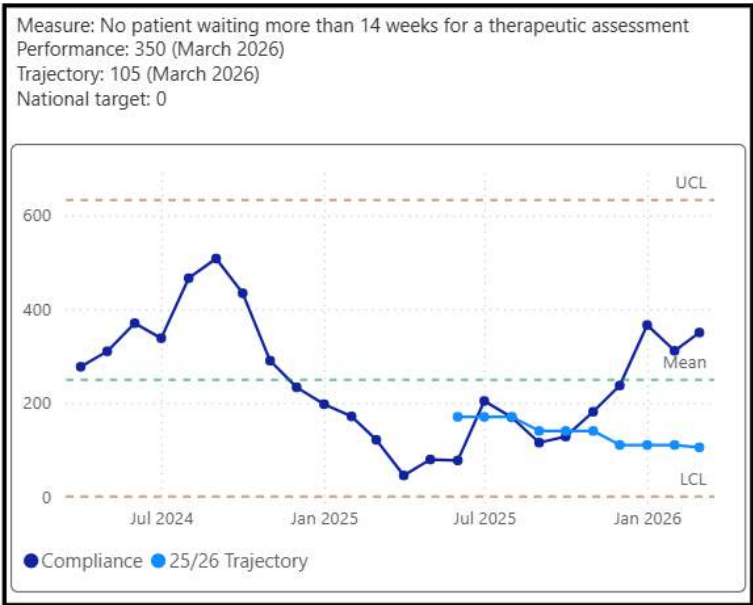


steadily improved throughout 2025/26. A targeted approach at specialty level was key to this improvement and will be further build on to address issues of variation where there is persistently higher DNA and CNA rates, supported by the widespread implementation of text message reminders across the majority of clinics. In

addition, work has commenced with Public Health colleagues to better understand cohort-specific factors influencing non-attendance within Care of the elderly (COTE) services, helping to inform more tailored and preventative interventions going forward.

5.4.3 Audiology and Therapies

Audiology and therapy services experienced increased pressure during 2025/26 as a result of system-wide elective recovery activity and rising demand. Within adult audiology pathways, additional demand generated through the national outpatient insourcing programme in ENT led to increased referrals into Adult Hearing New and diagnostic pathways, resulting in higher than planned numbers of patients waiting more than 14-weeks. In contrast, paediatric audiology benefited from targeted end-of-year investment, enabling a reduction in long waiting patients and delivering a year-end position lower than at the start of the year and well below planned levels. Across therapy services, 14-week performance

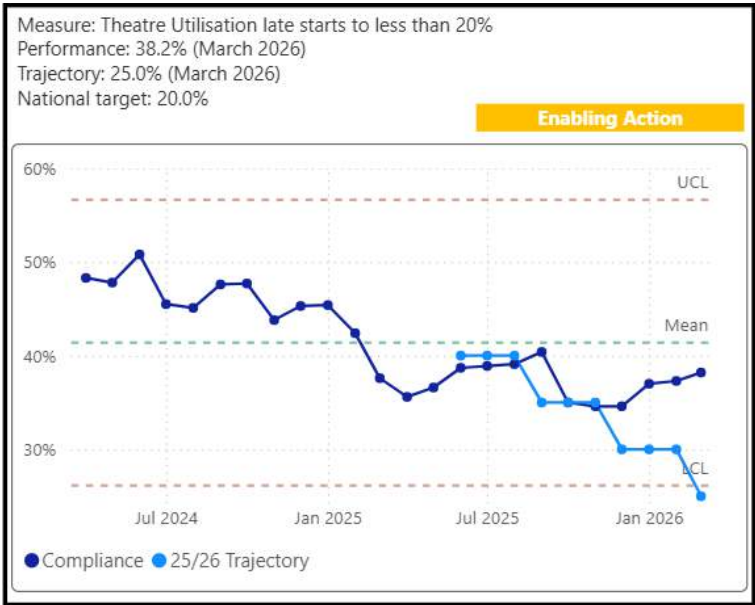


deviated from the IMTP trajectory in the second half of the year, reflecting ongoing capacity challenges. Dietetic services continue to face workforce constraints, particularly within paediatrics and gastroenterology. Physiotherapy services have also seen increased demand due to higher volumes of spinal and

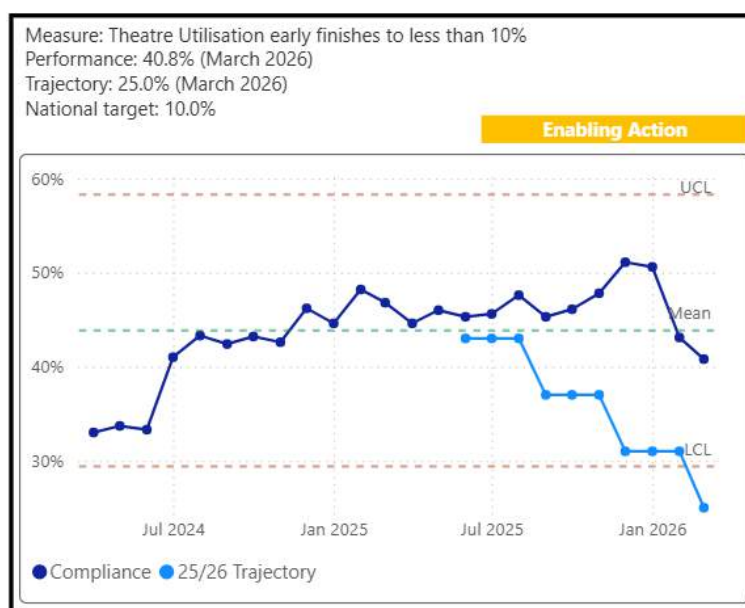
knee referrals redirected from Orthopaedics, alongside a planned reduction in capacity to support delivery of the end of year 104-week RTT performance.

5.4.4 Theatres

Performance against key Theatre efficiency metrics during 2025/26 was variable across the suite of metrics, with some showing signs of improvements and others remaining relatively static. Elective theatre protection has been consistently maintained for the past 18 months, minimising disruption to planned care and continuing to demonstrate a key advantage of the service redesign with the opening of the GUH. Improvements in late starts have been delivered over the past two years, supported by the full implementation of Autosend and Golden Patient initiatives across all sites. These projects have helped standardise processes and improve readiness at the start of the day to maximise the time available. However, the additional improvement anticipated

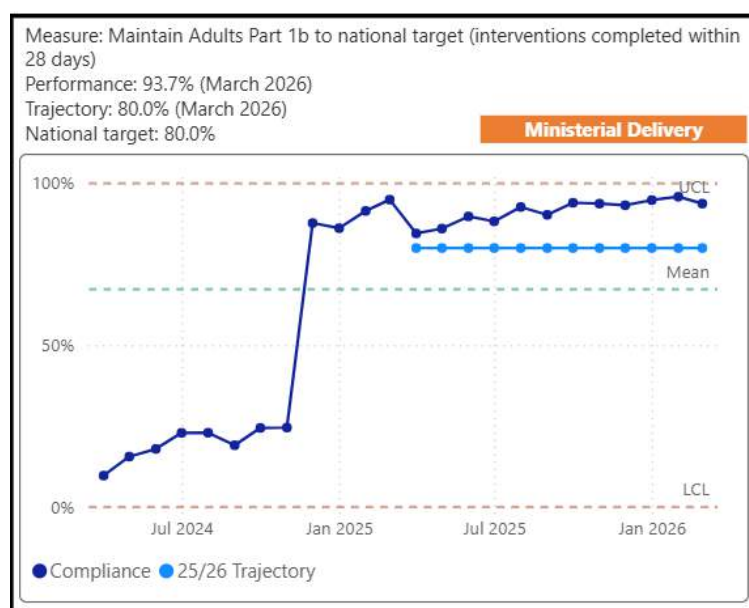


in the second half of the year was not fully realised, reinforcing the need for continued attention to list preparation, resource alignment and operational discipline. Early finishes remain a key challenge and continue to sit behind the IMTP trajectory; encouragingly, performance improved notably in the final two months of the year, with March recording the lowest early finish rate since June 2024. This indicates growing traction from optimisation actions, although further improvement is required to maximise productive theatre time. Session utilisation remained close to the national standard of 85% for most of the year, aside from expected seasonal variation. Day surgery performance has remained broadly aligned with national expectations, with BADS rates tracking near the 80% standard and ongoing maximisation meetings supporting delivery. Theatre optimisation, particularly reducing late starts and early finishes, remains a key organisational priority for 2026/27.



5.5 Improving our Mental Health services

Delivery Expectation	ABUHB commitment	Latest position	MD/TI/EA
Maintain Adults Part 1a to national target (assessment completed within 28 days)	80% (Mar-26)	86.6% (Mar-26)	MD
Maintain Adults Part 1b to national target (interventions completed within 28 days)	80% (Mar-26)	93.7% (Mar-26)	MD
Maintain Adults Part 2 rates (number of individuals with a valid care and treatment plan)	90% (Mar-26)	91.3% (Mar-26)	
Maintain rate of psychological therapy received within 26 weeks	60% (Mar-26)	46.9% (Mar-26)	
Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	80% (Mar-26)	99.0% (Mar-26)	MD
Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	80% (Mar-26)	80.4% (Mar-26)	MD
Maintain CAMHS Part 2 national target compliance	90% (Mar-26)	95.0% (Mar-26)	
Improvement in Neurodevelopment waiting times compliance	80% (Mar-26)	57.0% (Mar-26)	
Maintain 80% compliance of Specialist CAMHS Choice Assessments within 28 days from referral	80% (Mar-26)	94.5% (Mar-26)	

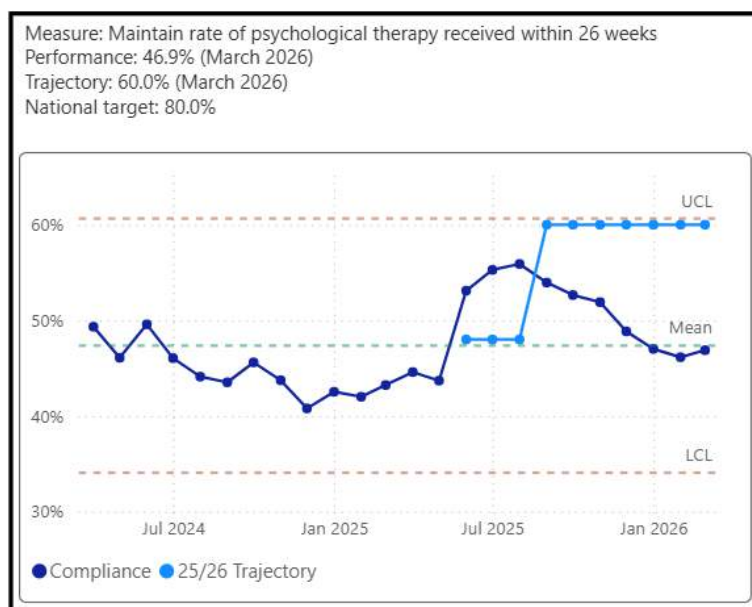


Delivery against the Mental health access standards during 2025/26 remained strong across the majority of core measures, reflecting effective demand and capacity management within both Adult and Children and Young People's services. Adult and CAMHS Part 1a and 1b standards were consistently achieved throughout the year. Adult and CAMHS 1a maintained continuous compliance

with national requirements. Adult Part 2 performance exceeded the IMTP trajectory across the year and surpassing the national standard of 90% from August onwards. While ongoing data cleansing activity continues, volumes of new Care and Treatment Plans (CTPs) and discharges are expected to stabilise, supporting sustained compliance.

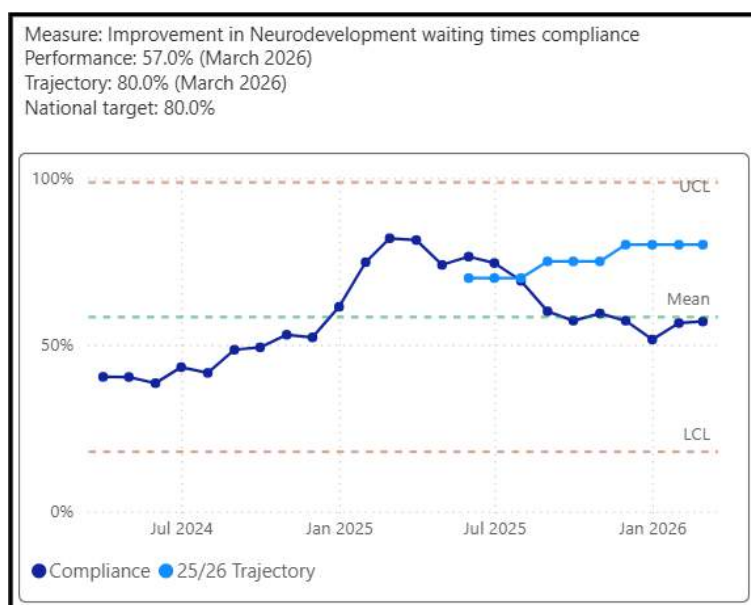
Similarly, Specialist CAMHS Choice assessments have continued to perform well above the national standard of 80%, despite temporary capacity

reductions earlier in the year, with improvement evident over the most final four months of the year. Within CAMHS Part 2, performance issues linked to non-compliance with CTP processes and data quality have been addressed through targeted audit activity, staff training, and the appointment of a dedicated CTP lead, resulting in a return to performance exceeding the national standard in the final four months of the year.



In contrast, some areas experienced increased pressure during the year, particularly within Psychological Therapies and CAMHS Neurodevelopmental pathways. Psychological Therapies performance declined during the second half of 2025/26, primarily because of workforce vacancies impacting capacity. In response, a revised divisional recovery plan has

been developed to support delivery of the 2026/27 trajectory, with an ambition to improve performance to 62% by end of 2026/27. This is supported by the implementation of performance dashboards across all adult teams, completion of booking process mapping, and the development of improved future-state processes.



CAMHS Neurodiversity services remain under sustained pressure, with increasing referrals and growing waiting lists contributing to performance stabilising at around 57% through the second half of the year. While this has impacted the 26-week standard, the service has consistently maintained the ministerial requirement for longest waits

to remain below 52 weeks. Strengthened screening processes and continued progress toward full implementation of the Neurodiversity Early

Support Hub model are expected to support improved pathway consistency and capacity during 2026/27.

5. Delivering the IMTP Priorities 2025/26

This chapter updates on delivery against the five system change themes and the key priorities outlined in our Three-Year Plan 2025/26.



6.1 Embedding Prevention and Population Health in all that we do

In Gwent there is the largest gap in healthy life expectancy between our least and most deprived communities of any Health Board in Wales. Male predicted years in healthy life at birth varies from 55.6 years in Blaenau Gwent to 68.7 years in Monmouthshire. Female predicted years in healthy life at birth varies from 55.3 years in Blaenau Gwent to 69.3 years in Monmouthshire.

Our Director of Public Health's report on Preventable Premature Mortality called [We are Gwent](#) highlights that 1 in 3 deaths in Gwent between 2018-2022 happened prematurely, the three main causes are Cardiovascular Disease, Diabetes and Cancer which could have been preventable through regular physical activity, a healthy diet, not smoking, reducing alcohol consumption and through regular health checks.

Our Public Health Delivery Plan articulates how we work with partners and outlines our public health offer to them through five building blocks:

- Preventable Premature Mortality (including Women's Health)
- Best Start in Life
- Evidence Base
- Natural and Built Environment
- Resilient Communities (including Health Protection)

Under the system change theme of embedding prevention and population health in all that we do there were 4 key areas we committed to delivery against in our Plan for 25/26:

- **Resilient Communities & Health Protection:** Deliver the National Immunisation framework for Communities and accelerate action to embed community interventions that tackle the wider determinants of health recognising the local need and deprivation.
- **Best Start in Life:** Using the evidence developed in the Joint Strategic Needs Assessment to produce the Early Years Delivery plan with partnership commitment to deliver the actions.
- **Women's Health:** Working in partnership and understanding the gap in provision for Women implement the first Women's Health Hub in Gwent.
- **Preventable Premature Mortality:** Support our population to prevent premature mortality through targeted implementation of the Diabetes Prevention Programme and Hypertension Programme.

We made the following key achievements against these areas:

Embedding Prevention and Population Health in all that we do	
Priority	Achievements
Resilient Communities & Health Protection	- Plans successfully implemented to increase flu vaccination uptake in 2- & 3-years olds based on learning from the targeted programmes in Blaenau Gwent and Caerphilly - Delivered Vaccination Service to offer flu and COVID-19 vaccinations to care home residents ensured timely flu vaccination of housebound patients - Implemented the seasonal respiratory plan for all eligible cohorts coupled with an additional catch-up campaign for Respiratory syncytial virus (RSV) - Established vaccine equity task and finish group to ensure we provide targeted support to those who need it most - Implemented a Midwifery led quality improvement project to increase RSV vaccination uptake with support of the vaccination service in antenatal clinics - Integrated Wellbeing Network Leads have convened Well-being Collaboratives in specific communities which brings together Health Board services, local authority, third sector organisations, community groups, volunteers and community leaders - Driven actions to embed community-based interventions that address wider determinants of health as part of the ongoing partnership between Integrated Wellbeing Networks and Neighbourhood Care Networks ensuring activity remains aligned with local need and levels of deprivation
Best Start in Life	- Best Start in Life (BSiL) embedded as an area of focus for the Public Service Board (PSB) with a strategic Leadership Group to shape and steer an evidence-based regional delivery plan - A multi-agency workshop took place that agreed the approach and programme milestones required to improve outcomes in the first 1000 days - Agreed a Gwent wide BSiL definition and set of ambitions, as well as the proposed structure for the Early Years Delivery Plan, which will focus on programme assurance, priorities and developing a community of practice

	Draft priorities for improvement were shared with the Best Start in Life (BSiL) Leadership Group in Q4, with further refinement now underway through the Regional Management Group. Priorities include a focus on improving preconception, pregnancy planning support, and increasing breastfeeding in Gwent through promotion of the Pump Loan Scheme and Peer Support Groups
Women's Health:	- Priorities and pathways agreed and mapping work has completed to assess the current service provision against the baseline within specification - The first tranche of funding from Welsh Government was successfully approved to progress implementation of training, engagement, accreditation and validation - An application was submitted for the second tranche of Welsh Government funding to support implementation of additional education and training, increased community presence and virtual signage of hub and spoke model - The Women's Health Discovery Report has been completed and translated into an action plan to inform future development of the pathfinder hub with the first pathfinder hub for Gwent successfully launching in April 26
Preventable Premature Mortality:	- Hypertension case finding service is up and running across Gwent in its first three months, over 1,100 blood pressure checks were completed and over 80 patients identified as hypersensitive - Commenced development of contract and service model with identified delivery partners for hypertension treat to target (TTT) service - Delivery of the 12-week behaviour change programme continues and in the first six month the total invited to participate was 4,354 with a total of 1,769 appointments issued - The Diabetes Prevention Programme has secured short term funding and planning continues for its integration into the Cardiovascular Disease service from September 2026.

6.2 Progressing Place Based Models of Care and sustainability in Primary and Community Services

Neighbourhood Care Networks (NCNs) were developed over 10 years ago within Gwent. In 2022 the Strategic Programme for Primary Care launched the Accelerated Cluster Development programme which aimed to broaden professional engagement in NCNs beyond GP practices to include Community Pharmacy, Optometry, Dental, Nursing and Allied Health Professionals.

Aligned with our strategy Gwent 35 it is important now more than ever, to plan for the redirection of resources towards helping people in Gwent maintain good health and well-being, so they can lead fulfilled and healthier lives for longer.

Place Based Care has long been recognised as the strategic approach for:

- Building resilient and connected communities
- Prevention and earlier intervention
- Reducing health inequalities
- Collaborative working through multi-disciplinary teams
- Providing care closer to home and streamlining access to specialist care
- Reducing preventable admissions and optimal hospital discharge through a Home First approach

Under the system change theme of progressing Place Based Models of Care and sustainability in Primary and Community Services, there were 4 key areas we outlined we would deliver against in our plan for 2025/26;

- **Rightsizing of Commissioned Care:** On-going review of all placements and addressing any areas where targeted support is needed to ensure we deliver value and sustainability in Continuing Healthcare.
- **Access & Sustainability:** Ensure sustainable GP Services across Gwent and implement of new pathways for Primary Care Optometry Services. In addition, increase the number of Pharmacies providing

Pharmacist Independent Prescriber Service and services through Common Ailments Service.

- **Focus on Community Pathways:** Working in partnership with Secondary Care Services develop prioritised workplan for pathway development that shifts care from an acute setting.
- **Place Based Care:** Working in partnership create a whole system Community Model based on need through multi-professional integrated neighbourhood making the necessary shift in resources and decision making from acute settings into our communities building community resilience.

Progressing Place Based Models of Care and sustainability in primary and community services

Priority	Achievements
Rightsizing of Commissioned Care	- Continued to build on positive work to manage and reduce enhanced care in care home setting including introducing additional scrutiny on enhanced care and one to one placements - Community Health Care top 50 reviews were completed and associated actions taken forward resulting in efficiencies 25-26 identified saving targets have been met with £306k of full year savings achieved for top the 50 placements and £305k full year savings for Funded Nursing Care assessment process
Access & Sustainability	- Following completion of supplementary and enhanced service mapping Neighbourhood Care Network Leads engaged with practices to improve equitable provision of supplementary and enhanced services - Continued robust management of GMS contractual changes including an updated Vacant Practice Policy reflective of the change in procurement regulations and ongoing Support for 3 practices under the Sustainability Assessment Framework - All five revised clinical pathways for optometry services have been developed and are available across Gwent including the successful transition of Primary Care providers previously commissioned through Ophthalmic Diagnostic Treatment Centre
Focus on Community Pathways	- Established Clinical Interface Groups underway in Mental Health, Urgent Care and Surgery to support the shift of acute services into community settings delivering care closer to home - Implemented programme management approach to progress the delivery of the Eye Care Plan through a series of workstreams with dedicated leads overseen by the Eye Care Collaboration Board - The Local Oral Health plan was revised in the context of the new General Dental Service Regulations, oversight will be led from the newly re-established Integrated Oral Health Group
Place Based Care	- Established work programme with agreed pilot areas of Blaenau Gwent and Torfaen as a federated local authority and Integrated Service Partnership Boards - Integrated Service Partnership Boards developed a costed implementation plan that articulates how the priorities will be addressed and identifying the key partners and stakeholders - Integrated Wellbeing Network Leads are now active members of the Neighbourhood Care Networks embedding social prescribing to utilise community assets

6.3. Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways

The six goals for Urgent and Emergency Care remained a significant priority with dedicated programmes coupled with targeted action to address Enhanced Monitoring in the Emergency Department at Grange University Hospital.

A strategic, coordinated approach was essential to ensure the system delivered timely, high-quality care. By focusing on improving Ambulance handovers, reducing prolonged stays, and addressing care delays, the system continued to progress in enhancing patient outcomes and operational efficiency.

Developed joined up place-based teams with the appropriate community infrastructure is necessary to tackle the complex and interrelated factors that affect health and well-being outcomes and health inequalities. An approach that solely relies on treating or providing care for individuals whilst ignoring the wider range of community assets in a 'place' will only achieve a partial response.

Under the system change theme of improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways, there were 4 key areas we delivered against in our plan for 2025/26;

- **Admission Avoidance (Goal 1):** Ensure wider access to Community Hospitals from the community to avoid an acute admission is rolled out across all sites and deliver increased support to the Community and Care Homes.
- **Integrated Front Door (Goals 2,3&4):** Further develop our Emergency Care Models and improve experience in our Emergency Departments. In addition, take actions to reduce community falls.
- **Integrated Back Door (Goals 5&6):** Continue to embed the optimal Hospital flow across all sites and progress Trusted Assessor Model working with Local Authorities across Gwent.
- **Medical Service Redesign:** Implementation of Clinical Service Models that redesign our Medical Service across our Hospital sites.

Improving our Urgent and Emergency Care System focusing on experience, access and discharge pathways

Priority	Achievements
Admission Avoidance (Goal 1)	- Extended weekday expansion of Community Resource Teams commenced in September 2024. Since going live, the average weekly referrals are up 26% and accepted up 25% versus 2023/24 - The Extended Weekend Frailty Service pilot ran for 10 weekends (25 January–30 March 2025) to reduce admissions and support winter pressures. During this period, 40 patients were identified, with 24 suitable for Frailty and 8 referred for interventions, alongside 37 Rapid Medical referrals accepted by Community Resource Teams - Upskilled care home staff to recognise red flags in residents with deteriorating diabetes supported through the development of a new Directory of Services, which outlines the support and training available to care - The Future Care Plan (FCP) facilitators have delivered training to 14 care homes across Gwent, with further sessions consistently booked through to July 2026. 92 care homes staff (from the 14 homes) have been trained with 48 NHS staff
Integrated Front Door (Goals 2,3 &4)	- Combined Same Day Emergency Care (SDEC) patient throughput has increased substantially in 2025 with 'SDEC first' principles embedded at The Grange University Hospital - Following the successful initial care home education and training initiative, a bid was submitted for National funding to increase the number of care home participation - Improved capacity of the enhanced community falls response service in Gwent and partnership working with Wels Ambulance Services Trust to maximize impact of the level 2 response - Frailty based MDT pilot implemented from November to March where 320 cases were reviewed resulting in 57% of patients remaining at home and 85% avoiding conveyance to the Grange University Hospital when community hospital admissions were included as alternative pathways

Integrated Back Door (Goals 5&6)

- Continued to embed the Optimal Hospital Flow Framework across all sites to support continuous flow model
- Continued to monitor benefits and opportunities of the Transfer Lounge via Safety Flow

Medical Service Redesign

- Undertaken review of best practice models from Swansea, Leicester and Bristol
- Stakeholder engagement continued to develop optimal model and clinical criteria
- Older Person Pathway development progressed through working with clinical teams to define the clinical criteria at each stage of the pathway
- 12-week public and staff engagement for Stroke was completed with additional sessions organised for Stroke patients groups across Gwent

6.4 Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care

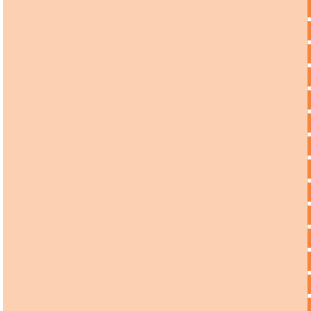
Planned Care and Cancer Services have continued to focus on reducing waiting times, streamlining pathways, and enhancing patient outcomes.

From a strategic perspective, these areas must be approached with a dual focus: meeting current demand while planning for future capacity. Rising referrals and treatments place additional strain on existing resources, making it essential to implement innovative solutions that enhance operational efficiency. Forensic-level management of patients along the Single Cancer Pathway is crucial for sustaining improvements in performance, patient experience, and clinical outcomes. This includes data-driven approaches to track progress, optimise pathways, and identify opportunities to reduce delays.

Under the system change theme of continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care, there were 4 key areas we outlined we would deliver against in our annual plan for 2025/26;

- **Single Cancer Pathway:** Working with Velindre University NHS Trust to deliver a new Satellite Radiotherapy Centre and Systemic Anti-Cancer Therapy Outreach Services in Gwent.
- **Health Pathways:** Achieve additional 50 localised Pathways live on Aneurin Bevan University Health Board local site.
- **Theatre Maximisation:** Theatres Service Model developed to inform the planning of a Day Case Centre of Excellence and delivery of improvements to increase Day Case activity.
- **Outpatient Transformation:** Ongoing monitoring of activity and opportunities for One-Stop Treatment Pathways in the Outpatient Treatment Unit and increased use of virtual clinics and identification of new pathways.

Continuing to prioritise Cancer, Urgent and the longest waiting patients for Planned Care	
Priority	Achievements
Single Cancer Pathway	- The Satellite Radiotherapy Centre in Nevill Hall Hospital opened in June 2025 for the first patient - Straight to test compliance has continued to progress across all tumour sites, with the exception of colorectal. For all tumour sites detailed recovery plans are in place to support this priority. - Systemic Anti-Cancer Therapy (SACT) outreach services has re-started at Nevill Hall Hospital in the Llanfoist suite following the closure of the Windsor suite due to RAAC - Work continues in partnership with Velindre NHS Trust on SACT outreach in line with new Velindre Cancer Centre opening in spring 2027 - Significant improvements within the Gynaecology Single Cancer Pathway, supported by the continuation of fortnightly Cancer Recovery Group meetings
Health Pathways	84 pathways are now live since 1st April 2025, this represents 188 pathways total - Page views have been consistently high throughout the year supported by dedicated education sessions increasing user traffic
Theatre Maximisation	- Planned Care Board workplan delivering key projects whilst also incorporating national priorities e.g. Clinical Implementation Network frameworks and Enabling Actions - A Theatres Service Model was developed to inform the planning of a Day Case Centre of Excellence as part of Nevill Hall Hospital Development Programme - Continued focus on day surgery maximisation to progress High-Volume Low Complexity lists - Successful implementation of golden patient in Grange University Hospital in September and is now rolled out across the Health Board - The Keeping Well Service continues to support patients who are experiencing long waits for planned care with a pilot to expand the service to incoming calls for Gynaecology in the new financial year
Outpatient Transformation	Increased use of virtual clinics compared to the previous year and the identification of new pathways through scoping of opportunities in CIN and GIRFT recommendations

- 
- Consistent communications in place to promote Consultant Connect, successful pilot of Neurology Epilepsy Patients Initiated Follow Up using Consultant Connect has resulted in opportunities in other specialties
 - Attendances in Outpatient Treatment Unit 25-26 were 3921, an increase of 1120 compared to the previous year
 - As part of the development of the one stop treatment pathways. The new one stop Gynae Heavy Menstrual Bleeding clinic is planned for 25-26 and scoping exercise is taking place for vasectomy procedures moving from daycase to treatment rooms.

6.5 Improving our Mental Health Services

Demand for Mental Health Services continued to increase highlighting the importance of finding ways to support people earlier with provision in the community with crisis prevention and recovery. The vision is to provide high quality, compassionate, person-centred Mental Health and Learning Disabilities Services, striving for excellent outcomes for the people for Gwent. There are several national strategic drivers including the Strategic Programme for Mental Health and National Programme for Suicide and Self harm Prevention.

Under the system change theme of improving our Mental Health Services there were four key areas we outlined we would deliver against in our plan for 2025/26:

1. **Quality Improvement:** Continue to engage with the work of the National Patient Safety Programme and embed and sustain the commitments within the Quality Improvement Plan.
2. **Ministerial Priority Performance:** Sustain progress of Part 1a and 1b for Adults and Children and improve measures for Psychological Services for Adults and start improvement project for Care Treatment Plans (CTP) for Children.
3. **Neurodevelopmental Services:** Complete Children's Neurodevelopmental Transformation Programme and deliver Single Neurodevelopmental Pathway for Adults.
4. **Rightsizing Inpatient & Transforming Community Services:** Develop model for Adult Inpatient, Community and Forensic Services. In addition, identify all access points into Mental Health Services and commence initial design options for Single Pathway.

Improving our Mental Health Services Achievements	
Priority	
Quality Improvement	- Fully engaged in the National Patient Safety Programme, contributing to the four national workstreams - Progressed the internal mock inspections for all wards throughout the year. All of Older Adult wards were complete and all of Adult wards apart from Carn Y Cefn have been completed. Feedback from wards that have completed the mock inspections was positive with staff finding the experience helpful and rewarding - Carn Y Cefn was subject to recent HIW inspection and therefore this audit will move into the 2026/27 financial year along with audits of all community teams - Embedded PROMS for adults and older adult functional services to ensure we act on what matters to individuals
Ministerial Priority Performance	- Increased triaging of referrals across Primary and Secondary Children & Adolescent Mental Health Services has supported a reduction in referrals which has enabled capacity to be flexed to meet both the 1A and 1B and support the waiting list for interventions despite having a significant rise in sickness absence - Care and Treatment Plan improvement has been delivered through a model change to commence aligned to the recovery plan for Part 2 improvement plan for Children and Young People - Psychological Therapies for Adults performance improved to 54% in October 2025, with a continued steady improvement since July 2025. Joint pathway work with Primary Care continues focusing on understanding the alignment between service areas - Part 1a and Part 1b progress was maintained throughout 2025/26 for Adults, with the service being consistently above the target of 80% in both Part1a (assessments completed within 28 days) and Part 1b (interventions completed with 28 days)
Neurodevelopmental Services	Whilst National Funding for Adults ADHD service ceased in 25/26 we put plans in place to manage the caseload and secured funding for ADHD for 2026/27 and will be developing the strategic direction for the service going forward.

	• The Children & Young People needs-led model is embedding across teams, evidenced by a shift from universal to targeted support and improved appropriateness of referrals entering the specialist pathway • For Children & Young People RTT increased slightly to 56.51% in February, indicating early signs of stabilisation despite rising demand with RIF funding secured for 2026/27, maintaining existing staffing and helping stabilise waiting times • Website development and digital access pathways continue to progress as a key improvement action.
Rightsizing Inpatient & Transforming Community Services	• All Crisis services have been scoped as part of the work around a Single Point of Access and the development of our 111 press 2 Mental Health Service • Continue to work in partnership with NHS Wales Performance and Improvement Team to progress towards Open Access and the Stepped Care 2.0 model • Following completion of a review of the Learning Disability service model work is continuing to develop the models of care for learning disabilities, including a pilot reducing the number of beds within the inpatient unit • An implementation plan is being developed which will inform actions needed in 26/27 to deliver the models of care programme for Adults, Older Adults and Community services

7. Decarbonisation and Sustainability

The Health Board's Decarbonisation and Sustainability Programme which runs across all workstreams across the Health Board is well-established and aligned with Welsh Government's National Strategic Delivery Plan. Work continues to refine and mature the reporting framework so that progress can be tracked consistently across all workstreams, with an emphasis on understanding how decarbonisation benefits our communities and supports equity.

Key deliverables in 2025/26 include:

- **Strengthening staff communications and engagement**, helping increase awareness of and participation in decarbonisation and sustainability activities across the organisation.
- **Developing and implementing site-specific biodiversity plans** to enhance nature recovery and environmental value across Health Board estate locations.
- **Progressing the Refit energy-efficiency programme** and advancing work on alternative energy generation facilities to reduce long-term carbon emissions.
- **Reviewing prescribing and procurement practices** to support low-carbon, environmentally sustainable choices in line with emerging national priorities.
- **Embedding sustainable change within the newly established Waste Group**, ensuring decarbonisation is a core feature of both operational delivery and strategic planning.
- **Strengthening monitoring and reporting processes**, including prioritisation of viable initiatives, target setting, improved data collection to support accurate carbon calculations, and routine reporting of progress.
- **Publishing of the sustainable IV Paracetamol guidelines** following endorsement by the Medicines Management Programme Board and the Medicines and Therapeutics Committee for a targeted reduction in its use in favour of oral paracetamol whenever clinically appropriate which has a significantly lower carbon footprint.

The Decarbonisation Programme Annual Report 2024/25, which outlines the positive progress being made by the Health Board to reduce its Carbon Footprint, was received by the Finance and Performance Committee in April 2026 and is available on the following [link](#). It is anticipated that the 2025/26 performance data will be reported in Quarter 4 2026/27.

The workplan for 2026/27 includes bringing the Health Board up to full compliance with the new recycling regulations, developing mandatory



sustainability training for staff and transitioning to reusable sharps containers.

8. Quality & Safety

The strong focus on improving the quality, safety and care of the services that we provide to our population continued throughout 2025/26 with the ongoing implementation of our *Quality Strategy 2023-26* [ABUHB Quality Strategy 202326](#). The Strategy supports the Health Board's legal responsibilities under the Duty of Quality and Duty of Candour, ensuring that we are always open, transparent and focused on what is right for patients.

The Health Boards Quality and Safety Performance report which is produced for the Patient Quality, Safety and Outcomes Committee and the Board brings together intelligence drawn from established reporting systems, including patient feedback platforms, the Once for Wales Datix system, Qlik dashboards and validated infection surveillance data. This data is mapped against the Health Board's Six Pillars of Quality as set out below.

8.1 Patient Experience and Feedback

Overall patient satisfaction remains stable at 87% over the year. Friends and Family Test results are unchanged, with an overall score of 83% and a negative response rate of 10%. The lowest scoring experience question continues to relate to waiting times, with a noted decline in March, indicating an ongoing risk to patient experience. Work continues to expand feedback coverage, address areas with limited engagement, and embed new national surveys, including those aligned with the Listening to People regulations and accessible formats.

8.2 Concerns and Complaints

Putting Things Right and Listening to people Performance against the 30-day response target for formal concerns dipped in January, reflecting operational pressures and a significant increase in complaint volumes. Despite this, January was the first time the Health Board exceeded the national average for compliance.

Targeted work was put in place to reduce the backlog of overdue complaints continues, including enhanced oversight of cases exceeding nine months, divisional trajectories and deep-dive support. March saw the highest number of case closures this year with progress made in reducing cases over twelve months, although this work remains resource intensive and requires significant senior and Executive involvement.

Early Resolution performance has improved substantially compared to the previous year. The introduction of the Listening to People regulations, including a ten working-day Early Resolution timeframe, has encouraged this and been supported by enhanced Putting Things Right training, twice weekly case reviews and dashboard monitoring.

8.3 Incidents and Patient Safety

Reported patient safety incidents continue to increase year-on-year. This growth is primarily driven by no-harm incidents, which are suggested to reflect improved reporting culture and awareness.

Falls data shows month-to-month variation but no evidence of sustained upward trend. The majority of falls continue to be assessed as resulting in no or low harm and falls rates per occupied bed day remain below the national benchmark. The Health Board introduced a revised process in year for reviewing falls with severe injury and published an updated Falls Policy for Hospital Adult Inpatients.

Pressure ulcer reporting shows a gradual reduction over time; however, interpretation is cautious due to delays in case closure and increased numbers of open incidents. Focused reviews for all grades of pressure damage are in place to improve the accuracy of avoidable v. unavoidable reporting.

Medication and IV fluid incidents show an upward trend, with administration errors remaining the most common category. Most incidents continue to result in no or low harm, and system improvements to enhance monitoring and targeted training are in progress.

The number of open Nationally Reportable Incidents has reduced over the past year, with improved compliance and a significant reduction in overdue cases. There has been a reduction in Early Warning notifications compared to 2024/25. Mental health-related incidents remain a prominent theme.

Reported Duty of Candour incidents have also fallen in 2025/26 compared to 2024/25 with cases continuing to be subject to the formal Duty of Candour process to support transparency and communication with those affected.

Learning from Events financial penalties have reduced significantly following service and divisional improvements. Open inquests remain high, generating pressure across the organisation, although there is positive use of written hearings.

8.4 Health Safety and Security

Improvements in safety compliance continue and there are ongoing workstreams in place both locally and nationally to improve this further.

Compliance against RIDDOR which is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations to the Health & Safety Executive has increased with the improvement attributed to clearer guidance and additional training although there are still improvements to be made.

Health and Safety mandatory training remains around 85% compliance for Fire Safety, Violence Prevention and Reduction and Health and Safety but has reduced in year for manual handling training. A range of actions to improve this are being taken including onboarding additional manual handling trainers, applying a risk-based approach to training requirements based on what is most appropriate to staff roles and exploring further initiatives to address barriers such as staff release time.

8.5 Infection rates

Infection Prevention and Control Healthcare-associated infection rates show reductions in some areas, including C-Difficile and staphylococcal bloodstream infections. Winter ward closures due to norovirus continued in 2025/26 and highlight ongoing system pressures. Workforce shortages, isolation capacity and environmental cleaning challenges continue to affect resilience.

The Health Board is taking ongoing actions to address these challenges including rapid outbreak responses, isolation and cohorting where possible, implementing advanced cleaning techniques and progressing anti-microbial stewardship to promote the appropriate use of antimicrobials including antibiotics to present their future effectiveness, improve patient outcomes and reduce the development of resistance.

8.6 Safeguarding

This was the final year of the Gwent Safeguarding Board's strategic plan 2023-26 which covers both adults and children. The priorities of this multi-agency plan are to protect children and adults from neglect and harm, protect those at risk of exploitation and improve safeguarding arrangements across the region.

At a Health Board level, Child level 1 and 2 and Adult level 1 and 2 safeguarding training continue to report compliance around the 85% benchmark whilst compliance with Adult and Child level 3 training continues to rise, with the Health Board on track to achieve our compliance target by March 2028.

9. Equality, Diversity and Inclusion

The Health Board remains committed to promoting equality, diversity and human rights across its workforce and the services it provides to the population of Gwent. During the reporting period, the Health Board has continued to progress delivery of its Strategic Equality Plan (SEP) 2024–2028, strengthening the integration of equality, diversity and human rights considerations across workforce practice, service delivery and organisational governance. This work supports the organisation’s statutory responsibilities under the Equality Act 2010, the Human Rights Act 1998, and the Public Sector Equality Duty (Wales) Regulations 2011.

Progress during the year has focused on embedding the Health Board’s equality objectives across key organisational programmes, including the People Plan, workforce development initiatives and service improvement activity. Governance and oversight arrangements have also been strengthened to ensure greater organisational accountability for equality, diversity and human rights delivery. Regular assurance on EDI activity continues to be provided to the Board through the People and Culture Committee, including monitoring progress against the Strategic Equality Plan and associated action plans

The Health Board has also continued to develop initiatives to support a more inclusive organisational culture, including strengthening engagement with staff networks, promoting inclusive leadership and progressing work to improve accessibility and equity in communication and information for patients and staff. This includes ongoing work aligned with the All-Wales NHS Accessible Communication and Information Standards (ACIS).

The Health Board continues to meet its statutory equality reporting requirements, including the annual publication of Gender Pay Gap data, based on the workforce snapshot taken on 31 March each year in line with national reporting requirements. The Health Board has seen a decrease in the pay gap percentage for average hourly rates, from 24.71% in March 2024 to 23.8% in March 2025, which is a move in the right direction. The median hourly pay gap has also reduced, from 9.69% in March 2024 to 6.13% in March 2025.

Through these arrangements, the Health Board maintains appropriate control measures to support compliance with equality, diversity and human rights legislation and to promote an inclusive and equitable environment for staff, patients and the communities it serves.

10. Welsh Language Requirements

The Health Board publishes an Annual Report in relation to Welsh language service delivery on its website bilingually. This fulfils the Health Board's statutory duty to provide the Welsh Language Commissioner with an annual account of compliance with the Welsh Language Standards in accordance with the Welsh Language (Wales) Measure 2011. Prepared in line with Welsh Language Standard 120, the report outlines our progress, highlights key achievements, and sets out our strategy and future plans in this area.

Some of the notable points from our work in the last year include:

- The development and approval of the Health Boards 5-year plan to increase the offer of clinical consultations through the medium of Welsh in line with the requirements of Welsh language Commissioner's standard 110. In line with the guidance received from the Commissioner's office, this new plan focusses on a specific service.
- Development of a learning programme that matches the need of the member of staff with the appropriate learning mechanism. This includes digital learning tools as well as tutor led courses. A specific confidence building mechanism places a dedicated tutor to work one on one with individuals who had higher levels of Welsh language abilities but have lost confidence in those skills.
- A robust programme of engagement events has been established with learners throughout their education journey. This includes fluent Welsh speaking students and Welsh learners, ensuring the Health Board is the employer of choice when they have finished their studies.
- A Welsh language awareness workshop was delivered to divisional managers across the Health Board to look at bespoke action plans to improve compliance and provide a better service to our service users. The Welsh language unit also delivers awareness sessions in a number of the Health Boards key learning and induction programmes, such as the 'Leadership Development Programme' and both the 'Newly Registered Nurse, and Health Care Supporter' induction programmes.

As a Health Board, we collaborate with partners across NHS Wales via the Welsh Language Leads group to identify and progress areas of collective focus. We maintain constructive engagement with Welsh Government and are committed to upholding a strong, positive relationship with the Welsh Language Commissioner's Office, ensuring we deliver the best possible care for our Welsh-speaking population.

11. Financial Management and Performance

The Annual Accounts 2025/26 in Section 3 of the Annual Report page XX set out the detailed accounts for the full year to 31 March 2026 for Aneurin Bevan University Health Board. These accounts are prepared until International Financial Reporting Standards (IFRS).

The Health Board has two statutory financial duties:

- To breakeven over a rolling three-year period; and
- To submit an IMTP to secure compliance with breakeven over three years

11.1 Revenue Resource Performance

The Health Board has not met its financial duty to break even against its Revenue Resource Limit over the three years 2023/24-2025/26. For the period 2025/26 the Board reported an overspend of XXX as shown in the table below:

3-year Revenue Breakeven duty	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Underspend against allocation	-49,766	-7,185	-18,282	-75,233

11.2 Capital Resource Performance

In addition to a revenue resource limit, the Health Board has a capital resource limit (CRL) that sets the target for capital expenditure. The Health Board met its financial duty to break even against its Capital Resource Limit over the 3 years 2023-24 to 2025-26. The target is measured over a three year period as shown in the table below:

3-year Capital Resource duty	2023/24 £'000	2024/25 £'000	2025/26 £'000	Total £'000
Underspend against allocation	41	66	47	154

11.3 Long Term Expenditure Trends

The below table sets out the long-term expenditure trends of gross operating costs across expenditure on Primary Healthcare Services, Healthcare from other providers and Hospital and Community services.

Analysis of gross operating costs

	£'000	£'000	£'000	£'000	£'000	£'000
	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Expenditure on Primary Healthcare Services						
General Medical Services	108,993	112,524	116,217	122,671	132,671	140,047
Pharmaceutical Services	27,109	25,082	25,273	25,756	29,224	29,396
General Dental Services	33,079	38,030	39,817	39,870	44,444	45,761
General Ophthalmic Services	8,734	9,343	8,866	10,659	15,075	17,251
Other Primary Health Care expenditure	2,289	2,487	2,612	4,373	4,729	3,715
Prescribed drugs and appliances	106,852	106,282	114,331	121,947	125,771	130,678
Total	287,056	293,748	307,116	325,276	351,914	366,848

	£'000	£'000	£'000	£'000	£'000	£'001
	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Expenditure on healthcare from other providers						
Goods and Services from Other NHS bodies	103,278	117,637	117,587	129,254	133,420	139,949
Goods and services from NHSW JCC	161,384	177,035	198,320	208,640	218,320	232,273
Continuing Care	81,347	83,675	86,006	99,136	99,904	110,957
Other	71,795	85,054	72,240	71,368	75,559	91,411
Total	417,804	463,401	474,153	508,398	527,203	574,590

Expenditure on Hospital and Community Health Services

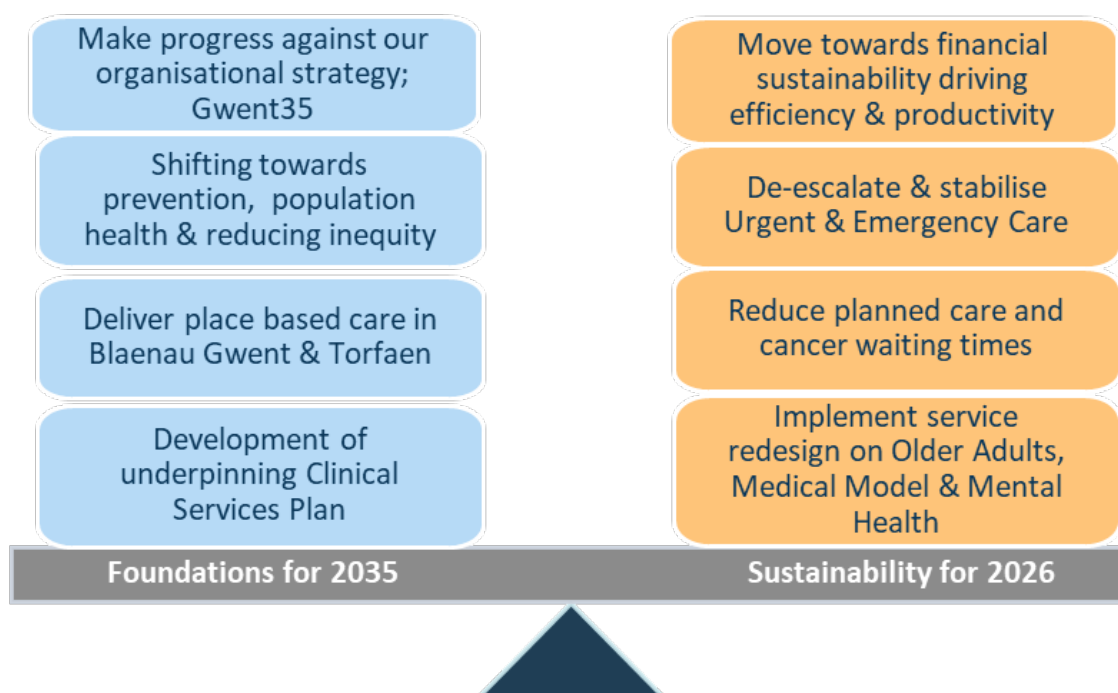
	£'000	£'000	£'000	£'000	£'000	£'001
	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Staff Costs	671,972	714,255	762,081	788,715	888,882	958,465
Non Pay	172,611	191,827	200,118	238,743	221,025	224,509
Depreciation and Impairments	96,361	31,056	30,804	59,994	49,908	46,193
Losses, special payments and irrecoverable debts	1,886	2,831	1,526	3,217	3,065	8,725
Other operating expenses	8,526	11,009	9,538	14,599	14,310	15,138
Total	951,356	950,978	1,004,067	1,105,268	1,177,190	1,253,030

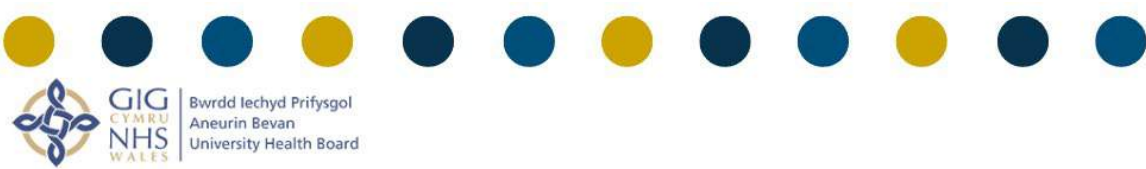
12. Conclusion and Forward Look

Significant progress has been made as the organisation strives to deliver improvements in quality and performance and come out of areas of escalation. The organisation is proud of its achievements in 2025/26 which include:

- Significantly reducing the number of patients waiting over 104 weeks for treatment and waiting over 52 weeks for first outpatient appointments
- Achieving over 80% on mental health Part 1a and Part 1b targets for adults and children
- Markedly reducing the number of ambulance handover delays
- The Emergency Department in the Grange University Hospital achieving its highest compliance against the 12 hour target
- Sustaining progress with Pathway of Care Delays by continuing to reduce the volume & numbers of days patients are delayed
- Increasing the number of neonates that receive weight & measurement at 8 weeks throughout the year
- A continued shift of services into the community through common ailment services and independent prescribing in community pharmacies

Looking forward to next year's plan, the below sets out the commitments for 2026/27 and beyond as the organisation continues its path to sustainability whilst making progress in delivering our new organisational strategy Gwent 35: Better Health, Better Care, Better Lives and addressing the immediate financial, service and quality challenges and opportunities:





Next year’s plan outlines the targeted actions we will take against the three strategic aims of:

- 1. **Better Health:** Together we will support people to be healthy, active, & happy
- 2. **Better Care:** Together we will deliver what matters to people – supporting our staff to thrive & achieving quality, kind, & sustainable care
- 3. **Better Lives:** Together we will create strong, safe, & connected communities

The diagram below outlines the four priorities against each of the strategic aims which will be progressed in 2026/27

Better Health: Together we will support people to be healthy, active, & happy.	Health Protection	Health Improvement
	Prevention	Babies Children & Young People
Better Care: Together we will deliver what matters to people – supporting our staff to thrive & achieving quality, kind, & sustainable care.	Place Based Care	Access & Sustainability
	Improving Quality & Experience	Embedding Value & Efficiency
Better Lives: Together we will create strong, safe, & connected communities.	Healthy Places	Resilient & Connected Communities
	Safe Spaces	Quality of Life

Signed:
Nicola Prygodzicz
Chief Executive

Date:

Part 2: Accountability Report

**1st April 2025 –
31st March 2026**



INTRODUCTION TO THE ACCOUNTABILITY REPORT

Aneurin Bevan University Health Board is required to publish, as part of our annual reporting, an Accountability Report. The purpose of the Accountability Report section of the Annual Report has been designed to demonstrate the ways in which the Health Board is meeting its key accountability and reporting requirements.

This Accountability Report has three sections:

- **Corporate Governance Report**

This explains the composition of the Health Board, its governance structures and arrangements and how the Health Board seeks to achieve its objectives and responsibilities to meet the needs of the people we serve. The Corporate Governance Report includes:

- A. The Directors' Report
- B. The Statement of the Chief Executive as the Accountable Officer and the Statement of Directors' Responsibilities in respect of the Accounts
- C. The Annual Governance Statement.

- **Remuneration and Staff Report**

This section contains information about the staff of the organisation, particularly focusing on the remuneration of its Board and senior management, fair pay ratios and other staff information, such as sickness absence rates.

- **Senedd Cymru/Welsh Parliament Accountability and Audit Report**

This section contains a range of disclosures on the regularity of expenditure, fees, charges, compliance with cost allocation, material remote contingent liabilities, long-term expenditure trends and charging requirements set out in HM Treasury guidance.

Corporate Governance Report 2025/26

Including:

A: The Directors' Report

**B (1): The Statement of the Chief Executive
as the Accountable Officer**

**B (2): The Statement of Directors'
Responsibilities in respect of the Accounts**

C: The Annual Governance Statement

A: THE DIRECTORS' REPORT

Aneurin Bevan University Local Health Board is a statutory body that was established on 1st June 2009 and became operational on the 1 October



2009 under *The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)*, "the Establishment Order".

The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779) ("The Constitution Regulations") set out the constitution and membership arrangements of Local Health Boards, the appointment and eligibility requirements of members, the term of office of non-officer members and associate members. In line with these Regulations the Board of Aneurin Bevan University Health Board comprises:

- a chair;
- a vice-chair;
- officer members; and
- non-officer members.

The members of the Board are collectively known as "the Board" or "Board members"; the officer and non-officer members (which includes the Chair) are referred to as Executive Directors and Independent Members respectively. All members have full voting rights.

In addition, Welsh Ministers may appoint up to three associate members. Associate members have no voting rights.

Before an individual may be appointed as a member or associate member they must meet the relevant eligibility requirements, set out in *The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)* ("The Constitution Regulations"), and continue to fulfil the relevant requirements throughout the time that they hold office. The Regulations can be accessed via the Government's legislation website:

<http://www.legislation.gov.uk/wsi/2009/779/contents/made>

Further detail on the Board's membership and composition during 2025/26 is available within Section C: The Annual Governance Statement.

Board Members' Interests

Details of company directorships and other significant interests held by members of the Board which may conflict with their responsibilities are maintained and updated on a regular basis.

The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Aneurin Bevan University Health

Board, and staff across the organisation, in line with the Standards of Business Conduct Policy, as at the 31st March 2026. This information is available on the Health Board's Internet site and can be accessed by following this [link](#).



Personal Data Related Incidents

Information on personal data related incidents formally reported to the Information Commissioner's Office and "serious untoward incidents" involving data loss or confidentiality breaches are detailed on page XX of the Annual Governance Statement at Section C.

Environmental, Social and Community Issues

The Board is aware of the potential impact that the operation of the Health Board has on the environment and it is committed to wherever possible:

- Ensuring compliance with all relevant legislation and Welsh Government Directives;
- Working in a manner that protects the environment for future generations by ensuring that long term and short-term environmental issues are considered; and
- Preventing pollution and reducing potential environmental impact.

The Health Board complies with Biodiversity and Resilience of Ecosystems Duty under Section 6 of the Environment (Wales) Act 2016, which seeks to enhance resilience and biodiversity across the Health Board's estate.

The Health Board also complies with the Social Partnership Duty in Wales, established by the Social Partnership and Public Procurement (Wales) Act 2023, which mandates that the Health Board works with trade unions and other worker representatives when making strategic decisions about their well-being objectives.

The Board's Integrated Medium Term-Plan (IMTP) 2025-28 (approved by the Board March 2025) sets out the Board's strategic priorities which have been set within the context (environmental, social and community issues) in which the Health Board is operating within.

The Performance Report (Part A) of the Annual Report and Accounts 2025/26 provides greater detail in relation to the achievements of the Health Board in delivering the IMTP during 2025/26.

Statement for Public Sector Information Holders

In-line with the disclosure requirements set out by the Welsh Government and HM Treasury, the Health Board confirms that it has complied with the



cost allocation and charging requirements set out in HM Treasury guidance during the 2025/26 year.

B(1): STATEMENT OF THE CHIEF EXECUTIVE AS THE ACCOUNTABLE OFFICER OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD

The Welsh Ministers have directed that the Chief Executive should be the Accountable Officer for Aneurin Bevan University Local Health Board. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officer's Memorandum issued by the Welsh Government.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

As Accountable Officer, I confirm that, as far as I am aware, there is no relevant audit information of which the Health Board's Auditors are unaware, and I have taken all the steps that ought to have been taken to make myself aware of any relevant audit information and that the Health Board's auditors are aware of that information.

As Accountable Officer, I confirm that the Annual Report and Accounts 2025/26 as a whole is fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining it as fair, balanced and understandable.

As Accountable Officer, I am responsible for authorising the issue of the financial statements on the date they are certified by the Auditor General for Wales.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accountable Officer.

Name: Nicola Prygodzicz, Chief Executive

Date:



SECTION B(2): STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS FOR 2025/26

The directors are required under the National Health Service Act (Wales) 2006 to prepare accounts for each financial year. The Welsh Ministers, with the approval of the Treasury, direct that these accounts give a true and fair view of the state of affairs of the Aneurin Bevan University Health Board and of the income and expenditure of the Health Board for that period.

In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting principles laid down by the Welsh Ministers with the approval of the Treasury
- make judgements and estimates which are responsible and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the account.

The directors confirm that they have complied with the above requirements in preparing the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the authority and to enable them to ensure that the accounts comply with requirements outlined in the abovementioned direction by the Welsh Ministers.

By Order of the Board

Signed:

Andrew Morgan, Chair

Dated:

Nicola Prygodzicz, Chief Executive

Dated:

Robert Holcombe, Executive Director of Finance

Dated:



C: ANNUAL GOVERNANCE STATEMENT 2025/26

SCOPE OF RESPONSIBILITY

The Board is accountable for Governance, Risk Management and Internal Control. As Chief Executive of the Board, I have responsibility for maintaining appropriate governance structures and procedures as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and the organisation's assets for which I am personally responsible. These are carried out in accordance with the responsibilities assigned by the Accountable Officer of NHS Wales.

The annual report outlines the different ways the organisation has had to work both internally and with partners in response to the unprecedented pressure in planning and providing services. It explains arrangements for ensuring standards of governance are maintained, risks are identified and mitigated and assurance has been sought and provided. Where necessary additional information is provided in the Governance Statement, however the intention has been to reduce duplication where possible. It is therefore necessary to review other sections in the Annual Report alongside this Governance Statement.

On 16 December 2025, the Cabinet Secretary escalated finance, strategy and planning from level 3 to level 4 under the [NHS Wales Oversight and Escalation Framework](#), following deterioration in the Health Board's financial position and failure to deliver the approved IMTP. Performance and outcomes relating to urgent and emergency care were also escalated from level 3 to level 4 and widened to cover the whole urgent and emergency care system. As a result, approval of the Health Board's IMTP was revoked with immediate effect.

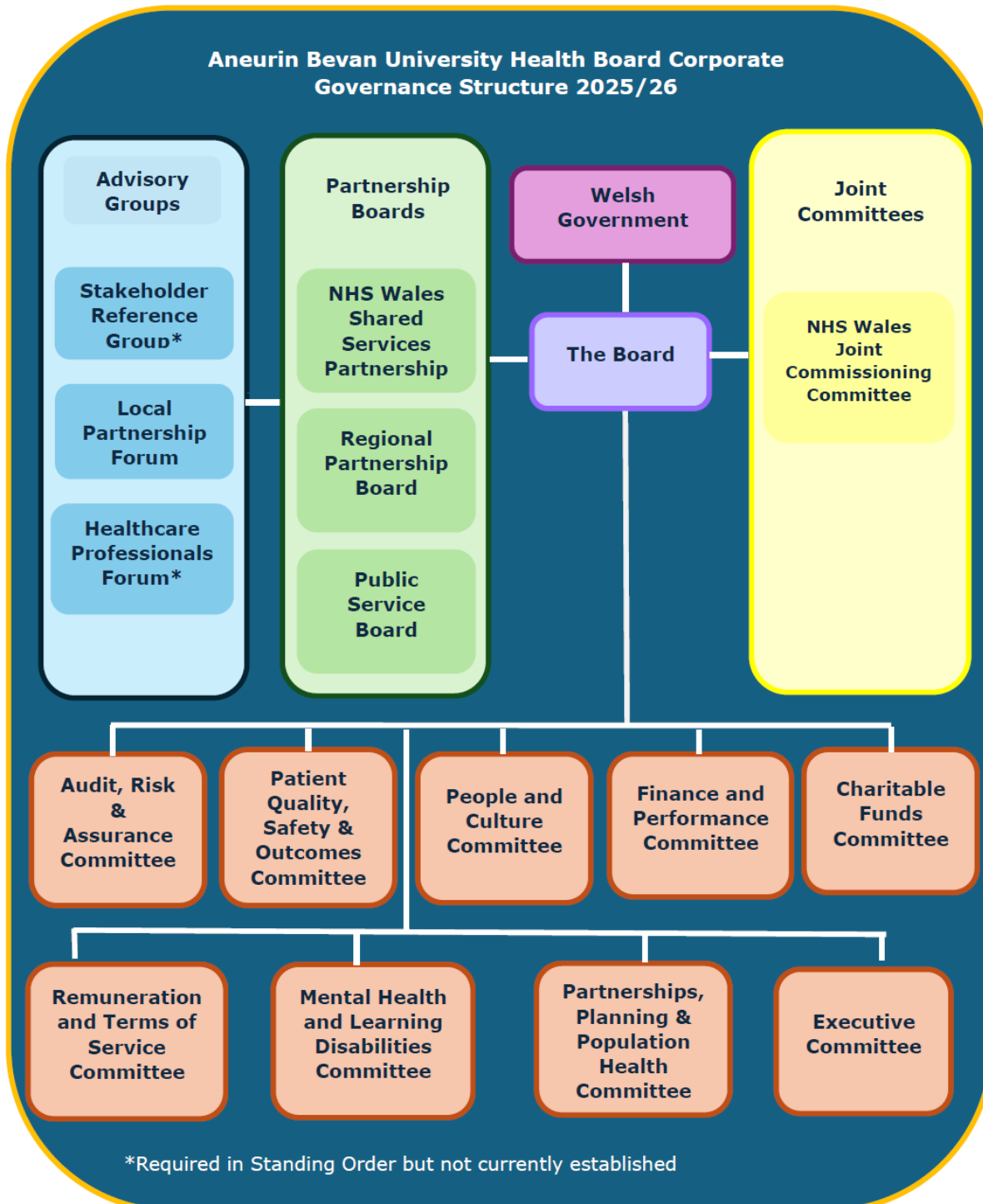
OUR GOVERNANCE AND ASSURANCE FRAMEWORK

Aneurin Bevan University Health Board has agreed Standing Orders for the regulation of proceedings and business of the organisation. These are designed to translate the statutory requirements set out in the *Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024*, which came into force on the 20 January 2025, and the *Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009*, into day to day operating practice. The Standing Orders, together with the adoption of a scheme of matters reserved to the Board, a scheme of delegation to officers and others and Standing Financial Instructions, provide the regulatory framework for the business conduct of the Health Board and define its 'ways of working'. These documents, together with the Strategic Risk Register and a range of corporate policies



set by the Health Board make up the Governance and Assurance Framework and arrangements of the organisation.

The diagram below outlines the corporate governance structure in place during 2025/26:





Delivery of the Governance Assurance Framework within the organisation is deployed through the Executive Team (as noted below in table 1), with each Executive Director having an agreed portfolio of delegated responsibilities. This is underpinned by operational divisions which lead operational planning and service delivery across primary and community care, mental health and learning disabilities, acute services, estates and facilities, all of which have ultimate accountability to the Chief Operating Officer.

Membership of the Health Board and its Committees

Attachment 1 provides the Board's membership during 2025/26 and attendance at Board meetings for this period. The membership of the Board and changes during 2025/26, are outlined in Table 1 below:

Name	Designation	Dates (If not full year)
Executive Directors		
Nicola Prygodzicz	Chief Executive	
Hannah Evans	Director of Strategy, Planning and Partnerships	
Rob Holcombe	Director of Finance and Procurement	
Dr James Calvert	Medical Director and Deputy Chief Executive	Until 05/08/2025
Dr Andy Bagwell	Interim Medical Director	05/08/2025 until 26/10/2025
Dr Seema Srivastava	Medical Director	From 27/10/2025
Sarah Simmonds	Director of Workforce and OD	
Jennifer Winslade	Director of Nursing	Until 02/09/2025
Jennifer Winslade	Director of Nursing and Deputy Chief Executive	From 03/09/2025
Peter Carr	Director of Allied Health Professions and Health Sciences	
Tracy Daszkiewicz	Director of Public Health	
Leanne Watkins	Chief Operating Officer	
Independent Members		
Ann Lloyd	Chair	
Phil Robson	Vice Chair	
Louise Wright	Independent Member (Trade Union)	Until 10/04/2025
Vivek Goel	Independent Member (Trade Union)	From 02/06/2025
Richard G Clark	Independent Member (Local Authority)	Until 19/09/2025



Name	Designation	Dates (If not full year)
Helen Cunningham	Independent Member (Local Authority)	From 03/11/2025
Professor Helen Sweetland	Independent Member (University)	
Paul Deneen	Independent Member (Community)	
Iwan Jones	Independent Member (Finance)	
Dafydd Vaughan	Independent Member (Digital)	
Neil Patrick	Independent Member (Community)	
Penny Jones	Independent Member (Community)	
Akmal Hanuk	Independent Member (Third Sector)	From 02/06/2025
Directors in Attendance*		
Paul Solloway	Director of Digital	
Associate Members**		
Vacant	Chair, Stakeholder Reference Group	
Vacant	Chair, Health Professionals Forum	
Vacant	Director of Social Services	
Director of Corporate Governance***		
Rani Dash	Director of Corporate Governance	

**The Director of Digital is not an Executive Post. The Director of Digital is therefore not a Board Member and attends meetings of the Board in an ex-officio capacity without voting rights.*

***Associate Members are Members of the Board but do not hold voting rights.*

****Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within the Health Board. The Director of Corporate Governance is responsible for providing advice to the Board as a whole and to individual Board members on all aspects of governance.*

The Board was chaired by Ann Lloyd, CBE, until 2nd April 2026. Andrew Morgan OBE, commenced as Chair on 5th May 2026. Phil Robson, Vice Chair, undertook the role of Acting Chair during the period 3rd April to 4th May 2026.



The Role of the Board

The Board has been constituted to comply with the *Local Health Board (Constitution, Membership and Procedures) (Wales) Regulations 2009* and the *Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024*. The Board functions as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

The Board is made up of individuals from a range of backgrounds, disciplines and areas of expertise. The Board comprises the Chair, Vice Chair and nine other Independent Members and the Chief Executive and eight Executive Directors. There are also Associate Independent Member positions and other senior managers who routinely attend Board Meetings. The full membership of the Board and their lead roles are outlined in **Attachment 1**.

The Board sits at the top of the organisation's governance and assurance systems. Its principal role is to exercise effective leadership, provide strategic direction and control. The Board is accountable for governance and internal control in the organisation and the Chief Executive as Accountable Officer, is responsible for maintaining appropriate governance structures and procedures.

In summary, the Board:

- ❖ Sets the strategic direction of the organisation within the overall policies and priorities of the Welsh Government and the NHS in Wales;
- ❖ Establishes and maintains high standards of corporate governance;
- ❖ Ensures the delivery of the aims and objectives of the organisation through effective challenge and scrutiny of performance across all areas of responsibility;
- ❖ Monitors progress against the delivery of strategic and annual objectives; and
- ❖ Ensures effective financial stewardship by effective administration and economic use of resources.

Committees of the Board

Section 3 of Aneurin Bevan University Health Board's Standing Orders provides that "*The Board may and, where directed by Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance in the exercise of its functions*". In line with these requirements, the Health Board had in place a Committee Structure for 2025/26.



The committee structure has been designed to enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of Board effectiveness.

During 2025/26, the following Committees were in place:

- ❖ Audit, Risk & Assurance Committee
- ❖ Patient Quality, Safety & Outcomes Committee
- ❖ People & Culture Committee
- ❖ Finance & Performance Committee
- ❖ Partnerships, Population Health and Planning Committee
- ❖ Mental Health and Learning Disabilities Committee
- ❖ Remuneration and Terms of Service Committee
- ❖ Charitable Funds Committee

The Terms of Reference and Operating Arrangements, meeting agendas and papers for each of these Committees can be found on the Health Board's [website](#).

These Committees are Chaired by Independent Members of the Board. The Chair of each Committee reports regularly to the Board on the committee's activities. This contributes to the Board's assessment of risk, level of assurance and scrutiny against the delivery of objectives. In addition, and in-line with Standing Orders, each committee is required to produce an annual report.

In addition to the Board's formal meetings and formal Committee meetings, the following informal arrangements have been established to support the Board to fulfil its responsibilities:

- ❖ Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
- ❖ Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation.

Conducting Business with Openness and Transparency

Members of the public have been able to attend all Board meetings in person during 2025/26. In addition, all Board meetings were livestreamed and published to the Health Board's You Tube Channel.

Committee meetings were held virtually, which meant that public attendance was not facilitated. To maintain transparency and public accountability, from October 2025, the Health Board implemented an



alternative arrangement whereby summaries of Committee meetings were published on the Health Board's website. These summaries provide an overview of the key discussions, decisions and outcomes of each meeting, ensuring continued openness in the conduct of the Committee's business.

It is acknowledged that a hybrid approach to meetings will continue to be required in the future and the Health Board will work to ensure members of the public can attend meetings in person and/or virtually.

To ensure Board and Committee business was conducted in as open and transparent manner as possible the following actions were taken:

- ❖ All Board and Committee meeting agenda packs have been published to the Health Board's [website](#) in advance of meetings;
- ❖ Meetings of the Board have been livestreamed and published to the Health Board's You Tube Channel within 24 hours;
- ❖ The Health Board's Annual General Meeting in September 2025 was livestreamed, with in person attendance also permitted.
- ❖ Summaries of Committee business were published to the Health Board's website within 24 hours of the meeting.

The Health Board and its Committees have sought to undertake a minimum of its business in private sessions and ensure business, wherever possible, is published in the public domain. The Committees that do not publish information publicly is either because of the confidential nature of their business, such as the Remuneration and Terms of Service (RATS) Committee, or they are informal developmental type meetings such as the Board Development Sessions discussing plans and ideas often in their formative stages.

Meetings of the Board and its Committees are formally recorded with minutes considered for approval at the next available meeting. In addition, the Director of Corporate Governance maintains Decision Logs for all decisions taken by the Board and the Executive Team.

Items considered by the Board in 2025/26

During 2025/26, the Board held 6 scheduled meetings, as well as its Annual General Meeting on 24th September 2025.

All the meetings of the Board in 2025/26 were appropriately constituted and quorate. The key business and risk matters considered by the Board during 2025/26 are outlined below.

Further information can be obtained from the published Board meeting papers on the Health Board's website via the following [link](#).



Business Cases:

- Approved the Outline Business Case for the **Transforming Access to Medicines (TRaM) South-East Wales Hub**.
- Approved the **Maternity and Neonatal Services Reconfiguration** Business Case.
- Approved the **Nevill Hall Hospital Strategic Outline Case** to address RAAC and long-term estate sustainability.
- Approved the Outline Business Case for the **Regional Orthopaedics Centre** (Llantrisant Health Park – Phase 2).
- Approved the **Digital infrastructure and AI oversight approach**.

Governance and Assurance:

- Received assurance in respect of arrangements for compliance with the **Nurse Staffing Levels (Wales) Act**.
- Approved the **Annual Report and Accounts 2024-25**.
- Approved the **Charitable Funds Annual Report and Accounts 2024-25**.
- **Received** the following **Annual Reports**:
 - Health, Safety & Fire Annual Report
 - Welsh Language Annual Report
 - Annual Quality Report
 - Annual Putting Things Right Report
 - Senior Information Risk Owner (SIRO) Annual Report
 - Strategic Equality Plan Annual Report
- Received the **Audit Wales Annual Audit Report** and **Structured Assessment 2025**.
- Received the **Public Services Ombudsman for Wales Annual Letter**.
- Approved interim changes to the **Standing Financial Instructions** and the **Scheme of Delegation – Delegated Limits**.
- **Noted** the **Pay Gap Reports 2025** (Gender Pay Gap and Ethnicity Pay Gap)

Plans/Strategies/Policies/Service Change:

- Noted progress in implementing the **Long-Term 10-Year Strategy** and associated outcomes framework.
- Approved the **Values and Behaviours Framework** (Kindness, Integrity, Respect).
- Approved the **People Plan 2025–28**.
- Approved the **Strategy Deployment Plan (Gwent 2035)**.
- Approved the **Winter Plan 2025/26** and noted the 2024/25 Winter Review.
- Noted updates on the **Nevill Hall Hospital Redevelopment Programme** and ongoing public engagement.
- Noted updates on **MSK / Community Therapy Transformation**.
- Noted progress and next steps on the **Digital, Data and Technology** modernisation programme.
- Noted the **Digital Programmes Update** and **Artificial Intelligence Review**.
- Endorsed the approach to **Quality Improvement**, including refreshed quality management structures.
- Approved the **Patient Safety Incident Reporting & Management Policy**.
- Received updates on **planned care performance**, including actions to reduce long waits and use Welsh Government funding for improvements.
- Noted development of **ReFit decarbonisation proposals**, funding uplifts and invest-to-save schemes.
- Endorsed improvement work across **urgent & emergency care**, including the Next/Your Next Patient flow initiatives.
- Noted updates on **Children and Young People's Services** including early pregnancy and gynaecology care improvements.
- Received the **Statutory and Mandatory Training Report** and **endorsed** actions to strengthen compliance.
- Received updates on implementation of the **NHS Wales Electronic Prescribing & Medicines Administration (ePMA)** programme.
- Approved service decisions relating to **General Medical Services**.



Routine Business:

- Ratified **actions taken by the Chair**, on behalf of the Board, to seal documents affixing the Health Board's Common Seal.
- Considered and discussed the Health Board's **financial performance** and the related risks being managed by the organisation.
- Considered the **Board's performance** against key local and national targets and the actions being taken forward to improve performance.
- Considered performance against the Health Board's **Quality Outcomes Framework**.
- Received assurance reports from the **Committees and Advisory Groups** of the Board.
- Received update reports from the **Executive Team** in respect of key issues locally, regionally and within NHS Wales.
- Reviewed the **Corporate Risk Register** and sought assurance on the management of mitigating actions.
- Noted progress on **Women's Health Hub development** and alignment with the national Women's Health Plan.
- Noted updates on **Respiratory and General Medicine Service Model** changes at the Grange University Hospital.
- Approved the **Capital Programme 2026/27**, including invest-to-save and discretionary schemes.
- Noted the community diagnostic hub **Llantrisant Health Park OBC** (regional, for information only).
- **Approved** the **Integrated Medium-Term Plan (IMTP) 2025–2028** for submission to Welsh Government.
- **Approved** the **Budget Delegation Proposal for 2026/27**.
- **Noted** updates on **Primary and Community Care development**, including Community by Design initiatives.
- **Noted** progress on **Dementia improvement**, including the Dementia Friendly Hospital Charter and refreshed three-year improvement plan.
- **Approved** the **Violence Prevention and Reduction Strategic Plan**.
- **Noted** the findings and priority actions arising from the **Maternity and Neonatal National Assurance Assessment**.

Patient Experience and Public Engagement:

Patient experience remained a core component of Board agendas, with powerful presentations demonstrating the impact of service developments and personal stories. Presentations during 2025/26 included:

- **Cryoablation and robotic innovation** in cancer and interventional radiology.
- **Early pregnancy and emergency gynaecology**: improvements introduced following a patient's experience of miscarriage care.
- **Knee osteoarthritis embolisation service**: showcasing innovative alternatives to surgery with strong outcome data.
- **Arts in Health** Programme for perinatal mental health, showing strong benefits for confidence, emotional regulation and social connection.
- **Closed loop insulin pump therapy** significantly improving quality of life for patients with Type 1 diabetes.
- **Dementia Care** highlighting learning and improvement actions across hospital and community services.

Throughout 2025/26, **Llais, Gwent Region** attended meetings of the Board to provide an overview of recent issues of concern and positive observations or public feedback being addressed by Llais in relation to the planning and delivery of health services in Gwent.



Items considered by Committees of the Board

During 2025/26, Board Committees considered and scrutinised a range of reports and issues, in line with the matters delegated to them by the Board. These included a range of internal and external audit reports and reports from other review and regulatory bodies, including Healthcare Inspectorate Wales.

As was the case in previous years, the Committees' consideration and analysis of such information has played a key role in the assessment of the effectiveness of internal controls, risk management arrangements and assurance mechanisms. The Committees also considered and advised on areas of local and national strategic developments and new policy areas.

An overview of the key roles and responsibilities, membership and areas considered by the Committees of the Board is provided below:

Audit, Risk and Assurance Committee		
Roles and Responsibilities	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.	
	Terms of Reference	
Chair	Iwan Jones, Independent Member (Finance)	8/8
Members and Attendance	Dafydd Vaughan, Independent Member	8/8
	Neil Patrick, Independent Member	8/8
	Helen Sweetland, Independent Member - from September 2025	4/5
	Richard Clark, Independent Member - to June 2025	1/3
	Paul Deneen, Independent Member -January 2026 only	1/1
Regular Executive Attendance	Rani Dash, Director of Corporate Governance Robert Holcombe, Director of Finance and Procurement (Attendance not required January 2026)	7/8 7/7
Number of Meetings per year	8	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: An overview of financial governance and control arrangements, including updates on Financial Control Procedures and Standing Financial Instructions self-assessment, payment performance, banking	



arrangements, and losses and special payments, together with routine monitoring of Single Tender Actions.

- An overview of **internal audit** activity, covering plan delivery and reports across areas such as clinical audit (local and national), job planning, discharge planning (follow-up), business continuity, divisional governance, mental health and learning disabilities, maternity, GUH Emergency Department extension, health & safety, Electronic Document and Records Management System, contract management, performance management framework, waiting list management, medical equipment & devices, and managed GP practices.
- An update on **external audit** work, including progress on the financial statements audit, Structured Assessment, Audit Fees consultation, and thematic reviews (e.g., Eye Care Services, Planned Care, Discharge Planning at Health Board and regional levels) and the National Fraud Initiative.
- An overview of meetings relating to the **Annual Report and Accounts**, considering Part 1 (Performance), Part 2 (Accountability and Annual Governance Statement), and Part 3 (Financial Statements), including processes to validate performance and financial data and recommendations to the Board for approval.
- Updates on **organisational risk, governance and compliance**, including risk maturity development, movements in strategic risks (e.g., industrial action, financial sustainability), and improvements to compliance with Welsh Health Circulars and Ministerial Directions with clearer escalation routes.
- An overview of **clinical audit** governance, including the Committee's continued emphasis on the absence (earlier in the year) of an approved local clinical audit plan, subsequent actions to strengthen corporate local clinical audit arrangements, and mid-year reporting on national audit participation.
- Updates on **job planning**, noting persistent challenges (e.g., expired plans, digital completion, local enforcement and training), with oversight aligned to the People & Culture Committee and a strengthened management approach.
- An overview of **discharge planning and urgent care performance**, noting improvements in delayed discharge metrics, documentation, real-time dashboards, and pathway redesign, while recognising ongoing system-wide challenges across partner organisations and digital systems.
- Updates on **quality governance, patient safety and assurance**, including follow-up of Quality Governance recommendations, safeguarding training compliance, the Post-Payment Verification annual programme and expanded scope, and counter-fraud performance and benchmarking across NHS Wales.

Further information is available in the Audit, Risk and Assurance Committee [Annual Report 2025/26](#).



Patient, Quality, Safety and Outcomes Committee		
Roles and Responsibilities	The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. Full Terms of Reference	
Chair	Helen Sweetland	5/5
Members and Attendance	Penny Jones	5/5
	Philip Robson - from June 2025	4/5
	Paul Deneen	5/5
	Vivek Goel - from October 2025	3/3
	Helen Cunningham – from February 2026	1/1
Regular Executive Attendance	Jennifer Winslade	5/5
	Seema Srivastava – from December 2025	2/2
	Peter Carr	3/5
	James Calvert - to October 2025	2/2
Number of Meetings per year	6 – July meeting was cancelled resulting in 5 taking place.	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of quality outcomes and performance reporting, including regular Quality Outcomes Reports aligned to the six Pillars of Quality. These reports provided assurance on patient and staff experience, complaints and concerns, patient safety, clinical effectiveness, health and safety, infection prevention and control, and safeguarding. The Committee considered trends in mortality, falls, pressure ulcers, medication safety, complaints performance, infection rates and safeguarding activity, and reviewed areas requiring targeted improvement. • An overview of the development and implementation of the Quality Management System, including the establishment and ongoing role of the Quality Management Group. The Committee received assurance on the alignment of quality governance arrangements with national requirements, the Duty of Quality and Duty of Candour, and the Health and Care Quality Standards. • An update on maternity and neonatal services, including workforce, safety, culture and performance. The Committee reviewed maternity and neonatal quality reports, neonatal service improvement activity, culture and listening exercises, infection prevention and control arrangements, medicines management, workforce capacity and training compliance, and received assurance on ongoing improvement plans and leadership oversight. • An overview of patient experience, concerns and complaints management, including the Patient Advice and Liaison Service (PALS),	



Putting Things Right (PTR) performance, and preparations for the implementation of the new *Listening to People* framework. The Committee considered early resolution performance, equity of access, resource implications, regulatory changes, and risks associated with implementation without additional national funding.

- **Updates on inspection and regulatory activity**, including Healthcare Inspectorate Wales (HIW) inspections, Audit Wales findings, Health and Safety Executive (HSE) interventions, and actions taken in response. The Committee monitored progress against inspection recommendations, reviewed assurance arrangements through the Assurance Monitoring and Tracking system, and considered learning and escalation where required.
- **An overview of specific risk and improvement programmes**, including safeguarding training compliance, health and safety leadership and workforce capacity, infection prevention and control, nutrition and hydration, mortuary and Care After Death services, learning from deaths, clinical audit activity, commissioning assurance, and the management of strategic risks delegated to the Committee.

Further information is available in the Patient Quality, Safety and Outcomes Committee [Annual Report 2025/26](#).

Partnership Population, Health & Planning Committee

Roles and Responsibilities

The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on:

- The robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership;
- Plans and arrangements for the following matters are adequate, effective, and robust and achieving intended outcomes: Joint committee and partnership planning; Engagement and communication; and Civil Contingencies and Business Continuity;
- That partnership governance and partnership working is effective and successful; and
- that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

Full [Terms of Reference](#)

Chair

Ann Lloyd, until April 2025
Phillip Robson, from July 2025

1/1
3/3

Members and Attendance

Phillip Robson, until July 2025
Dafydd Vaughan
Penny Jones
Richard Clark, until October 2025
Akmal Hanuk, from July 2025
Neil Patrick, provided IM Committee Support

0/1
4/4
3/4
2/2
1/3
1/1



Regular Executive Attendance	Hannah Evans, Director of Strategy, Planning and Partnerships, Tracy Daszkiewicz, Director of Public Health	4/4 2/4
Number of Meetings per year	4	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of the development and approval status of the Integrated Medium Term Plan (IMTP), including the early development of the 2026/27 IMTP. • An overview of priority programmes and transformation activity, including planned care, urgent and emergency care, place-based care, population health, cancer services, mental health transformation, decarbonisation and digital foundations. • An update on regional planning and collaboration, including ophthalmology, orthopaedics, diagnostics, endoscopy, radiology and wider regional service models. • An overview of meetings of the Regional Partnership Board and Public Services Boards, with focus on priority setting, alignment of structures, winter pressures, and strengthening collaboration across system partners. • Updates on population health, prevention and health protection, including vaccination programmes, communicable disease response, health protection system maturity, and learning from incidents and national exercises. • An overview of estates and infrastructure planning, including the development of an updated Estates Strategy, rationalisation of St Woolos Hospital and development proposals for Nevill Hall Hospital. • Updates on business continuity, emergency planning and digital resilience, including preparedness for cyber incidents, business continuity assurance, and alignment with wider emergency planning and response arrangements. • Committee risk report. Further information is available in the Partnership, Population Health and Planning Committee Annual Report 2025/26.	



People & Culture Committee		
Roles and Responsibilities	The purpose of the People and Culture Committee is to provide assurance to the Board on: • all matters relating to staff and workforce planning of the Health Board; • plans to enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the Health Board to deliver safer better health care; • the direction and delivery of Organisational Development and other related frameworks to drive continuous improvement and to achieve the objectives of the Health Board. Full Terms of Reference	
Chair	Paul Deneen	3/3
Members and Attendance	Helen Sweetland	3/3
	Philip Robson	3/3
	Vivek Goel	2/3
Regular Executive Attendance	Sarah Simmonds	3/3
Number of Meetings per year	3	
Items Considered	Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered: • An overview of workforce performance, including sickness absence, turnover, workforce supply, recruitment timelines, job planning compliance, statutory and mandatory training, occupational health performance and variable pay, through regular review of the Workforce Performance Dashboard. • An overview of the Health Board's People Plan 2025–2030, including its strategic pillars, delivery measures, success indicators and governance arrangements, alongside confirmation of refined outcome-focused measures to support effective implementation and assurance. • An update on staff experience and engagement, including the NHS Wales Staff Survey approach, response rates, outcomes and the development of divisional and organisational action plans, as well as efforts to reduce survey fatigue and strengthen staff voice. • An overview of equality, diversity and inclusion assurance, including progress against the Strategic Equality Plan and the Welsh Government's Race Equality Action Plan for Wales, with particular focus on workforce data quality, recruitment and progression inequalities, staff networks and Board-level leadership and oversight.	



- Updates on **employee relations activity**, including suspensions, disciplinary cases, employment tribunal claims and learning from complex cases, alongside implementation of new policies and frameworks such as Respect and Resolution and anti-sexual harassment arrangements.
- An overview of **workforce governance** and assurance, including Disclosure and Barring Service compliance, workforce risk management, establishment control, workforce planning and organisational change, and the monitoring of delegated strategic workforce risks.
- Updates **on professional workforce frameworks and reforms**, including arrangements for speciality doctors, locally employed doctors and clinical fellows, medical revalidation, job planning systems, and preparations for the Resident Doctors contract reform.
- An overview of **workforce safety and wellbeing initiatives**, including the Speaking Up Safely framework, violence prevention and reduction strategy, staff safety measures and organisational responses to concerns raised by staff.

Further information is available in the People and Culture Committee [Annual Report 2025/26](#).

Finance and Performance Committee

Roles and Responsibilities

The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek

- ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework;
- that arrangements for financial management and financial performance are sufficient, effective and robust;
- that services are improving efficiency and productivity and financial plans are being delivered;
- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

Full [Terms of Reference](#)

Chair

Richard Clark (Until July 2025)
Neil Patrick (From September 2025)

2/2
5/5

Members and Attendance

- Iwan Jones, Independent Member
- Dafydd Vaughan, Independent Member
- Akmal Hanuk, Independent Member

4/5
5/5
4/4



Regular Executive Attendance	- Paul Solloway, Director of Digital - Hannah Evans, Director of Strategy, Planning and Partnerships - Robert Holcombe, Director of Finance	4/5 5/5 5/5
Number of Meetings per year	5	
Items Considered	Among the key issues considered by the Committee during 2025/26, as outlined in the Committee's Work Programme, the following were also considered: An overview of the Committee Risk Report, including strategic risks relating to financial sustainability, performance management, digital infrastructure, estates compliance, and carbon reduction, with ongoing consideration of risk tolerance, mitigation effectiveness, and interdependencies between workforce absence, operational pressures, and financial risk. An overview of organisational performance and escalation arrangements, including national and internal escalation frameworks, progress against de-escalation criteria, and sustained challenges in Urgent and Emergency Care, Planned Care, Mental Health, and Financial Performance. An update on the Integrated Performance Report, including performance against Ministerial Priorities, covering prevention and population health, Primary and Community Care, Urgent and Emergency Care, Planned care, Cancer and Diagnostics, Mental Health services, and Workforce productivity, alongside consideration of system-wide pressures and national supply constraints. An overview of financial performance through the Monthly Finance Report and Monitoring Returns, including in-year deficit forecasts, savings delivery, cost pressures, income risks, capital expenditure, cash management, and engagement with Welsh Government on funding and financial risk mitigation. Updates on value, sustainability, efficiency, and productivity programmes, including assurance from the Value and Sustainability Board, efficiency opportunities in theatres, beds, outpatients, medicines management, non-pay expenditure, and planned care productivity, recognising the distinction between performance improvement and cash-releasing savings. An overview of major service and transformation developments, including ophthalmology diagnostic hub progress, outpatient transformation, theatres efficiency, stroke service improvement, benefits realisation from business cases, commissioning arrangements, and the alignment of service redesign with quality, safety, workforce, digital readiness, and financial sustainability.	



An overview of **digital, data, information governance, and cybersecurity assurance**, including progress on major digital programmes, electronic patient records, digital prescribing, data standards, information governance compliance, and the management of digital and cyber risks.

An overview of **estates compliance and infrastructure assurance**, including statutory compliance, backlog maintenance, estate condition risks, workforce challenges within estates services, and the prioritisation of investment based on clinical and safety risk.

Further information is available in the Finance and Performance Committee [Annual Report 2025/26](#).

Charitable Funds Committee

Roles and Responsibilities	The purpose of the Charitable Funds Committee is to ensure the stewardship and effective management of funds which have been donated, bequeathed and given to the Aneurin Bevan Health Charity for charitable purposes by making and monitoring arrangements for the control and management of the Health Board's Charitable Funds.	
	Full Terms of Reference	
Chair	Paul Deneen	4/4
Members and Attendance	Neil Patrick	4/4
	Richard Clark (Until June 2025)	1/1
	Akmal Hanuk (Since June 2025)	2/3
	Nicola Prygodzicz	4/4
	Robert Holcombe	4/4
Regular Executive Attendance	N/A	
Number of Meetings per year	4	



Items Considered

Among the key issues considered by the Committee during 2025-26, as outlined in the Committee's Work Programme, the following were also considered:

- An overview of the **Finance and Performance position**, including quarterly financial performance, income and expenditure trends, investment valuation movements, management of fund balances, and the approval of new charitable funds to support specific initiatives and services. During the year, the Committee also considered the impact of market volatility on charitable investments and agreed actions to strengthen future assurance, including enhanced scrutiny of investment performance, engagement with investment managers, and preparation for the re-tendering of investment arrangements.
- An overview of **funds available to the Committee**, including updates on general-purpose funds, legacy receipts, commitments, and the level of discretionary funding available to support bids and grant applications. The Committee recognised the importance of balancing the active use of charitable funds with the long-term financial sustainability of the charity.
- An update on **bids and Small Grant Scheme applications**, including the approval of multiple small grants and larger funding bids, consideration of affordability and future commitments, and the establishment of strengthened governance arrangements. This included the operation of a bids and grants sub-group to enhance consistency, transparency, and alignment with charitable objectives, alongside agreement to improve application requirements and introduce proportionate monitoring of funded activity.
- An overview of **legislative and regulatory changes**, including updates on the Charities Statement of Recommended Practice (SORP), assurance that the charity was prepared for forthcoming requirements, and confirmation that no material impacts were anticipated for the organisation.
- Updates on the **management of slow-moving funds**, including attendance from fund holders, review of spending plans, encouragement of timely and appropriate use of charitable funds, and agreement to strengthen oversight where funds had remained unspent for extended periods.
- An overview of **investment composition and performance**, including updates from the charity's investment managers, consideration of market conditions, and assurance regarding the ongoing suitability and monitoring of investment arrangements.
- An update on the **priority plan to raise the profile of the charity and support future fundraising**, including approval of a refreshed charity brand identity, registration with the Fundraising Regulator, development of new fundraising mechanisms, and early engagement with potential corporate supporters and patronage opportunities.
- An overview of **governance and assurance matters**, including approval of the Committee's Programme of Business, Terms of Reference, administration charge for 2025/26, and the review and approval of the Annual Accounts, Annual Report, and related audit documentation.

	Further information is available in the Charitable Funds Committee Annual Report 2025/26.

Mental Health and Learning Disabilities Committee		
Roles and Responsibilities	The purpose of the Mental Health and Learning Disabilities Committee is to advise the Board to assist it in discharging its functions and meeting its responsibilities with regard to mental health, learning disabilities and CAMHS issues; and especially the Health Board’s compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Equality Act 2010 (where relevant) and associated legislative and statutory frameworks. Full Terms of Reference	
Chair	Penny Jones	5/5
Members and Attendance	Paul Deneen Philip Robson Dafydd Vaughan	5/5 4/5 4/5
Regular Executive Attendance	Leanne Watkins, Chief Operating Officer Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director (from November 2025) Tracey Daszkiewicz, Director of Public Health	3/5 3/5 0/2 1/5
Number of Meetings per year	5	
Items Considered	Among the key issues considered by the Committee during 2025/26, as outlined in the Committee’s Work Programme, the following were also considered: An overview of Mental Health Act compliance, including activity trends under the Act, use of Sections 4, 135 and 136, rectifiable and unlawful detentions, Community Treatment Orders, Hospital Managers’ hearings, and multi-agency working.	



- An overview of **Mental Health services performance, quality, safety and activity**, including assurance on Adult Mental Health, learning disabilities and Child and Adolescent Mental Health Services.
- An update on **service transformation and improvement**, including psychological therapies, neurodevelopmental services, CAMHS recovery and sustainability, community-based models of care, and the redesign of pathways to support demand management, earlier intervention and more sustainable delivery.
- An overview of **restrictive practice**, including restraint, enhanced observations and segregation, alongside actions to reduce restrictive interventions through SafeWards, Safety Pods, improved training, strengthened policies, thematic reviews and divisional oversight arrangements.
- Updates on **Mental Capacity Act and Deprivation of Liberty Safeguards**, including training compliance, audit findings, backlog pressures, governance arrangements, and preparation for future Liberty Protection Safeguards requirements, recognising ongoing legal, workforce and financial challenges.
- An overview of **Right Care, Right Person**, including phased implementation, multi-agency collaboration, crisis pathways, transport and conveyance challenges, and ongoing development of integrated models to ensure individuals receive the appropriate response at the right time.
- An overview of **Dementia assurance**, including progress against the All-Wales Dementia Standards, community hubs, carers' support, workforce development, memory assessment pathways, dementia-friendly environments and sustainability risks associated with future funding.
- An overview of **quality improvement and inspection activity**, including Healthcare Inspectorate Wales inspections, internal audits, action plans, governance reviews, leadership visibility, and learning from incidents, complaints and external scrutiny.
- An overview of **digital enablement and maturity**, including digital process improvement, robotic process automation, electronic patient record readiness, data quality, and the findings of the Mental Health Digital Maturity Assessment.

Further information is available in the Mental Health and Learning Disabilities Committee [Annual Report 2025/26](#).

Remuneration and Terms of Service Committee

Roles and Responsibilities

The Committee considers and approves the remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government, on behalf of the Board. The Committee seeks assurance in respect of objectives for Executive Directors and other Very Senior Managers and the associated performance assessment; agreeing actions on behalf of the Board where required.

Full [Terms of Reference](#)



Chair	Ann Lloyd, Chair	3/3
Members and Attendance	Philip Robson, Vice Chair Iwan Jones, Independent Member	3/3 3/3
Regular Executive Attendance	Sarah Simmonds, Director of Workforce and OD Nicola Prygodzicz, Chief Executive	3/3 3/3
No Meetings per year	Quarterly, as required	
Items Considered	The Committee received updates on: • Chief Executive and Executive Director Performance • Executive and Senior Manager Secondments • Settlement Agreements • Progress with AFC non pay collective agreement and other pay related issues (national discussions)	

The Chief Executive, as Accountable Officer, regularly attends all Committee meetings.

Board Development and Briefing

Board members took part in a number of development and briefing sessions through 2025/26. Topics covered at these sessions included:

- Long Term Strategy Development
- Organisational Priorities and Parameters
- Service Development Business Cases
- Financial Plan 2025/26
- Welsh Government Priorities and Requests
- Annual Update from the Joint Commissioning Committee (JCC)
- Place Based Care, Including Primary Care Model
- Board Development Programme Delivered by Good Governance Institute (GGI)
- Records Management Update

Self Assessment and Evaluation

In line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups.

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and to develop and improve leadership and governance. It helps boards identify strengths and development areas to deliver continuous improvement. High performing boards are likely to carry out some form of self-review of their leadership and governance regularly.



The Health Board commenced its Board Development Programme, delivered in partnership with the Good Governance Institute (GGI), during 2025/26. This work remains ongoing to support continuous improvement.

This programme focused on core concepts such as governance, risk, culture and effective decision-making and leadership – these are components drawn directly from the principles which underpin high performing boards and organisations and the opportunity to better understand and improve our performance in these areas will ensure a more effective board and better outcomes for patients and service users.

Committees of the Board undertook self-assessment during November and December 2025. The outcomes of these assessments are summarised in the Committee Annual Reports. In undertaking these assessments, committee members considered their composition, establishment and ways of working, the outcomes of which informed a review of Committee Terms of Reference. The revised Terms of Reference for each Committee were approved by the Board in May 2026.

Compliance with Standing Orders

A review of compliance has been undertaken against the Health Boards Standing Orders; Reservation and Delegation of Powers. Although further work is identified to strengthen arrangements in a number of areas, three (3) key areas have been identified where the Health Board is not currently compliant with the Standing Orders. These are:

Section 5 – *The LHB's Advisory Groups include a Stakeholder Reference Advisory Groups Group, Healthcare Professionals' Forum and Local Partnership Forum.* [Local Partnership Forum is established]

Section 7 – *The availability of papers in English and Welsh languages and in Meetings accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;*

Actions will be put in place to address each of these areas during 2026/27.

ADVISORY GROUPS AND JOINT COMMITTEES

Advisory Groups

Aneurin Bevan University Health Board's Standing Orders require the Board to establish three advisory groups. These allow the Board to seek advice from and consult with staff and key stakeholders. They are the:

- Stakeholder Reference Group;
- Local Partnership Forum; and
- Healthcare Professionals' Forum.



Information in relation to the role and terms of reference of each Advisory Group can be found in the Health Board's Standing Orders on the Health Board's [website](#).

Stakeholder Reference Group (SRG)

Aneurin Bevan University Health Board established its Stakeholder Reference Group (SRG) in 2010.

The SRG's role has been to provide independent advice on the Health Board's business, including: Early engagement and involvement in the determination of the Health Board's overall strategic direction; the provision of advice on specific service proposals prior to formal consultation; as well as feedback on the impact of the Health Board's operations on the communities it serves. The SRG should provide a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the Health Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the Health Board's decision making.

Since its establishment, the Health Board's engagement arrangements have evolved and continue to develop and mature. In particular, the COVID-19 pandemic required the Health Board to engage with our stakeholders and communities in new and different ways.

In view of these evolving engagement arrangements and given that the Stakeholder Reference Group last met in October 2021, a decision was taken to disband the SRG in its current form in October 2022, whilst the Health Board reviewed and redesigned the role and constitution of the Group, ensuring it is fit for purpose and fully effective. A proposal for re-establishment of the SRG will be considered by the Board in 2026.

In the meantime, the Health Board continues to work alongside partners to engage and involve people who others are also seeking to engage. This enables strong partnership working, the sharing of resource and the ability to collaborate regarding joint solutions to challenges shared. Many organisations have been extremely generous in enabling our participation in their existing activities. The Health Board has previously attended:

- ❖ Local Authority Community Talk to Us Sessions, Warm Spaces and Cost of
- ❖ Living events;
- ❖ Housing Association Resident Complexes and events;
- ❖ Health & Wellbeing events and Freshers Fairs at Coleg Gwent Campuses; and
- ❖ School Parents evenings, coffee mornings and PTA events.



The Health Board is also represented at Gwent Citizens Panel, Torfaen Access Forum and works with third sector organisations, Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance.

The Health Board runs a comprehensive community engagement program that ensures communities can speak directly with Health Board staff and share their views on health services.

The Health Board is committed to working constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for the population of Gwent. This is delivered in accordance with the Health Board's statutory duties and any specific requirements or directions made by the Welsh Ministers, which includes the development of population assessments and area plans.

Local Partnership Forum (Known as the Trade Union Partnership Forum [TUPF])

The TUPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. The TUPF is co-chaired by the Chair of Staff Representatives and the Chief Executive of the Health Board. Members are Staff Representatives (including the Independent Member for Trade Unions), the Executive Team and Chief Executive, the Director of Corporate Governance, the Assistant Directors of Workforce and OD and the Head of Workforce Governance. The Forum meets 6 times a year and the Board receives an Annual Report on the work of the Forum.

Healthcare Professionals' Forum (HPF)

The purpose of the HPF is to facilitate engagement and debate amongst the wide range of clinical interests within the Health Board's area of activity, with the aim of reaching and presenting a cohesive and balanced professional perspective to inform the Health Board's decision making.

The Health Board is continuing to develop its Quality Management System and as a part of this a review and design of the Healthcare Professional's Forum will be undertaken, ensuring it is fit for purpose and fully effective and does not duplicate other aspects of the Health Board's clinical engagement mechanisms. A proposal for re-establishment of the HPF will be considered by the Board in 2026.

In the absence of a formal HPF, the Board also continues to engage clinical professionals through its professional executive directors (Medical Director, Director of Nursing, Director of Therapies and Health Sciences and Director of Public Health) and existing professional management groups, such as



the Clinical Directors Forum and System Leadership Group. The Board also engages with primary care providers through its cluster arrangements.

In addition, in 2024/25, the Health Board established a Clinical Advisory Forum, which is a non-executive advisory group that provides advice to the Executive Team and onwards to the Board where relevant. The Clinical Advisory Forum is a multi-professional advisory group which offers advice or recommendations on new treatments, Quality Impact Assessments and processes and services within the Health Board.

NHS Wales Joint Commissioning Committee

The NHS Wales Joint Commissioning Committee (NWJCC) is a formal committee representing all seven Health Boards in Wales. While each Health Board plans and delivers services for its own local population, some services are so specialist, complex, or low-volume that they need to be commissioned once for the whole of Wales.

NWJCC brings the Health Boards together to do this, ensuring that nationally commissioned services are planned consistently, collaboratively, delivered safely, and available equitably to everyone, wherever they live in Wales.

The [National Health Service Joint Commissioning Committee \(Wales\) Directions 2024](#) (the Directions) came into force on 7th February 2024 which provide that the Local Health Boards in Wales will work jointly to exercise functions relating to the planning and securing of services specified within the Directions or as identified by the Local Health Boards. Specifically, these are: (a) specialised services for: (i) cancer and blood disorders, (ii) cardiac conditions, (iii) mental health and vulnerable groups, (iv) neurosciences, and (v) women and children; (b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis; (c) emergency medical services; (d) non-emergency patient transport services; (e) emergency medical retrieval and transfer services; (f) NHS 111 services; (g) sexual assault referral centres; and (h) other services as directed by the Welsh Ministers.

The Health Board is represented on the Committee by the Chief Executive and reports of the Joint Committee's activity are regularly reported to the Board.

Further detail in respect of the Joint Commissioning Committee is available on their [website](#)

Statutory and Strategic Partnerships

Gwent Regional Partnership Board



The Gwent Regional Partnership Board (RPB) is established under Part 9 Social Services and (Wales) Wellbeing Act 2014 and the Partnership Arrangements (Wales) Regulations 2015, within which local authorities and local health boards are required to establish Regional Partnership Boards to manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services, and care and support is in place to best meet the needs of their respective population. The objectives of the Gwent Regional Partnership Board are to ensure the partnership bodies work effectively together to:

- ❖ Respond to the population assessment carried out in accordance with section 14 of the Act;
- ❖ Develop, publish and implement the Area Plans for each region covered as required under section 14A of the Act;
- ❖ Ensure the partnership bodies provide sufficient resources for the partnership arrangements, in accordance with their powers under section 167 of the Act; and
- ❖ Promote the establishment of pooled funds where appropriate.

Welsh Government has distributed a Health and Social Care Regional Integration Fund across Wales to the seven Regional Partnership Boards (RPBs) in Wales. The aim of the fund is to drive and enable integrated working between social services, health, housing and the third sector and independent providers to develop sustainable services.

The Regional Integration Fund (RIF) is hosted by Aneurin Bevan University Health Board on behalf of the Gwent Regional Partnership Board and is a standing agenda item on the Regional Partnership monthly meetings. All matters in relation to the RIF are discussed and approved within the partnership forum. Information is cascaded throughout the partnership structures for transparency. Where needed, the RPB accommodates special meetings to sign off RIF investment plans where meetings schedules do not align with reporting or development timeframes.

Aneurin Bevan University Health Board Members included in the membership of the Regional Partnership Board in 2025/26 were:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracy Daszkiewicz, Director for Public Health
- Hannah Evans, Director of Strategy, Planning & Partnerships
- Phil Robson, Vice Chair

Further detail in respect of the Gwent RPB can be found on the RPB's [website](#).

Gwent Public Services Board



The Gwent Public Services Board (PSB) is the statutory body established by the Well-being of Future Generations (Wales) Act 2015 which brings together the public bodies in Gwent to meet the needs of Gwent citizens present and future. The aim of the group is to improve the economic, social, environmental and cultural well-being of Gwent. Working in accordance with the five ways of working, the Board has published its Well-being Assessment and Well-being Plan.

The Health Board contributes to achieving these objectives through the delivery of the Clinical Futures Strategy and the Integrated Medium-Term Plan (IMTP).

Aneurin Bevan University Health Board Members included in the membership of the Public Services Board are:

- Ann Lloyd, Health Board Chair
- Nicola Prygodzicz, Chief Executive
- Tracey Daszkiewicz, Executive Director for Public Health

Further detail in respect of the Gwent PSB can be found on the PSB's [website](#).

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership (NWSSP) was established in November 2010 to deliver economies of scale; efficiencies and consistency of quality and process for the business and professional services that were directly managed and delivered by local NHS bodies.

As a hosted organisation, NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General/CEO of NHS Wales, Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by Professor Tracy Myhill OBE. The membership is comprised of representatives from each NHS organisation, including Aneurin Bevan University Health Board.

The Partnership Committee is responsible for exercising the Velindre NHS Trust's functions in relation to shared services, including the setting of policy and strategy and the management and provision of shared services to Local Health Boards, Special Health Authorities and Trusts. Several committees and advisory groups have been established to help support the governance arrangements that underpin how NWSSP operates.

Further detail in respect of NHS Wales Shared Services Partnership can be found on NWSSP's [website](#).



Partnership working with other Health Boards

The Health Board is fully committed to active collaboration where this delivers added value to clinical service delivery, access, and sustainability.

The Health Board meets on a regular basis with other Health Boards in South Wales to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

In addition, the Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Velindre University NHS Trust have agreed to work together on a portfolio of regional opportunities that at the time of writing includes Orthopaedics, Ophthalmology, Diagnostics, Stroke, and the development / implementation of a single regional clinical strategy for South-East Wales. A Regional Portfolio Oversight Board has been established to oversee the portfolio of work. Each Health Board / Trust is represented on this forum via its Chief Executive, Director of Planning and Chief Operating Officer.

Directed by the Cabinet Secretary for Health and Social Care, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board have established a Joint Regional Committee to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working.

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

As Chief Executive and Accountable Officer, I have overall responsibility for maintaining a sound system of internal control that supports the achievement of the Health Board's policies, aims and objectives, while safeguarding public funds and assets.

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Governance Framework and Capacity to Handle Risk



The Health Board has established a clear governance framework to support effective risk management and internal control.

The Board is supported by its committees, in particular:

- The Audit and Risk Assurance Committee, which provides independent assurance on the adequacy of governance, risk management and internal control
- The Patient Quality, Safety and Outcomes Committee, which oversees risks relating to quality and safety
- The Executive Committee provides a forum for the identification, review and escalation of risks, ensuring that emerging risks are actively managed and reported through the governance structure.

Responsibility for risk is clearly defined and delegated to Executive Directors, ensuring appropriate expertise and accountability across key domains including operational delivery, workforce, digital and patient safety.

The Risk Management Framework

The Health Board operates a comprehensive Risk Management Framework (RMF), approved by the Board and subject to annual review. The framework supports a consistent and structured approach to risk identification, assessment, mitigation and review.

Risk management is embedded within organisational processes, including planning and performance management, and aligned to the Integrated Medium-Term Plan (IMTP) and Gwent 35 Strategy.

Staff are supported through training and development to ensure that risk management is understood and applied consistently across the organisation, and aligned with the Board's Risk Appetite Framework.

An Internal Audit review undertaken during 2025/26 concluded a reasonable assurance opinion on the effectiveness of the Strategic Risk Register and associated processes.

Opportunities for improvement were identified in relation to consistency and clarity, but these do not detract from the overall effectiveness of the framework.

Risk Appetite Determination

The Health Board's Risk Appetite Framework defines the level of risk the organisation is willing to accept in pursuit of its strategic objectives. The framework is informed by consideration of operational pressures,

stakeholder expectations, regulatory requirements and the broader risk environment in which the Health Board operates.

The Board adopts a balanced and proportionate approach to risk-taking. Whilst there is recognition that some level of risk is inherent in delivering healthcare services and driving improvement, the Board maintains a low tolerance for risks relating to patient safety, quality of care and regulatory compliance, and a cautious approach in relation to financial sustainability.

The Risk Appetite Framework supports:

- Informed decision-making and prioritisation of resources
- Clear articulation of acceptable levels of risk exposure
- Structured escalation and oversight of risks operating outside of appetite

The Board explicitly recognises that, in the current operating environment, some risks will remain outside of appetite in the short to medium term. However, this does not represent a position of acceptance. Rather, such risks are subject to enhanced scrutiny, with a clear expectation that action is taken to reduce risk exposure to within acceptable levels as far as is reasonably practicable.

The table below summarises the Health Board's position in relation to its risk appetite and tolerance levels. The full Risk Appetite Statement is available separately [here](#)

	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
RISK APPETITE	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below



	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below

Risk Profile and Principal Risk

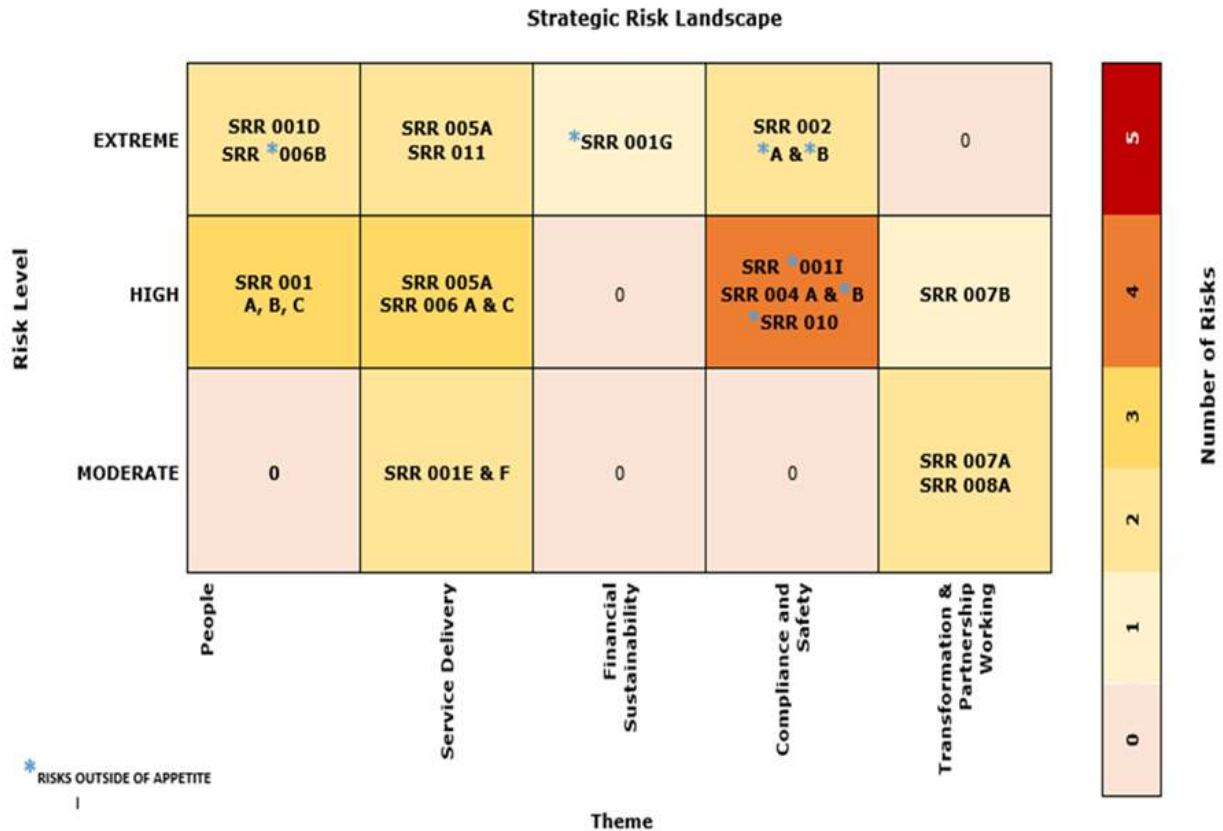
The Health Board maintains a Strategic Risk Register (SRR) which identifies and manages the principal risks to the achievement of its objectives. A copy of the latest Strategic Risk Report, presented to the Board in May 2026, is available on the Health Board's website.

The overall risk profile during 2025/26 remained stable within a high-risk operating environment. The majority of strategic risks are assessed as high, with a smaller number rated as extreme.

Key principal risks include:

- Financial sustainability
- Workforce capacity
- Service performance and operational resilience
- Patient safety and quality

The Board recognises the interdependencies between these risks and their potential cumulative impact on organisational performance and service delivery.



Seven of the strategic risks remain outside the Board's defined risk appetite and are subject to enhanced monitoring, scrutiny and management action, these are:

Risk ID & Score Threshold	Sub Risk Description	Current Score	Management of the Risk
SRR 001G Score 12 and below	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population Due to the failure to deliver a sustainable financial position and longer-term financial plan.	20	The residual risk is being treated through strengthened financial controls, while opportunities are being taken to redesign services for long-term sustainability.
SRR 001I Score 8 and below	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population Due to a failure to implement the required performance improvements in some areas	12	The residual risk is being treated and opportunities taken to strengthen services and accountability structures.



	of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.		
SRR 002A Score 8 and below	There is a risk that there will be significant failure of the Health Board's estate Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	15	The residual risk is being tolerated pending completion of remediation plans.
SRR 002B Score 8 and below	There is a risk that there will be significant failure of the Health Board's estate Due to significant levels of backlog maintenance and structural impairment.	12	The residual risk is being treated through proactive estate investment and maintenance planning.
SRR 004B Score 8 and below	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident Due to ineffective and insufficient arrangements across service areas.	12	The residual risk is being treated through the development, standardisation, and testing of business continuity and incident response plans.
SRR 006B Score 17 and below	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery. Due to an adverse impact on service delivery in the implementation of new digital systems.	20	The residual risk is being treated through strengthened governance, investment, implementation controls and contingency planning. At the same time, the Health Board is seeking to take advantage of opportunities presented by digital transformation.
SRR 010 Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974 Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act.	12	The residual risk is being treated through strengthening governance and taking the opportunity to enhance staff safety culture.



Assurance Framework (Three Lines of Assurance)

The Health Board applies the three lines of assurance model to support a structured and transparent approach to assurance.

First line:	Operational management and internal controls
Second line:	Oversight functions including governance, risk and compliance
Third line:	Independent assurance from Internal Audit and External Audit

The Audit, Risk and Assurance Committee receives regular reports on the effectiveness of this framework, including:

- Adequacy of controls
- Progress against mitigating actions
- Identification of gaps in assurance

Sources of assurance include Internal Audit, External Audit, performance and financial reporting, quality and safety information, and management assurances.

Significant Issues, Risks and Control Challenge

During 2025/26, the Health Board has continued to operate in a challenging environment, with a number of risks remaining outside risk appetite, particularly in relation to:

- Financial sustainability
- Workforce constraints
- Operational performance and demand pressures
- Infrastructure and estate resilience

These represent ongoing system pressures rather than failures of control but require continued focus and management action.

Actions taken to address control issues

In response to these challenges, the Health Board has taken steps to strengthen its control environment, including:

- Enhanced financial governance and oversight
- Targeted service improvement and recovery actions
- Strengthened workforce planning
- Improved oversight of digital and infrastructure risks
- Development of business continuity arrangements

In addition, actions are underway to:



- Strengthen Executive oversight of the Strategic Risk Register
- Improve the quality and consistency of risk reporting
- Enhance alignment between risk management and strategic planning

Overall Assurance Conclusion

Based on the sources of assurance outlined above, I can confirm that the Health Board has in place an effective system of internal control that supports the management of risk to a reasonable level.

While some risks remain outside the Board's defined appetite due to the external operating environment, these are clearly identified, actively managed and subject to enhanced scrutiny.

I am therefore able to provide reasonable assurance that the Health Board's arrangements for governance, risk management and internal control are operating effectively.

Public and Stakeholder Engagement

The Health Board engages with patients, the public and external stakeholders to inform its approach to risk management. This includes:

- Public consultation and engagement activity
- Collaboration with patient advocacy organisations, including Llais
- Partnership working with regulators, emergency services and local authorities

These arrangements support improved identification of emerging risks and strengthen organisational responsiveness.

Emergency Planning

In accordance with the statutory duties of the Civil Contingencies Act (2004) and Emergency Planning Guidance issued by Welsh Government the Health Board have in place emergency plans, business continuity arrangements, health protection response plans and supporting documents. These plans were considered by the Board's Partnerships, Population Health and Planning Committee in July 2024. The plan is currently undergoing a review in readiness for its 3 yearly review in 2027.

An internal business continuity audit was undertaken in October 2025 providing reasonable assurance. Within the scope of the audit the effectiveness of the business continuity management system in place was assessed and substantial assurance provided. A recommendation from the audit was for services to test and exercise their local plans, to address this the emergency planning team have scheduled dates throughout the year to facilitate exercising these plans.



There has, additionally, in accordance with the Act, been collaborative planning and exercising with Local Resilience Forum (LRF) partners throughout the year aligned to the LRF Risk Register, and shared and collaborative response to incidents.

THE CONTROL FRAMEWORK

Patient Safety, Quality, Experience and Learning

In 2025/26, Aneurin Bevan University Health Board continued to strengthen its quality governance arrangements to ensure effective oversight of clinical risk, patient safety, experience and clinical effectiveness. The Duty of Quality and Duty of Candour remained embedded as the golden thread from ward to Board, supported by the Quality Management Framework (2025–2028) and a maturing Quality Management System (QMS).

The QMS provides a structured and consistent approach to quality planning, quality control, quality improvement and assurance, enabling the Board to understand risk, variation and learning through triangulation of incidents, audit, outcomes, mortality, patient experience and staff feedback. Quality intelligence flows through divisional governance to the Quality Management Group (QMG), Executive Committee and Patient Quality, Safety and Outcomes Committee (PQSOC), providing assurance to the Board.

Further integration of corporate quality functions during 2025/26 (Quality and Patient Safety, Putting Things Right, Clinical Legal Services and Quality Improvement) strengthened escalation routes, reduced duplication and improved the reliability of movement from insight to action and assurance.

Quality Outcomes Framework (QOF) and Assurance Reporting

During 2025/26, the operating discipline of the QMS was strengthened through refreshed Quality Outcomes Framework (QOF) reporting. Quarterly submissions to PQSOC became more standardised, with clearer narrative, improved visualisation and stronger alignment to the six pillars of quality.

Run-chart data for key safety indicators (including falls and pressure ulcers) improved visibility of variation and supported earlier intervention at divisional and service level. These developments enhanced the Board's ability to gain assurance on quality performance and risk.

Clinical Effectiveness, Mortality and Clinical Audit

The Six Pillars of Quality continue to provide the assurance spine for the Health Board. In 2025/26, Pillar 3 – Clinical Effectiveness was strengthened to improve visibility of clinical outcomes, audit, benchmarking and adherence to evidence-based practice.



The local Clinical Audit approach underpinned participation in the National Clinical Audit Programme alongside local priority audits. Audit findings were reviewed through the Clinical Standards and Effectiveness Group (CSEG) and escalated to PQSOC where required. All actions arising from audit are recorded and tracked via the Audit Management and Tracking (AMaT) system, providing clear accountability and oversight.

Learning from Deaths processes were strengthened through more consistent templates, improved data validation and enhanced triangulation with audit, safety and outcome data. Thematic outputs now inform CSEG, QMG and PQSOC, supporting a more integrated view of harm and variation.

Clinical Risk Management and Deteriorating Patients

Clinical risk is identified and managed through multiple sources including incident reporting, mortality reviews, audit findings, complaints, claims and patient feedback. Risks are reviewed within divisional governance structures and escalated through QMG and PQSOC as required, aligned to the Board Assurance Framework.

In 2025/26, a key area of focus was the deteriorating patient agenda and sepsis. Significant progress was made in implementing national deterioration tools (NEWS2, PEWS and NEWTT2) and preparing for Call 4 Concern (Martha's Rule). Training delivery was supported through ESR reporting and local training packages, with coordinated oversight via the Deteriorating Patient Health Board Group.

The Big Conversation on Sepsis strengthened governance focus by incorporating lived experience from patients, families, clinicians and leaders, reinforcing the importance of early recognition, escalation and reliable systems of care.

Patient Experience, Putting Things Right (PTR) and Learning Systems

PTR governance continued to strengthen in 2025/26 through earlier acknowledgement, more consistent initial contact, Datix validation dashboards and targeted improvement work, particularly within Medicine. Patient and staff stories were increasingly used within governance forums to support compassionate, just learning and improvement.

These arrangements improved transparency, data quality and timeliness, and strengthened the role of lived experience within quality assurance and improvement.

Infection Prevention and Control (IPC)

IPC governance was strengthened through enhanced surveillance, standardisation of policies and active oversight of infection risks. Integration of IPC metrics into QMS dashboards improved early



identification of infection-related risks and strengthened divisional accountability and assurance.

Health and Safety

Health and safety governance was reinforced through improved RIDDOR oversight, policy standardisation and focused fire safety close-out. The early development of the Violence Prevention and Reduction Strategy strengthened links between staff safety, patient outcomes and organisational culture. Integration of health and safety metrics into QMS dashboards improved consistency of assurance.

End of Life Care and Bereavement (GRACE)

End of life and bereavement care continued to develop through the rollout of the GRACE model, aligned to the National Bereavement Framework. Governance arrangements supported the establishment of a single point of contact, People Participation Panels and Graces' Places across boroughs, improving continuity of bereavement care and early support for families. Stronger multidisciplinary coordination, clearer pathways and early Grief Awareness training improved system visibility and consistency of care.

Overall Assurance

In 2025/26, the Health Board's quality governance arrangements provided a coherent and increasingly mature system for managing clinical risk, overseeing clinical audit and effectiveness, and assuring the quality and safety of care. The continued development of the QMS strengthened the Board's ability to triangulate intelligence, escalate risk appropriately and gain assurance that improvement actions are implemented and sustained.

Information Governance

Information is a critical asset, essential for both the clinical management of individual patients and the efficient management of services and resources. Information Governance (IG) involves establishing high standards for handling this information and equipping the organisation with the necessary tools to achieve these standards.

The Health Board has designated several key roles with specific responsibilities related to the information it holds, uses, and shares. The Medical Director serves as the Caldicott Guardian, the Director of Digital is the Senior Information Risk Owner (SIRO), and the Assistant Director of Digital Governance & Assurance is the Data Protection Officer (DPO).

Throughout 2025/2026, the Health Board continued to enhance its forums to address information governance requirements consistently. These forums facilitate processes and communications to ensure compliance with Data Protection obligations. Dashboards are produced to support and assist in training compliance, complaint handling, incident, and breach



management. Annual reports detailing progress are disseminated to relevant divisions and boards.

The organisation continued to demonstrate a strong information governance and data protection control environment through its performance against the Information Governance Toolkit, achieving a compliance score in excess of 96% and meeting all essential criteria. This performance provides assurance of alignment with national data security and protection standards.

The Senior Information Risk Owner (SIRO) report was published which provided an overview of the organisation's information governance activities and performance. It informs senior management about the organisations efforts in managing information risks and ensuring compliance with relevant regulations.

The Wales Accord on the Sharing of Personal Information (WASPI) framework is firmly embedded in the Health Board's practices for sharing relevant information with partner organisations.

In 2025/2026, the Information Governance Department received a total of 224 Subject Access Requests (SAR's) from individuals seeking access to personal information held about them. These requests were separate from and did not include Access to Health Records requests.

The number of Subject Access Requests (SAR's) processed under the Access to Health records provisions increased by 3.9% rising from 7,568 in 2024/2025 to 7,862 in 2025/2026.

There was also a 22% increase in Information Governance (IG) incidents reported by staff, from 555 incidents in 2024/2025 to 676 incidents in 2025/2026.

During the reporting period, a total of 82 Information Governance related complaints were received from members of the public. Of these, 4 complaints were referred to the Information Commissioners Office (ICO), with 3 not upheld and 1 pending a final outcome at the time of writing.

In 2025/26, the Health Board reported no serious lapses in data security to the ICO.

Performance Management and Accountability Framework (2025/26)

During 2025/26, the Health Board continued to strengthen its performance management and accountability framework to ensure a clear line of sight from strategic objectives through to operational delivery, supported by



robust governance, transparent reporting, and timely intervention where required. The framework is aligned to the requirements of the NHS Wales Planning Framework and reflects the organisation's commitment to high standards of stewardship, quality improvement, and public accountability. Throughout 2025/26, the Health Board maintained a comprehensive and balanced suite of indicators across key domains, including:

- Urgent and emergency care
- Planned care and waiting times
- Cancer performance
- Mental health and community services
- Workforce, finance, and quality and safety

Performance is reviewed on a monthly basis, with escalation protocols applied where delivery falls outside agreed tolerances. Exception reporting has been further refined to ensure a sharper focus on areas of underperformance, including root cause analysis, recovery actions, and defined timescales for improvement.

The Board continues to receive integrated performance reports, enabling triangulation of quality, activity, workforce and financial data to support informed decision-making and effective oversight.

The strengthened framework has supported more consistent oversight and earlier identification of performance risks. While wider system pressures have continued to impact delivery, particularly within urgent and emergency care and planned care, the Health Board has demonstrated:

- Improved organisational grip on performance, with clearer accountability and more structured follow-through of actions
- Enhanced visibility of risks and delivery challenges, enabling earlier escalation and intervention
- Stronger assurance to the Board, through more comprehensive and integrated reporting

Within mental health services, the application of strengthened performance management arrangements has supported targeted improvement activity and greater operational focus, resulting in measurable progress during 2025/26. These improvements have been underpinned by clearer lines of accountability, strengthened leadership oversight, and a more systematic approach to performance management within mental health services.

Overall, the progress made during 2025/26 provides a stronger and more coherent framework for delivery, with improved grip, enhanced assurance, and clearer accountability across the organisation.

Quality of Data



The Health Board makes every attempt to ensure the quality and robustness of its data and has regular checks in place to assure the accuracy of information relied upon. However, it is recognised that the multiplicity of systems and data inputters across the organisation means that there is always the potential for variations in quality, and therefore always scope for improvement. We have an on-going data quality improvement approach which routinely assesses the quality of our data across key clinical systems. Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

The Board relies upon independent and objective assurances, such as those provided by auditors and inspectors, to comment upon the effectiveness of the Board's assurance system. This assurance system includes reporting on financial performance, operational performance and quality of and associated outcomes.

The Corporate Governance Code

The Corporate Governance Code currently relevant to NHS bodies is 'The corporate governance in central government departments: code of good practice' (published 21 April 2017). The Health Board, like other NHS Wales organisations, is not required to comply with all elements of the Code, however, the main principles of the Code stand as they are relevant to all public sector bodies. The Corporate Governance code is reflected within key policies and procedures. Further, within our system of internal control, there are a range of mechanisms in place that are designed to monitor our compliance with the Code. These include Self-assessment; Internal and External Audit; and Independent Reviews.

The Board is clear that it is complying with the main principles of the Code and is conducting its business openly and in line with the Code, and that there were no departures from the Code as it applies to NHS bodies in Wales. A copy of the current self-assessment against the code is provided as **Attachment Three**.

Planning Arrangements

In March 2025, the Board approved a balanced Integrated Medium-Term Plan (IMTP) for 2025-28 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework.

This was subsequently approved by the Cabinet Secretary for Health and Social Care (the Cabinet Secretary) in July 2025, however the Welsh Government's Collective Review process concluded that the IMTP carried a



number of risks that would need to be actively managed and mitigated and was therefore approved subject to a range of accountability conditions.

On 16 December 2025, the Cabinet Secretary announced that, in-line with the NHS Wales Oversight and Escalation Framework, and due to a deterioration in the financial position, failure to deliver the approved IMTP, and waiting times at the Grange University Hospital emergency department: finance, strategy and planning would be escalated from level 3 to level 4; and performance and outcomes related to urgent and emergency care at the Grange University Hospital emergency department would be escalated from level 3 to level 4 and be widened to include the whole urgent and emergency care system. Consequently, the Cabinet Secretary informed the Health Board that a decision had been taken to revoke the approval status of the Health Board's IMTP with immediate effect.

Throughout the year the Board and its Finance and Performance Committee has maintained a focus on overseeing delivery of the commitments set out by the Health Board within the IMTP for 2025/26.

In March 2026, the Board approved its Annual Plan (with a Three-Year Intent) for 2026/27, forecasting a financial deficit of £43.7m, which did not fully comply with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and the NHS Planning Framework.

On 22 April 2026, the Health Board received confirmation from Welsh Government that as the Annual Plan 2026/27 represented a deteriorating financial and performance position, the Plan was considered by Welsh Government to be unacceptable and unsupportable. At the time of writing, the Health Board is expected to consider and address feedback received from Welsh Government and provide a response which demonstrates tangible improvements to the Plan in relation to performance and finance by 29 May 2026.

MANDATORY DISCLOSURE STATEMENTS

Equality, Diversity & Human Rights

The Health Board remains committed to promoting equality, diversity and human rights across its workforce and the services it provides to the population of Gwent. During the reporting period, the Health Board has continued to progress delivery of its Strategic Equality Plan (SEP) 2024–2028, strengthening the integration of equality, diversity and human rights considerations across workforce practice, service delivery and organisational governance. This work supports the organisation's statutory responsibilities under the Equality Act 2010, the Human Rights Act 1998, and the Public Sector Equality Duty (Wales) Regulations 2011.



Progress during the year has focused on embedding the Health Board's equality objectives across key organisational programmes, including the People Plan, workforce development initiatives and service improvement activity. Governance and oversight arrangements have also been strengthened to ensure greater organisational accountability for equality, diversity and human rights delivery. Regular assurance on Equality, Diversity and Inclusion (EDI) activity continues to be provided to the Board through the People and Culture Committee, including monitoring progress against the Strategic Equality Plan and associated action plans.

The Health Board has also continued to develop initiatives to support a more inclusive organisational culture, including strengthening engagement with staff networks, promoting inclusive leadership and progressing work to improve accessibility and equity in communication and information for patients and staff. This includes ongoing work aligned with the All-Wales NHS Accessible Communication and Information Standards (ACIS).

The Health Board continues to meet its statutory equality reporting requirements, including the annual publication of Gender Pay Gap data, based on the workforce snapshot taken on 31 March each year in line with national reporting requirements. The Health Board has seen a decrease in the pay gap percentage for average hourly rates, from 24.71% in March 2024 to 23.8% in March 2025, which is a move in the right direction. The median hourly pay gap has also reduced, from 9.69% in March 2024 to 6.13% in March 2025.

Through these arrangements, the Health Board maintains appropriate control measures to support compliance with equality, diversity and human rights legislation and to promote an inclusive and equitable environment for staff, patients and the communities it serves.

Pensions Scheme

I can confirm that as an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments into the Scheme are in accordance with Scheme rules and that the member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Further detail in this regard is included within the provisions note within the 2025/26 Financial Statements (Note 20).

Carbon Reduction Delivery Plans

The Health Board is able to confirm compliance with the following statement:



"The organisation has undertaken risk assessment and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projections to ensure that the organisation's obligation under the Climate Change Act and the Adaptation Reporting requirements are complied with."

Counter Fraud, anti-corruption and anti-bribery matters.

Aneurin Bevan University Health Board is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care.

The Health Board's Counter Fraud Team undertake proactive/preventative work with the intention of safeguarding the organisation from economic crime. Further information on the valuable work undertaken is available in the [Counter Fraud Annual Report 2025/26](#).

Ministerial Directions & Welsh Health Circulars

The Welsh Government has previously issued Non-Statutory Instruments and reintroduced Welsh Health Circulars (WHCs) in 2014/15. Details of these and a record of any ministerial directions given is available on the Welsh Government website. A full detail of the WHCs and Ministerial Directions issued to the Health Board in 2025/26 and the Health Board's responding action is included at **Attachment 2**.

There was one Ministerial Direction issued in December 2019, to address the operational challenges arising as a consequence of pension tax arrangements. Further detail in this regard is included in provisions within the 2025/26 Financial Statements (Note 20).

Modern Slavery Act 2015 – Transparency in Supply Chains

The Health Board is fully committed to the Welsh Government Code of Practice Ethical Employment in Supply Chains. This has been established by the Welsh Government to support the development of more ethical supply chains to deliver contracts for the Welsh public sector and third sector organisations in receipt of public funds.

NHS Wales Shared Services Partnership (NWSSP) Procurement Services, on behalf of the Health Board, commits to ensure that any parts of our supply chain comply with all elements of the code of practice including:

- Modern slavery & human rights abuses;
- Blacklisting;
- False self-employment;
- Unfair use of umbrella schemes and false self-employment; and
- Paying the living wage.

NWSSP Procurement Services has:



- Embedded the Code of Practice in standard operating procedures, including terms and conditions of contract;
- Provided training to those involved in buying/procurement on modern slavery and ethical employment practices, through various training mediums;
- Aligned the Code of Practice within our broader Sustainable Procurement Code of Practice;
- Developed standard questions that ensure ethical employment practices are considered as part of the procurement process;
- Became a signatory to the Transparency in Supply Chains (TISC) register, and published the NWSSP Ethical Employment Statement; and
- Encouraged our suppliers sign up to the TISC register, and publish their own modern slavery/ethical employment policies and statements;
- Engaged with wider NHS Scotland, NHS Northern Ireland and NHS England colleagues to continue to develop and share best practice.

NWSSP Procurement Services will continue to:

- Conduct appropriate and targeted engagement with our bidders, to ensure that the way in which we work does not contribute to the use of illegal or unethical employment practices within the supply chain;
- Maintain and share knowledge of ethical employment issues and themes, ensuring continuing support of fair and decent work;
- Leverage our tender processes to encourage our suppliers to sign up to the commitments of Ethical Employment in Supply Chains Code of Practice and also to the TISC register, to publicise their commitments and their Modern Slavery/Ethical Employment Statements;
- Assess our expenditure to identify areas of high risk, and continue to address any issues of modern slavery, human rights abuses and/or unethical employment practice.

The NWSSP Ethical Employment statement and more information can be found on the NWSSP [Website](#)

REVIEW OF EFFECTIVENESS OF SYSTEM OF INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the system of internal control is informed by the work of the internal auditors, and the executive officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate,



escalated or de-escalated through the governance mechanisms of the organisation.

During 2025/26, the Board's Audit, Risk and Assurance Committee and, Patient Quality, Safety and Outcomes Committee played a key role in monitoring the effectiveness of internal control and the process for risk management. During 2025/26 work has continued to embed the Risk Management Framework and the Board's Quality Strategy ensures that the work of all regulators, inspectors and assurance bodies is mapped and evidenced in our assurance framework so that the Board is fully aware of this activity and the level of assurance it provides. We will also continue to strengthen arrangements for monitoring and reporting progress in implementing recommendations arising from the work of auditors.

The Health Board also uses reports from Healthcare Inspectorate Wales, the Welsh Risk Pool and other inspectorates and regulatory bodies to inform the governance and assurance approaches established by the organisation. A tracking mechanism for these recommendations is also in place and progress in delivering these recommendations is overseen by the Patient Quality, Safety and Outcomes Committee via updates in respect of Inspections.

INTERNAL AUDIT

Internal audit provides me as Accountable Officer and the Board, through the Audit, Risk and Assurance Committee with a flow of assurance on the system of internal control. I have commissioned a programme of audit work which has been delivered in accordance with public sector internal audit standards by the NHS Wales Shared Services Partnership. The scope of this work is agreed with the Audit, Risk and Assurance Committee and is focussed on significant risk areas and local improvement priorities.

The overall opinion by the Head of Internal Audit on governance, risk management and control, is a function of this 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.

The Head of Internal Audit is satisfied that there has been sufficient internal audit coverage during the reporting period in order to provide the Head of Internal Audit Annual Opinion. In forming the Opinion, the Head of Internal Audit has considered the impact of the audits that have not been fully completed.

The assurance sections that follow provide a brief summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year 2025-26.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

Standing Orders Compliance 2025/26

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

Welsh Intensive Care Information System 2025/26

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

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Divisional Governance Arrangements 2024/25

The review assessed whether the governance arrangements in place within the Primary Care and Community (PCC) Division ensure key risks and matters arising were escalated and managed effectively. This review was completed in line with the Aneurin Bevan University Health Board 2024/25 Internal Audit Plan.

Mental Health and Learning Disabilities 2024/25

The review assessed the arrangements from the 90-day Plan for the Mental Health and Learning Disabilities division to ensure that these have been embedded.



Maternity Services Improvement Plan 2024/25

This review followed the 2023/24 internal audit of the Maternity Services Action Plan, assessing whether previously raised external recommendations were being effectively implemented on schedule and appropriately monitored.

Staff Survey 2024//25

A review of the actions underway to influence change following on from the Employee Experience Survey (staff survey) results.

GUH Emergency Department Extension 2024/25

The audit was undertaken to review the management arrangements established to progress the extension of the Grange University Hospital Emergency Department.

Health Board Managed Practices 2024/25

The review examined the letting of a group of five Health Board managed GP practices that were let to a single partnership in early 2024 (one that commenced operation from 1 January 2024 and four from 1 April 2024) and which were subsequently returned to the Health Board's management in 2025. The review was to ensure that the Health Board had an appropriate process in place to assist in managing the return of a Managed Practice to Independent Contractor status, including the application and shortlisting processes.

Performance and Accountability Framework 2024/25

The review examined the adequacy of the Performance and Accountability Framework arrangements put in place at Aneurin Bevan University Health Board. The review assessed the appropriateness of the Framework implemented, rather than the associated performance recorded.

Technical Continuity 2024/25

To review the enactment of technical resilience and awareness of fault domains and to ensure that Aneurin Bevan University Health Board is maximising the potential for resilience within the architecture.

Medical Equipment and Devices 2024/25

This audit assessed the controls in place for the management of a sample of medical equipment and devices within the Health Board. The term medical device includes all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability but the scope of this audit was limited to electronic patient connected medical equipment, excluding ultrasound devices, which were the subject of a similar audit during 2023/24.

Newport East Health and Wellbeing Centre 2024/25

The audit was undertaken to evaluate whether the Health & Wellbeing Centre, as commissioned, had achieved the desired objectives and whether issues raised

at prior audits have been addressed. This was the third audit of the project (the previous review in April 2024 having determined Reasonable Assurance).

Waiting List Management 2024/25

The review focused on adult weight management, which has Health Board derived targets in the absence of national targets.

Electronic Document and Records Management Solution (EDRMS) 2024/25

To review the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services within Aneurin Bevan University Health Board.

Financial Sustainability 2024/25

To determine if appropriate recovery plans were in place to achieve a sustainable financial position, including the impact of any associated reduction in non-recurrent funding. The audit provided assurance over the establishment, implementation and tracking of financial savings targets, in relation to the recovery plans.

Safeguarding 2025/26

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

Business Continuity Plan 2025/26

As a Category 1 responder, with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response. The audit examined and assessed the adequacy and completeness of business continuity plans and response protocols in a sample of the services within the Health Board's divisions. IT disaster recovery testing was not covered within this review, as it is assessed separately.

Cyber Security 2025/26

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

RGH Central Decontamination Unit 2025/26

The overall objective of this audit was to evaluate the progression and delivery of the project against the key business case objectives and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

Strategic Risk and Assurance 2025/26

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.

Capital Projects – Service Readiness 2025/26

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.

Directorate Review – Child and Adolescent Mental Health Services 2025/26

To ensure that appropriate arrangements are in place for the management of risk and performance within the Health Board and CAMHS Directorate.

Occupational Health 2025/26

To provide assurance over the arrangements and controls in place for the management of the Occupational Health Service within the Health Board.

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with moderate impact on residual risk exposure until resolved.

The Management response and action plan to respond to the issues and weaknesses identified, which form part of the final reports, are considered by the Audit, Risk and Assurance Committee. The Committee monitor progress in line with agreed timescales via the Audit Recommendations Tracker.

In addition for all limited assurance rated reports, executive leads attend the Audit, Risk and Assurance Committee to provide assurance on the actions identified.

Internal Audit also conduct a follow up of limited assurance reviews as part of their rolling audit plan.

Embedding of Policies 2024/25

The review assessed whether the Speaking up Safely: A Framework for the NHS in Wales has been fully implemented.



The Framework was released in December 2024 and work remained ongoing to address the gaps. Monitoring the effectiveness of the new process would continue. Follow Up audit included in the 2025/26 Internal Audit Plan.

Job Planning 2024/25

To provide assurance that arrangements are in place and operating effectively for consultant job planning.

A robust process was in place, with actions to increased compliance with job planning. The main challenge lay in the uptake and completion of job plans. Regular updates on progress provided to ARAC and People and Culture Committee.

Health and Safety 2024/25

To review how key health and safety risks were managed in accordance with the Health Board policies and procedures, including RIDDOR reporting.

Significant work had been undertaken since audit fieldwork concluded, with improvements made, but governance remained in development, with a review of divisional accountability underway.

Subject Access Requests 2025/26

To ensure the Health Board is complying with legal and regulatory obligations with effective processes and that the system for managing Subject Access Requests (SARs) is robust, secure, and efficient. The audit only looked at information held by the Health Board and did not include information managed by other parties e.g. GP practice records maintained by NWSSP. In addition, the quality of records that were issued to the requestor was not assessed.

Despite the limited assurance outcome, the team's operational performance was exceptionally strong, with more than 99% of SARs processed within statutory timescales and a high monthly volume of 600–700 requests being managed effectively. The limitation in assurance arose from control weaknesses, rather than performance. Improvement actions have been put in place to address this.

Speaking up Safely

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. Speaking Up Safely framework is an overarching model supporting existing policies, but local interpretation has created complexity, requiring the need to formalise processes through a standard operating procedure (SOP) to clarify pathways, responsibilities, and expectations. A number of improvements are underway, including the appointment of a Speaking Up Safely Guardian, procurement of a unified case management system (with full implementation expected by October 2026), and strengthened governance, training, and communication arrangements.

The GUH Emergency Department

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.

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Contract Management 2024/25

The review assessed whether appropriate contract management arrangements were in place within the Health Board. This review had been undertaken further to the advisory review of Contract and Procurement at Betsi Cadwaladr University Health Board (BCUHB), completed at the request of Welsh Government in 2023/24, which identified several areas of concern and non-compliance with the organisation's Standing Financial Instructions. Through inclusion within NHS Wales Organisations 2024/25 Internal Audit plans, this review has compared and contrasted the appropriateness of contract management arrangements across eight more organisations, with common issues and challenges noted.

Follow up of previous Audit Recommendations 2024/25

To assess whether a sample of high and medium priority internal audit recommendations have been implemented by Aneurin Bevan University Health Board

Health Board Managed Practices 2024//25

A follow up to the audit report listed above (in reasonable assurance). This supplementary report included additional considerations for the Health Board to consider, which are in addition to the expectations specified within the existing control environment (i.e. applicable regulations, Welsh Health Circular and/or Vacant Practice Policy).

Public Health 2025/26

To determine if the Health Board had effective controls in place to ensure that public health objectives are being met at a local level, in support of the IMTP and the requirements of the Wellbeing of Future Generations (Wales) Act 2015, whilst recognising the responsibilities of Public Health Wales. A number of items were raised aimed at improving internal controls and/or compliance. These will

need to be considered against other priorities and available financial / non-financial resources.

The following three reports included in the 2025/26 Internal Audit Plan have been deferred to 2026/27:

- Clinical Audit
- Six Goals Programme
- Directorate Review – Ophthalmology/ENT

The following **6** reports form the 2025-26 audit schedule will be presented at Committee meetings during Quarters 1 and 2 of 2026-27.

- Divisional Budgetary Control
- Benefits Realisation (Excluding digital)
- Professional Staff Registration
- Cancer Referral Rates
- Estates Assurance – Space Utilisation
- NHH Regional Satellite Centre

Monitoring and Implementation of Audit Recommendations

The Audit, Risk and Assurance Committee maintains oversight of the monitoring and implementation of audit recommendations. Over the past year, the Health Board has strengthened its internal audit guidance, including the development of formalised procedures and supporting documentation. This has established a consistent framework for tracking both internal and external audit recommendations, reinforcing effective monitoring to support organisational learning, strengthen governance, and provide assurance.

During 2025/26, further progress has been made in enhancing the maturity and effectiveness of audit recommendation management. Targeted action has been taken to improve the timeliness of implementation, with particular emphasis on addressing longstanding recommendations (pre-2023) and those previously delayed due to factors outside the Health Board's control.

In-year, a series of focused "deep dive" reviews were undertaken in key areas, including discharge planning and digital. These reviews identified a number of longstanding recommendations that remained unimplemented and highlighted areas where there was overlap across recommendations, as well as instances where management responses had extended beyond the original scope of the recommendation. This work has provided greater clarity on prioritisation, improved alignment between recommendations and actions, and strengthened oversight of delivery.

Work is also underway to strengthen the reliability, visibility, and control of the tracking process through the transition from an Excel-based system to Microsoft Lists. All post-2023 recommendations are now managed within the new system. Once the remaining pre-2023 recommendations (20 in total) have been implemented and closed, the Health Board will complete the transition to a single, standardised digital platform. This will enhance data accuracy, improve version control, and provide a clearer audit trail, while also supporting the efficiency and robustness of Internal Audit’s annual review process.

In addition, the development and implementation of an Audit Handbook, alongside an embedded quality assurance process, has further strengthened the Health Board’s approach. This has improved the consistency and quality of management responses, ensuring they meet audit standards and are specific, measurable, achievable, relevant, and time-bound (SMART).

To provide independent assurance to the Committee and the Board, Internal Audit undertakes an annual review of the implementation of audit recommendations, with particular focus on those assessed as high priority. The review assesses whether appropriate and timely action has been taken and considers any residual risks arising from delays in implementation. Although this is an advisory audit, it is an important tool that supports organisational learning and provides valuable insight to strengthen the future management of audit recommendations.

At the end of the 2025/26 financial year, the Audit Recommendations Tracker recorded 80 outstanding recommendations across 34 audit reports. This reflects continued focus on implementation to support improvements in quality, safety, and governance across the Health Board.

Number of Live Recommendations on the Corporate Audit Tracker by Priority Rating				
High	Medium	Low	Not Rated*	Total
20	35	2	23	80

*Not rated covers External Audit recommendations which are not given a priority rating as well as Internal Audit Advisory Reports

Head of Internal Audit’s Opinion for 2025/26

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. 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.

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.

EXTERNAL AUDIT: AUDIT WALES STRUCTURED ASSESSMENT

The Audit Wales 2025 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress in implementing recommendations from previous structured assessment reports and the Audit Wales 2024 report on cost savings.

Overall, the Audit Wales report stated:



"The Health Board's Board and committee governance arrangements are stable and generally effective. However, given its financial and performance challenges, the Health Board's development of a new long-term strategy and delivery of its three-year route map are crucial to enabling the organisation to transform services to meet current and future demand."

The report went on to say that:

- **Board transparency, effectiveness, and cohesion** – "Despite reasonably effective Board and committee arrangements, the Health Board should increase the number of patient safety leadership walk rounds and improve committee chairs' reporting to Board."
- **Corporate systems of assurance** – While the Health Board is strengthening its assurance arrangements and its performance management approach is improving; further work is needed."
- **Corporate approach to planning** – "The Health Board has generally effective arrangements for developing strategic plans built on good engagement. Developing a new long term strategy is a clear priority for the Health Board. However, it needs to ensure clinical services plans are developed in consultation with all relevant stakeholders and fully reflect the changes needed to further deliver sustainable clinical service models."
- **Corporate approach to managing financial resources** - "The Health Board is improving its financial controls and has a stronger focus on value and savings delivery. However, its significant ongoing financial challenges suggest that it needs a longer term and detailed financial strategy aligned to sustainable care models."

The Annual Audit Report for the Health Board is available on the following [link](#). This report summarises the findings from Audit Wales' 2025 audit work at Aneurin Bevan University Health Board undertaken to fulfil their responsibilities under the Public Audit (Wales) Act 2004.

Copies of all reports produced by Audit Wales can be accessed via [Audit Wales Publications](#).

CONCLUSION

As Accountable Officer for Aneurin Bevan University Health Board, based on the assurance process outlined above, I have reviewed the relevant evidence and assurances in respect of internal control. I can confirm that the Board and its Executive Directors are alert to their accountabilities in



respect of internal control and the Board has had in place during the year a system of providing assurance aligned to corporate objectives to assist with identification and management of risk.

During 2025/26, the Health Board proactively identified areas requiring improvement and requested that Internal Audit undertake detailed assessments in order to manage and mitigate associated risks. Work will continue in 2026/27 to ensure implementation of recommendations arising from audit reviews, in particular where a limited assurance rating is applied. Work will also continue in 2026/27 to further embed and mature risk management and assurance arrangements at a corporate and operational level. Implementation of further improvements identified by External Audit will see a further strengthening of the Board's effectiveness and the system of internal control in 2026/27.

This Annual Governance Statement confirms that Aneurin Bevan University Health Board has continued to mature as an organisation and, whilst there are areas for strengthening, no significant internal control or governance issues have been identified. The Board and the Executive Team has had in place a sound and effective system of internal control that provides regular assurance aligned to the organisation's strategic objectives and strategic risks. Together with the Board, I will continue to drive improvements and will seek to provide assurance for our citizens and stakeholders that the services we provide are efficient, effective and appropriate, and are designed to meet patient needs and expectations and that our governance framework continues to develop and mature.

It is disappointing that in 2025/26, the Health Board has remained under enhanced escalation and intervention arrangements in some areas with Welsh Government. Significant progress has been made, and we will continue to progress at pace towards sustainable improvements that enable de-escalation to routine monitoring arrangements.

It is widely known that the demands on the health and care system remain significantly pressured, increasing health inequalities, and sustained economic and cost of living challenges. The health and care landscape in Gwent is rapidly changing. The Health Board has an agreed long-term strategy, '*Gwent 2035: Better Health, Better Care, Better Lives*', which articulates our joint commitments with the population of Gwent through to 2035. This strategy will continue to guide the Health Board in all we do to achieve our ambition that by 2035 everyone has the same chance to live a long healthy life.

Signed:

Nicola Prygodzicz



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Chief Executive
Dated: XX 2026

Attachment One

The Board has been constituted to comply with the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. In addition to responsibilities and accountabilities set out in terms and conditions of appointment, Board members also fulfil Champion roles where they act as ambassadors for these matters.

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Independent Members				
Ann Lloyd	Chair		7 out of 7	
Philip Robson	Vice Chair		6 out of 7	Mental Health
Louise Wright	Independent Member (Trade Union)	Until 10/04/2025	0 out of 0	
Vivek Goel	Independent Member (Trade Union)	From 02/06/2025	4 out of 6	
Richard Clark	Independent Member (Local Authority)	Until 19/09/2025	2 out of 3	
Helen Cunningham	Independent Member (Local Authority)	From 03/11/2025	3 out of 3	
Professor Helen Sweetland	Independent Member (University)		6 out of 7	Research
Paul Deneen	Independent Member (Community)		7 out of 7	Children and Young People
Iwan Jones	Independent Member (Finance)		7 out of 7	Welsh Language
Dafydd Vaughan	Independent Member (Digital)		7 out of 7	
Neil Patrick	Independent Member (Community)		7 out of 7	Armed Forces
Penny Jones	Independent Member (Community)		7 out of 7	Speaking Up Safely
Akmal Hanuk	Independent Member (Third Sector)	From 02/06/2025	5 out of 6	

Name	Designation	Dates (If not full year)	Attendance at Board Meetings	Champion Role
Executive Directors				
Nicola Prygodzicz	Chief Executive		7 out of 7	
Hannah Evans	Director of Strategy, Planning and Partnerships		7 out of 7	Emergency Planning
Rob Holcombe	Director of Finance and Procurement		7 out of 7	
Dr James Calvert	Medical Director / Deputy Chief Executive	Until 05/08/2025	1 out of 3	Caldicot
Dr Andy Bagwell	Interim Medical Director	05/08/2025 to 26/10/2025	1 out of 1	
Dr Seema Srivastava	Medical Director	From 27/10/2025	3 out of 3	Caldicot
Sarah Simmonds	Director of Workforce and OD		6 out of 7	Raising Concerns Welsh Language
Jennifer Winslade	Director of Nursing		7 out of 7	
Peter Carr	Director of Allied Health Professions and Health Sciences		5 out of 7	Fire Safety Violence and Aggression
Tracy Daszkiewicz	Director of Public Health		7 out of 7	
Leanne Watkins	Chief Operating Officer		5 out of 7	
Directors in Attendance				
Paul Solloway	Director of Digital		7 out of 7	
Director of Corporate Governance				
Rani Dash	Director of Corporate Governance		7 out of 7	

Membership and attendance at Committees of the Board is provided on pages 17-28

Quoracy of Meetings

Quorate	Non-Quorate

Board	21 May 2025	25 June 2025	16 July 2025	24 September 2025	26 November 2025	28 January 2026	25 March 2026	
Patient Quality, Safety and Outcomes Committee	31 March 2025	3 June 2025	29 July 2025 (meeting cancelled)	1 October 2025	2 December 2025	17 February 2026		
Audit, Risk and Assurance Committee	22 April 2025	20 May 2025	24 June 2025	18 September 2025	21 October 2025	16 December 2025	22 January 2026	12 February 2026
Charitable Funds Committee	4 June 2025	30 September 2025	7 January 2026	22 April 2026				
Partnerships, Population Health and Planning Committee	2 April 2025	1 July 2025	7 October 2025	27 January 2026				
Mental Health and Learning Disabilities Committee	9 April 2025	17 June 2025	9 September 2025	20 January 2025	24 March 2025			
Finance and Performance Committee	8 April 2025 (meeting cancelled)	17 June 2025	31 July 2025	29 September 2025	15 December 2025	23 February 2025		
People and Culture Committee	11 June 2025	15 October 2025	10 February 2026					

Remuneration and Terms of Service Committee	19 May 2025	3 September 2025	4 February 2026					

Attachment Two

Welsh Health Circulars

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/004	14/04/2025	<u>NHS Wales National Clinical Audit and Outcome Review Plan 2025 to 2026</u>	Complete
WHC/2025/006	06/05/2025	<u>Recording of Mental Health Outcome Measures</u>	In Progress
WHC/2025/008	25/06/2025	<u>Introduction of a National Mandatory Licensing Scheme for Special Procedures in Wales</u>	In Progress
WHC/2025/010	11/04/2025	<u>Changes to prescribing antiviral and antibody treatments for COVID-19</u>	Complete
WHC/2025/011	11/04/2025	<u>Identity Verification for Digital Health Services in Primary Care</u>	Complete
WHC/2025/012	29/05/2025	<u>Interim changes to NHS Model Standing Financial Instructions</u>	Complete
WHC/2025/013	24/04/2025	<u>NHS Wales Financial Monitoring Return Guidance 2025 to 2026</u>	Complete
WHC/2025/015	22/04/2025	<u>People's Experience framework</u>	Complete
WHC/2025/016	06/05/2025	<u>Update on NHS Wales Vaccination programme against respiratory syncytial virus (RSV)</u>	Complete
WHC/2025/017	06/05/2025	<u>Tranexamic acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)</u>	In Progress
WHC/2025/018	09/05/2025	<u>Tirzepatide (Monjourro) for the management of obesity and overweight</u>	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/019	12/05/2025	<u>Changes to the routine childhood vaccination schedule and to the selective hepatitis B vaccination programme</u>	Complete
WHC/2025/020	06/06/2025	<u>National Influenza Vaccination Programme 2025-26</u>	In Progress
WHC/2025/021	03/06/2025	<u>Introduction of routine vaccination programmes for prevention of mpox and gonorrhoea</u>	In Progress
WHC/2025/022	26/06/2025	<u>National Covid 19 Vaccination Programme autumn 2025</u>	In Progress
WHC/2025/023	13/06/2025	<u>PPE Stockpile volumes in Wales</u>	Complete
WHC/2025/024	11/12/2025	<u>NHS Wales hearing care: future approach to audiology services</u>	In Progress
WHC/2025/025	11/07/2025	<u>Overseas Visitors' Eligibility to Receive Primary Care</u>	In Progress
WHC//2025/026	04/08/2025	<u>The safe and responsible adoption of ambient voice technologies ('AI Scribes') in clinical and practice settings</u>	In Progress
WHC/2025/027	16/07/2025	<u>All-Wales gluten free subsidy card scheme (WHC/2025/027) GOV.WALES</u>	In Progress
WHC/2025/028	09/07/2025	<u>Expansion of the shingles immunisation programme for severely immunosuppressed individuals aged 18-49</u>	In Progress
WHC/2025/029	14/07/2025	<u>Introduction of new RSV passive immunisation from autumn 2025</u>	Complete
WHC/2025/031	26/09/2025	<u>Data standards notice of change for Waiting Well Single Point of Contact</u>	Complete
WHC/2025/034	25/09/2025	<u>Data Standards notice of change for Planned Care Referrals</u>	In Progress

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/037	25/09/2025	<u>Infected Blood Inquiry: Implementing recommendation 7e, Shot Reports</u>	In Progress
WHC/2025/038	22/09/2025	<u>Accessible Communication and Information Standards in healthcare</u>	In Progress
WHC/2025/039	23/10/2025	<u>Antimicrobial resistance and healthcare associated infection Improvement goals for 2025-2027</u>	In Progress
WHC/2025/042	20/10/2025	<u>Update: NHS Wales national clinical audit and outcome review plan 2025 to 2026</u>	Complete
WHC/2025/043	23/10/2025	<u>New clinical pathway for treating and managing obesity</u>	In Progress
WHC/2025/044	04/02/2026	<u>Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services</u>	In Progress
WHC/2025/045	30/10/2025	<u>Changes to Standing Orders for the Joint Commissioning Committee</u>	Complete
WHC/2025/046	31/10/2025	<u>Routine varicella (chickenpox) vaccination programme for young children in Wales from 1 January 2026</u>	Complete
WHC/2025/049	15/12/2025	<u>Patient Travel Policy</u>	Complete
WHC/2025/051	08/12/2025	<u>Safety netting discharge leaflets for adults and children</u>	In Progress
WHC/2025/052	15/01/2026	<u>COVID 19 Spring Vaccination Programme 2026</u>	Complete
WHC/2025/053	02/02/2026	<u>Expansion of RSV vaccine eligibility to adults aged 80+ and residents in care</u>	Complete

WHC No	Date Issued	Name of WHC	Rating
WHC/2025/054	17/12/2025	<u>Pneumoccal vaccination product change</u>	Complete
WHC/2025/055	19/12/2025	<u>2026-27 Health Boad Allocation</u>	Complete
WHC/2026/001	08/01/2026	<u>Call4Concern: timelines and responsibilities</u>	In Progress
WHC/2026/002	04/03/2026	<u>Data standards notice of change for planned care activity</u>	In Progress
WHC/2026/004	26/03/2026	<u>Refreshed Intellectual Property guidance for NHS Wales Organisations.</u>	In Progress
WHC/2026/007	24/02/2026	Critical UK-wide Bone Cement Shortage - Immediate National Requirements for NHS Wales	In Progress
WHC/2026/008	10/03/2026	<u>NHS Research and Development Finance Policy</u>	In Progress
WHC/2026/006	27/03/2026	<u>Listening to people: The amended NHS Wales complaints, incidents and redress process</u>	In Progress
WHC/2026/011	01/04/2026	<u>Maternity Reporting Data Set (MR ds) - Data Requirements</u>	In Progress
WHC/2026/017	31/03/2026	<u>Welsh health Circular enabling community pharmacies to supply medicines ordered by optometrists as part or providing NHS care in Wales</u>	Complete

Ministerial Directives

Date Issued	Ministerial Direction	Progress
22/04/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2025 GOV.WALES	Implemented
19/05/2025	The Primary Medical Services (Intra-Periarticular Injections) (Directed Supplementary Services (Wales) Directions 2025 GOV.WALES	Implemented
19/05/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 GOV.WALES	Implemented
30/05/2025	The Primary Care (Contracted Services: Immunisations) (Influenza) Directions 2025 GOV.WALES	Implemented
09/06/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2025 GOV.WALES	Implemented
24/06/2025	Amendments to Model Standing Orders and Model Standing Financial Instructions – NHS Wales (WHC/2023/032) GOV.WALES	Implemented
23/07/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025	Implemented
08/08/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025	Implemented
13/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 GOV.WALES	Implemented
13/08/2025	The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) Directions 2024 GOV.WALES	Implemented
04/09/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025	Implemented
04/09/2025	https://www.gov.wales/directions-local-health-boards-personal-dental-services-statement-financial-entitlements-wales	Implemented
30/09/2025	The directed supplementary services directions and specification for people living with severe frailty in their own homes 2025 GOV.WALES	Implemented
14/10/2025	The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions and Specification 2025 GOV.WALES	Implemented
11/11/2025	Statement of general ophthalmic services remuneration and fee directions: 2025 GOV.WALES	Implemented
02/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 6) Directions 2025 GOV.WALES	Implemented
03/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) Directions 2026 GOV.WALES	Implemented

Date Issued	Ministerial Direction	Progress
16/12/2025	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 7) Directions 2025 GOV.WALES	Implemented
22/12/2025	The Primary Medical Services (Minor Surgery) (Directed Supplementary Services (Wales) Directions 2025 GOV.WALES	Implemented
23/12/2025	The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No 5) Directions 2025 GOV.WALES	Implemented
05/01/2026	Mental Health Review Tribunal for Wales (Membership) Bill GOV.WALES	Implemented
14/01/2026	The Nursery Milk Scheme (Wales) Directions 2026 GOV.WALES	Implemented
16/01/2026	The Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 2) Directions 2026 GOV.WALES	Implemented
04/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 GOV.WALES	Implemented
04/02/2026	Code of Practice Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services (WHC/2025/044) GOV.WALES	Implemented
04/02/2026	The Directions to Local Health Boards and NHS Trusts in Wales on Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 (NWSI 2026 No.17) GOV.WALES	Implemented
05/02/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2026 (NWSI 2026 No. 18) GOV.WALES	Implemented
23/02/2026	The Primary Care (Contracted Services: Immunisations) (RSV) Directions 2024	Implemented
06/03/2026	The Wales Infected Blood Support Scheme (Amendment) Directions 2026 GOV.WALES	Implemented
11/03/2026	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 3) Directions 2026 GOV.WALES	Implemented
13/03/2026	The Directions to Local Health Boards and NHS Trusts in Wales on Quality Assurance and Performance Management, Escalating Concerns, and Closure of Regulated Care and Support Services 2026 (NWSI 2026 No.17) GOV.WALES	Implemented
19/03/2026	The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) (Amendment) Directions 2026 GOV.WALES	Implemented
24/03/2026	https://www.gov.wales/mental-health-review-tribunal-for-wales-membership-act-2026#description-block	Implemented

Corporate governance in central government departments: code of good practice 2017

Aneurin Bevan University Health Board Assessment 2025/26

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
2.1 2.2	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust.	The Board meets in public on a bi-monthly basis. A forward work programme of Board Business is in place and approved on an annual basis. The work of the Board is guided and determined by its Standing Orders, Standing Financial Instructions and Schemes of Delegation. This provides the framework for delegation and decision making within the Health Board. The Board receives, as standing items to each meeting, finance, performance and corporate risk reports.	Comply	Board and Committee Minutes – demonstrate Scrutiny and support Audit Wales Structured Assessment 2025
2.3	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance	The Board provides leadership and direction to the organisation and has a key role in ensuring that the organisation has sound governance arrangements in place. The Board seeks an open culture and high standards in the ways in which its work is conducted. Board Members share corporate responsibility for all decisions and undertake a key role in monitoring the performance of the organisation. Progress on the development and delivery of the Health Board's Integrated Medium-Term Plan 2026–29 is presented to the Board on a regular basis. The Health Board's Standing Orders and Standing Financial Instructions are designed to translate the	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2025 IMTP Value and Behaviours Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	• Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there.	statutory requirements into day to day operating practice, and, together with the adoption of a Schedule of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values and Behaviour Framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.		
2.4 3.10	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information	The Board meets at least six times a year and in addition holds an Annual General Meeting. Discussions, actions and decisions of all meetings of the Board and its Committees are formally recorded as minutes or action notes. The Board's role, as set out in its Standing Orders, is to: • Set the strategic direction for the organisation • Hold the organisation to account for performance and delivery • Set the tone and culture of the Board and the organisation The Board's business is therefore structured in this way and encompasses the five main areas set out in point 2.4.	Comply	Standing Orders and Standing Financial Instructions Audit Wales Structured Assessment 2025 Board and Committee Agenda and Meeting Papers
2.7	The Board also supports the accounting officer in the discharge of obligations set out in Managing Public	The Board approves the Accountability Report, following scrutiny by the Audit, Risk and Assurance Committee, on an annual basis which includes the Statement by the	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	Money for the proper conduct of business and maintenance of ethical standards.	Accountable Officer assuring the Board on the System of Internal Control.		
2.12	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes.	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	Comply	Board and Committee Agenda and Papers Role of the Director of Corporate Governance
3.1 3.11 3.12 3.13	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size.	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. The Board has a range of skills and expertise. Individuals are appointed to Independent Member or Executive roles based on their particular backgrounds and specialist knowledge. All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. The appointment panels for all Executive appointments, although organisation appointments, will have external independent assessors and Welsh Government representation. All Executive Directors are appointed to permanent NHS contracts. Independent Members are appointed for up to four years at any one time and can be re-appointed	Comply	Health Board Establishment Orders Standing Orders Board Member Induction checklist

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		up to a maximum of eight years in the organisation. This is controlled by Welsh Government as they are Ministerial appointments. The Board is provided with a range of information including performance information at Board and Committee Meetings. The format and content of these is informed by national standards and requirements and also locally requested information. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings		
3.2	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework.	The Board is constituted in accordance with the Health Board's Establishment Orders and Standing Orders	Comply	Health Board Establishment Orders Standing Orders
3.3	The Finance Director should be professionally qualified.	The Director of Finance and Procurement is professionally qualified	Comply	Recruitment and appointment documentation for the Director of Finance and Procurement
3.5	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive	The Structured Assessment 2025 concluded that: <i>The Health Board has an effective Board supported by strong governance arrangements, with clear and high-quality information enabling the Board to discharge</i>	Comply	Audit Wales Structured Assessment 2025

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		<i>its duties. Board and committee meetings are well chaired, with Independent Members participating fully and providing appropriate scrutiny and challenge, particularly in relation to performance, finance and quality matters. Executive Directors were found to be open and transparent about the organisation's challenges and priority areas for action, and Board discussions were described as open and constructive, particularly when considering areas of risk and organisational pressure.</i> The Health Board has robust arrangements in place to support Board capability and continuous improvement. There is a national programme of induction for Board members, coordinated by Health Education and Improvement Wales, alongside a locally tailored induction programme for new Independent Members. These arrangements are supported by an ongoing programme of Board Development Sessions, Board Briefings and targeted training. During 2025–26, the Board has been supported by the Good Governance Institute through a comprehensive Board development programme, focusing on how the Board works together, effective relationships, scrutiny and governance, and the provision of strategic, risk-based assurance. These development activities are used to strengthen Board effectiveness and collective leadership on an ongoing basis.		Independent Member Induction Pack
3.15	The Board should agree and document in its board operating framework a <i>de minimis</i> threshold and	A forward work programme of Board Business is in place and approved on an annual basis.		Board Forward Work Programme

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	mechanisms for board advice on the operation and delivery of policy proposals.	The Terms of Reference Operating Arrangements for the Board Committees articulate their remit. A forward work programme for each Committee is in place and approved on an annual basis.		Committee Forward Work Programmes Committee Terms of Reference
4.1	The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date 4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience	All Independent Member appointments including the Chair and Vice Chair are appointed by Welsh Government and the appointment processes are managed by the Public Appointments Department of Welsh Government. All Executive appointments, although internal appointments have external independent assessors on the panels and also Welsh Government representation. The Director of Corporate Governance monitors the terms of office of Independent Members to ensure succession planning is timely and managed in conjunction with the public appointments unit. Agenda Setting meetings are held with the Chair, Chief Executive and Director of Corporate Governance to plan the agenda and ensure sufficient time is allocated to the right things at Board meetings. Board Induction programme in place (as previously referenced), supplemented by ongoing Board Briefing and Board Development sessions. The Chair undertakes regular one to ones and annual Personal Appraisal and Development Reviews with all Independent Members.		Terms of Reference and Operating Arrangements for Board and Committees Board and Committee Forward Work Programmes

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
		Agenda and papers for Board meetings are published one week prior to the meeting. Report templates are in place to support the provision of appropriate and relevant information. The Board's Quality Strategy and Quality Assurance Framework ensure learning as a key pillar of quality, embedded across the organisation. The Board undertakes an assessment of its effectiveness using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews. Committees undertook self assessments for 2025/26 during January which will inform the Board's end of year assessment.		
4.5	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance	The Terms of Reference and operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committees capture scrutiny and assurance roles. The Chair reviews the membership of Committees on an annual basis to ensure the appropriate balance of skills and expertise and support succession planning.	Comply	Terms of Reference for Board Committees Standing Orders
4.6	The attendance record of individual board members should be disclosed in the governance statement and	The Annual Governance Statement provides details on the membership of the Board and Committee and the attendance record of individuals at these meetings.	Comply	Annual Governance Statement

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	cover meetings of the board and its committees held in the period to which the resource accounts relate.			
4.10	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate.	Independent Members of the Board have direct access to members of the executive team in order to seek further information or clarification on issues as and when they arise. Regular Board Development sessions and Board briefings are also held to ensure that Board members are kept up to date on the breadth of issues. The Director of Corporate Governance acts as an independent voice within the organisation to advise and support the Board on governance matters and its approach to openness and transparency. The Director of Corporate Governance is responsible for developing the programmes of work for the Board and Committees of the organisation. Ensuring that agenda and papers are developed and reviewed prior to publication to ensure the quality of reports and maximum transparency and openness in the way in which the organisation conducts its business.	Comply	Board Secretary role profile
4.11	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include: - developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention - ensuring good information flows within the board and its committees and between senior management and non-executive board members, including:	The Director of Corporate Governance undertakes these roles as Board Secretary for the Health Board	Comply	Board Secretary role description Standing Orders

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	- challenging and ensuring the quality of board papers and board information - ensuring board papers are received by board members according to a timetable agreed by the board - providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements - ensuring the board follows due process - providing assurance to the board that the department: - complies with government policy, as set out in the code - adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) - acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up - arranging induction and professional development of board members (including ministers)			
4.14	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates	Individual annual assessment of Board Executive Directors is undertaken by the Chief Executive and Independent Members by the Chair, with the former	Comply	Appraisal documentation and process

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	commitment to the role (including commitment of time for board and committee meetings and other duties).	reported to the Remuneration and Terms of Service Committee.		
4.15	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed.	Board Members complete annual Declarations of Interest, with a 6 monthly validation check, and this register is available on the Health Board's website. Declarations of Interest in relation to items on the agenda are also sought at each Board and Committee meeting and are formally recorded within the minutes. Standards of Business Conduct for Employees in place and details responsibilities for declarations of interests.	Comply	Declarations of Interest Register Standards of Business Conduct for Employees Policy
5.1 5.8	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: - an audit and risk assurance committee, chaired by a suitably experienced non-executive board member - an internal audit service operating to Public Sector Internal Audit Standards¹ - sponsor teams of the department's key ALBs	The Health Board has established an Audit, Risk and Assurance Committee, chaired by the Independent Member Finance lead. NWSSP Internal Audit Services are appointed as the Health Boards Internal Auditors. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management.	Comply	Terms of Reference and Operating Arrangements for the Audit, Risk and Assurance Committee Accountability Report Audit Wales Structured Assessment
5.2 5.13	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year.	The Audit, Risk and Assurance Committee is responsible for reviewing the system of governance and assurance established within the Health Board and the arrangements for internal control, including risk management for the organisation and, in particular,	Comply	Accountability Report

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board.	advises on the Annual Governance Statement signed by the Chief Executive. The Governance Statement is included within the Accountability Report which is considered by the Audit, Risk and Assurance Committee prior to approval by the Board.		
5.3 5.10	The board's regular agenda should include scrutinising and advising on risk management.	The Health Board approve the Risk Management Framework. The Health Board and its Committees monitor the management of risk considering the risks profile and actively engaging in its management. A Strategic Risk Register is maintained and considered at each Board Meeting, and by the Audit, Risk and Assurance Committee. Each Committee monitors risks associated with its portfolio and provides assurance reports on these to the Board.		Board and Committee Agendas and papers Risk Management Strategy Board Assurance Framework Strategic Risk Register
5.4 5.9 5.11 5.12 5.14 5.15	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making	An Audit, Risk and Assurance Committee is established. The Terms of Reference and Operating Arrangements for the ARA Committee are clear in relation to authority and delegated responsibilities. These Terms of Reference are published on the Health Board's website. Full secretariat support is provided by the Corporate Governance Team.	Comply	Terms of Reference and Operating Arrangements for Audit, Risk and Assurance Committee Board Assurance Framework

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
	or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the <i>Audit and risk assurance committee handbook</i>. The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy.	The Board Assurance Framework is scrutinised by the Audit, Risk and Assurance Committee.		
5.5	The head of internal audit should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs.	The role of Head of Internal Audit is clearly set out in the Health Board's Standing Orders. The Head of Internal Audit attends all meetings of the Audit, Risk and Assurance Committee. Audit Wales and Internal Audit have a routine invite to all Board and Committee meetings.	Comply	Standing Orders Terms of Reference for the Audit, Risk and Assurance Committee

Para	Corporate Governance Code Principles	Evidence of Internal assurance/Supporting Narrative	Comply or Explain	Supporting documentation / Evidence
5.6 5.7 5.10	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.	The Health Board has an agreed Risk Management Strategy which articulates a clear risk escalation pathway. A Risk Management Community of Practice is in place, led by the Head of Risk and Assurance.	Comply	Risk Management Strategy Strategic Risk Register

Remuneration and Staff Report 2025/26

The Treasury's Government Financial Reporting Manual (FReM) requires that a Remuneration Report shall be prepared by NHS bodies providing information under the headings in SI 2008 No 410, made to the extent that they are relevant. The Remuneration Report contains information about senior managers remuneration. The definition of 'Senior Manager' is: "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This section of the Accountability Report meets these requirements.

The Remuneration and Terms of Service Committee

Remuneration and Terms of Service for Executive Directors and the Chief Executive are agreed, and kept under review, by the Board's Remuneration and Terms of Service Committee. The Committee also monitors and evaluates the annual performance of the Chief Executive and individual Directors (the latter with the advice of the Chief Executive). In 2025/26, the Remuneration and Terms of Service Committee was chaired by the Health Board's Chair, Ann Lloyd CBE, and the membership included the following Members:

- Philip Robson, Vice Chair of the Board;
- Iwan Jones, Chair of Audit, Risk and Assurance Committee

Meetings are minuted and decisions fully recorded.

Independent Member Remuneration

Remuneration for Independent Members is determined by the Welsh Government, along with the tenure of appointments. Details of Independent Members' remuneration for the 2025/26 financial year, together with comparators are given in Tables below.

Directors' Remuneration

Details of Directors' remuneration for the 2025/26 financial year, together with comparators are given in Tables below. The norm is for Executive Directors and Senior Managers salaries to be uplifted in accordance with the Welsh Government identified normal pay inflation percentage. In 2025/26, Executive Directors received a pay inflation uplift, in-line with Welsh Government's Framework.

The Remuneration and Terms of Service Committee also reviews objectives set for Executive Directors and assesses performance against those objectives when considering recommendations in respect of annual pay uplifts. It should be noted that Executive Directors are not on any form of performance related pay. All contracts are permanent with a three-month notice period. Conditions are in line with those set by Welsh Government as part of the NHS Reform Programme of 2009.

The Remuneration and Terms of Service Committee considers issues of equality and diversity when evaluating and setting remuneration for Directors', particularly in relation to gender and ethnicity in pay levels, in line with Welsh Government's Framework.

Salary and Pension Disclosure Table: Salaries and Allowances (Audited position)

Remuneration Report											
Salary and Pension entitlements of Senior Managers Remuneration											
Name	Title	2025-26					2024-25				
		Full Year Equivalent Salary (bands of £5,000)	Salary (bands of £5,000)	Benefits in kind (to nearest £100)	Pension Benefits	Total (bands of £5,000)	Full Year Equivalent Salary (bands of £5,000)	Salary (bands of £5,000)	Benefits in kind (to nearest £100)	Pension Benefits	Total (bands of £5,000)
		£000	£000	£00	£000	£000	£000	£000	£00	£000	£000
Executive Directors											
Nicola Prygodzicz	Chief Executive	245 - 250	210 - 215	23	94	305 - 310	240 - 245	200 - 205	16	175	380 - 385
Dr James Calvert	Medical Director (Until 04.08.25) Deputy Chief Executive (Until 04.08.25)	230 - 235	80 - 85	0	0	80 - 85	225 - 230	225 - 230	0	92	315 - 320
Dr Andy Bagwell	Interim Medical Director (From 05.08.25 Until 26.10.25)	210 - 215	45 - 50	5	41	85 - 90					
Dr Seema Srivastava	Medical Director (From 27.10.25)	210 - 215	85 - 90	5	111	200 - 205					
Robert Holcombe	Director of Finance and Procurement	170 - 175	170 - 175	0	65	235 - 240	165 - 170	165 - 170	0	68	235 - 240
Hannah Evans	Director of Strategy, Planning and Partnerships	160 - 165	155 - 160	0	56	210 - 215	155 - 160	155 - 160	0	38	190 - 195
Jennifer Winslade	Director of Nursing Deputy Chief Executive (From 03.09.25)	170 - 175	155 - 160	18	66	220 - 225	155 - 160	140 - 145	12	20	160 - 165
Sarah Simmonds	Director of Workforce and Organisational Development	160 - 165	150 - 155	23	56	210 - 215	155 - 160	145 - 150	15	55	200 - 205
Peter Carr	Director of Therapies and Health Sciences	140 - 145	135 - 140	0	85	220 - 225	130 - 135	130 - 135	0	99	230 - 235
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	155 - 160	150 - 155	0	44	195 - 200	150 - 155	150 - 155	0	44	195 - 200
Chief Operating Officer											
Leanne Watkins	Chief Operating Officer	160 - 165	150 - 155	22	88	240 - 245	155 - 160	140 - 145	17	59	205 - 210
Other Directors											
Rani Dash	Director of Corporate Governance	130 - 135	125 - 130	16	43	170 - 175	130 - 135	120 - 125	10	28	150 - 155
Paul Solloway	Director of Digital	135 - 140	125 - 130	16	44	170 - 175	130 - 135	120 - 125	9	150	270 - 275

Independent Members											
Ann Lloyd CBE	Chair	70 - 75	70 - 75	0	0	70 - 75	65 - 70	65 - 70	0	0	65 - 70
Pippa Britton	Vice Chair (Until 30.11.24)						55 - 60	35 - 40	0	0	35 - 40
Philip Robson	Vice Chair (From 01.04.25) Special Advisor to the Board (Until 31.03.25)	55 - 60	55 - 60	0	0	55 - 60	15 - 20	15 - 20	0	0	15 - 20
Martin Blakebrough	Independent Member (Third Sector) (Until 08.06.24)						15 - 20	0 - 5	0	0	0 - 5
Akmal Hanuk	Independent Member (Third Sector) (From 02.06.25)	15 - 20	10 - 15	0	0	10 - 15					
Prof. Helen Sweetland	Independent Member (University)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	5 - 10	0	0	5 - 10
Richard Clark	Independent Member (Local Authority) (Until 19.09.25)	15 - 20	5 - 10	0	0	5 - 10	15 - 20	15 - 20	0	0	15 - 20
Helen Cunningham	Independent Member (Local Authority) (From 03.11.25)	15 - 20	5 - 10	0	0	5 - 10					
Paul Deneen	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Neil Patrick	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Penny Jones	Independent Member (Community)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Dafydd Vaughan	Independent Member (Digital)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Iwan Jones	Independent Member (Finance)	15 - 20	15 - 20	0	0	15 - 20	15 - 20	15 - 20	0	0	15 - 20
Louise Wright	Independent Member (Trade Union) (Until 10.04.25)	0	0	0	0	0	0	0	0	0	0
Vivek Goel	Independent Member (Trade Union) (From 02.06.25)	0	0	0	0	0					

Band of Highest paid Director's Total Remuneration £000
25th percentile pay £
Median pay £
75th percentile pay £

2025-26	
Pay	Ratio
245 - 250	
29,758	8.3:1
38,364	6.5:1
49,046	5.0:1

2024-25	
Pay	Ratio
240 - 245	
29,484	8.2:1
37,030	6.5:1
48,530	5.0:1

Salary has been reported as gross pay, after deduction of any salary sacrifice schemes (the 2024-25 salary has also been restated to reflect this).
The table below shows the Gross Salary (in bandings) prior to the deduction of salary sacrifice schemes. The following salary was sacrificed.

	2025-26						2024-25				
	Gross Salary	Lease Car Scheme	Home Electronics Scheme	Pensions Advice	Annual Leave Purchase		Gross Salary	Lease Car Scheme	Home Electronics Scheme	Pensions Advice	Annual Leave Purchase
	£'000	£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000
Nicola Prygodzicz	220 - 225	9					210 - 215	9		<1	
Dr Andy Bagwell	45 - 50	2									
Dr Seema Srivastava	90 - 95	2		<1							
Hannah Evans	160 - 165				3						
Jennifer Winslade	165 - 170	12					155 - 160	12			
Sarah Simmonds	160 - 165	8					155 - 160	8		<1	
Tracy Daszkiewicz	155 - 160				3						
Leanne Watkins	160 - 165	8	1				150 - 155	11	1		
Rani Dash	130 - 135	9					130 - 135	9			
Paul Solloway	135 - 140	9					130 - 135	9			

The value of pension benefits is calculated as follows:
(real increase in pension* x20) + (real increase in any lump sum) – (contributions made by member)
*excluding increases due to inflation or any increase of decrease due to a transfer of pension rights

This is not an amount which has been paid to an individual by the Health Board during the year, it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a persons salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Ann Lloyd 2025-26 salary includes £1k backpay.

Prof. Helen Sweetland has been remunerated since 1st September 2024.

Former Chief Executive Andrew Goodall has been seconded to Welsh Government since 8th June 2014. Welsh Government Accounts has disclosed remuneration received, the Health Board was reimbursed for the employment costs incurred. The salary for Andrew Goodall for 2025-26 was between £250,000 to £255,000 (£240,000 to £245,000 2024-25).

Former Medical Director and Deputy Chief Executive James Calvert has been seconded to Welsh Government since 5th August 2025. The Health Board was reimbursed for the employment costs incurred. The full salary for James Calvert was between £230,000 to £235,000 (£225,000 to £230,000 in 2024-25).

Remuneration Report continued
Salary and Pension entitlements of Senior Managers Pension Benefits

Name	Title	Real	Real	Total accrued	Lump sum at	Cash	Cash	Real	Employer's contribution to stakeholder pension
		increase in pension at pension age (bands of £2,500)	increase in pension lump sum at pension age (bands of £2,500)	pension at pension age at 31 March 2026 (bands of £5,000)	pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Equivalent Transfer Value at 31 March 2026	Equivalent Transfer Value at 31 March 2025	increase in Cash Equivalent Transfer Value	
		£000	£000	£000	£000	£000	£000	£000	£00
Nicola Prygodzicz	Chief Executive	5.0 - 7.5	2.5 - 5.0	90 - 95	235 - 240	2,140	1,974	106	0
Dr James Calvert	Medical Director / Deputy Chief Executive	0.0	0.0	95 - 100	235 - 240	2,361	2,404	0	0
Dr Andy Bagwell	Interim Medical Director	2.5 - 5.0	2.5 - 5.0	60 - 65	150 - 155	1,413	1,174	44	0
Dr Seema Srivastava	Medical Director	5.0 - 7.5	10.0 - 12.5	65 - 70	165 - 170	1,443	1,138	111	0
Robert Holcombe	Director of Finance and Procurement	2.5 - 5.0	2.5 - 5.0	65 - 70	165 - 170	1,596	1,474	75	0
Hannah Evans	Director of Strategy, Planning and Partnerships	2.5 - 5.0	0.0 - 2.5	50 - 55	115 - 120	1,055	964	54	0
Jennifer Winslade	Director of Nursing / Deputy Chief Executive	2.5 - 5.0	2.5 - 5.0	65 - 70	160 - 165	1,573	1,449	81	0
Sarah Simmonds	Director of Workforce and Organisational Development	2.5 - 5.0	0.0 - 2.5	45 - 50	100 - 105	939	852	53	0
Peter Carr	Director of Therapies and Health Sciences	2.5 - 5.0	5.0 - 7.5	55 - 60	135 - 140	1,245	1,118	91	0
Tracy Daszkiewicz	Director of Public Health and Strategic Partnerships	2.5 - 5.0	0.0	20 - 25	0	344	288	32	0
Leanne Watkins	Chief Operating Officer	5.0 - 7.5	5.0 - 7.5	60 - 65	155 - 160	1,339	1,212	88	0
Rani Dash	Director of Corporate Governance	2.5 - 5.0	0.0 - 2.5	35 - 40	75 - 80	643	585	33	0
Paul Solloway	Director of Digital	2.5 - 5.0	0.0 - 2.5	50 - 55	125 - 130	1,109	1,029	47	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

Clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff had until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provision of £689,932 (£685,920, 2024-25) as notified by Welsh Government within these accounts.

Remuneration Relationship (Audited position)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

Total Pay and benefits	£'000			£'000		
Chief Executive Total pay and benefits range	245-250			240-245		
Highest paid Director Total pay and benefits range	245-250			240-245		
	2025-26	2025-26	2025-26	2024-25	2024-25	2024-25
	£	£	£	£	£	£
	Chief			Chief		
Total pay and benefits mid-point	Executive	Employee	Ratio	Executive	Employee	Ratio
25th percentile pay ratio	247,500	29,758	8.3	247,500	29,484	8.2
Median pay	247,500	38,364	6.5	247,500	37,030	6.5
75th percentile pay ratio	247,500	49,046	5.0	247,500	48,530	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	247,500	29,758		247,500	29,484	
Median pay	247,500	38,364		247,500	37,030	
75th percentile pay ratio	247,500	49,046		247,500	48,530	
	Highest Paid			Highest Paid		
Total pay and benefits mid point	Director	Employee	Ratio	Director	Employee	Ratio
25th percentile pay ratio	247,500	29,758	8.3	247,500	29,484	8.2
Median pay	247,500	38,364	6.5	247,500	37,030	6.5
75th percentile pay ratio	247,500	49,046	5.0	247,500	48,530	5.0
Salary component of total pay and benefits						
25th percentile pay ratio	247,500	29,758		247,500	29,484	
Median pay	247,500	38,364		247,500	37,030	
75th percentile pay ratio	247,500	49,046		247,500	48,530	

In 2025-26, 14 (2024-25, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £371k (2024-25, £17k to £459k).

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees.

Financial Year Summary

The 2025-26 pay ratio is comparable with 2024-25 with minimal variation. The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2024-25 to 2025-26	2023-24 to 2024-25
% Change from previous financial year in respect of Chief Executive	%	%
Salary and allowances	2	7
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director	%	%
Salary and allowances	2	7
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	1	5
Performance pay and bonuses	0	0

STAFF REPORT

Staff Numbers (Audited position)

9.2 Average number of employees										
	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25		
	Number	Number	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board	2,800	8	11	0	0	0	2,819			2,722
Medical and dental	890	5	39	447	0	13	1,394			1,339
Nursing, midwifery registered	4,180	0	111	0	0	0	4,291			4,121
Professional, Scientific, and tech	455	0	10	0	0	0	465			433
Additional Clinical Services	2,910	0	23	0	0	0	2,933			2,903
Allied Health Professions	981	5	14	0	0	0	1,000			982
Healthcare Scientists	258	0	2	0	0	0	260			257
Estates and Ancilliary	1,081	0	25	0	0	0	1,106			1,054
Students	3	0	0	0	0	0	3			6
Total	13,558	18	235	447	0	13	14,271			13,817

The data above represents an average over 52 weeks of the year and includes agency workers and specialist trainees. There has been a small increase in staff in post overall. The strategic work to reduce agency over the past 12 months has been successful along with reducing vacancies.

Turnover has increased to 9.02% compared to the previous year of 8.67%.

In the last 12 months staff in post has increased by 2.18%. The largest increases have been within Medical & Dental staff increased by 4.36% and Nursing and Midwifery increased by 3.63%.

Retirements Due to Ill Health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be borne by the NHS Pension Scheme.

9.3. Retirements due to ill-health

	2025-26	2024-25
Number	15	16
Estimated additional pension costs £	962,243	1,456,012

Staff Composition

The table below provides the breakdown of staff numbers split by Directors and all other staff within the Health Board.

The gender breakdown for all staff groups as of 31 March 2026 is provided below:

	2025-26			2024-25			2023-24		
	Directors	WTE	%	Directors	WTE	%	Directors	WTE	%
Female	7.85	10,901	79.54%	7.85	10,682	79.67%	8.00	10,413	76.60%
Male	3.00	2,804	20.46%	3.00	2,742	20.33%	4.00	2,669	20.40%
Total	10.85	13,705		10.85	13,424		12.00	13,082	

Sickness Absence Data

The Health Board’s sickness absence rate for 2025/26 was 6.55%. This is an increase from 6.44% in 2024/25 and 6.10% in 2023/24. During the period sickness absence remained above 6% from June 2025 to February 2026 reducing to 5.94%, in March 2026. December 2025 recorded the highest in month sickness absence rate at 7.46%.

The table below provides the sickness absence trend data for the Health Board over the last eleven years.

Sickness Absence	Data Calculations	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
WTE Days Lost (Short Term <28 days)	The WTE days Lost due to sickness calculates the impact of sickness absence based on the employees contracted hours WTE days lost x FTE by the number of calendar days absent	61261	53097	60406	54759	68229	60411	79761	98573	85948	86029	86865
WTE Days Lost (Long Term >28 days)		144562	147711	153345	162684	194289	188778	203781	205131	207218	223369	237875
Total WTE Days Lost		205823	200808	213751	217443	262518	249189	283542	303704	293166	309398	324740
Sickness Absence %		5.23%	5.26%	5.23%	5.29%	5.79%	6.51%	6.51%	6.73%	6.21%	6.44%	6.55%
Total Staff Years	WTE days lost / 365 days per year	564	550	586	596	719	683	777	832	803	848	890
Average Working Days Lost	WTE days lost / headcount	14.7	14.2	15.2	15.2	15.2	16	17.2	18	17.5	18.08	18.71
Total staff employed in period (headcount)	Avg headcount as at March each year	14020	14155	10412	14334	14835	15528	15863	16245	16735	17111	17352
Total staff employed with no absence (Headcount)	Avg headcount without absence/headcount available	5608	5803	5852	5016	5340	6055	5710	5035	5188	5133	5379
Percentage staff with no sick		40%	41%	37%	35%	36%	39%	36%	31%	31%	30%	31%
Source: Electronic Data Record (ESR) All data has been sourced via ESR BI Reports												

The Sickness Absence Focus Group supports the People Plan and Health Board objectives by reviewing attendance trends and identifying ways to reduce sickness absence. The work is taken forward through its subgroups:

- Education and Training
- Stress, Anxiety & Depression
- Data Analysis
- Communications & Engagement

Staff Policies

Aneurin Bevan University Health Board has a robust framework of Policies and Procedures to enable appropriate action in order to discharge its statutory requirements and appropriate accountability for:

- Giving full and fair consideration to applications for employment made by disabled persons or other protected characteristics, having regard to their particular aptitudes and abilities;
- Continuing the employment of and for arranging appropriate training for employees, who have become disabled persons during the period when they were employed by the company;
- For the training, career development and promotion of staff with protected characteristics persons employed by the Health Board.

Staff policies renewed or newly applied during the reporting period 01 April 2025 to 31 March 2026 include:

- All Wales Procedure for Staff to Raise Concerns (review)
- All Wales Anti Sexual Harassment Policy (new)
- All Wales Flexible Working Policy (review)
- All Wales Organisational Change Policy (review)
- Internal Lateral Transfer Scheme (new)
- Neonatal Care Leave and Pay Policy (new)
- Manual Handling Policy (review)
- Nursing and Midwifery Professional Regulation Policy (review)
- People in Positions of Trust (PiPoT) (new)
- The use of Restrictive Physical Intervention (RPI) Policy (review)
- Using the Welsh Language Internally Staff Policy (review)
- Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy (review)
- Violence Prevention and Reduction Policy (review)
- All Wales Reserve Forces Training and Mobilisation Policy (review)
- Employment Break Scheme (review)
- Unpaid Parental Leave Policy (review)
- Paternity Leave Policy (review)
- Roster Policy (review)
- Adverse Weather (review)
- Health and Safety Policy (review)
- Professional Regulation Policy (review)
- Preceptorship Policy (review) Recruitment and selection policy (new)
- Keeping of Personal Records Policy (review)
- Maternity and Adoption Leave Policy (review)
- Annual Leave and Statutory Holidays Policy for Non -Medical and Dental Staff (review)

Between 01 April 2025 and 31 March 2026, the following policies were identified as being superseded by All Wales policies previously implemented within the Health Board and were therefore decommissioned Banding of New Posts Policy

- Re-evaluation of Existing Posts Policy

All policies are developed in partnership with Trades Union colleagues and are assessed via an Equality Impact Assessment to ensure that every policy is fair and does not present barriers to participation or disadvantage any protected groups from participation.

Employee Relations Matters

Details of the number of disciplinary cases between 01 April 2025 to 31 March 2026 is provided below:

Disciplinary Cases	Dismissals	Appeals	Employment Tribunals	Upholding Professional Standards in Wales	Respect and Resolution	Capability

71	6	3	9	5	34	11

The Health Board has continued to apply the principles of its avoidable employee harm programme of work to disciplinary investigations, to consider the impact on the people involved and improved application of process. Work is ongoing to embed the avoidable employee harm approach in the management of Respect and Resolution cases.

Improved initial assessments of situations have supported proportionate and appropriate management of misconduct that emphasises opportunities for learning and continuous improvement. Where applicable, alternative policies have been applied, resulting with an increase in the application of alternative policies and procedures such as respect and resolution and capability.

Payment to Past Directors (Audited position)

No payments have been made to any person who was not a director at the time the payment was made, but who had been a director of the Health Board previously.

Expenditure on Consultancy

Supplier	Services provided	Amount £p
Boo Coaching & Consulting Ltd	Coaching Consultancy Support for the Board	11,400
Dorset Software Services Ltd	G Cloud Focus Consultancy Services	588,539
Ernst & Young LLP	VAT Consultancy & Advisory Services	29,806
Supportive Care UK	Consultant Support to the Specialist Palliative Care Service	18,900
Total Consultancy 2025/26		648,645

Expenditure on Temporary Staff

	£000
Administrative, Clerical and board members	436
Medical and dental	10,528
Nursing, midwifery registered	8,242
Professional, Scientific, and technical staff	1,159
Additional Clinical Services	1,440
Allied Health Professions	1,495
Healthcare Scientists	250
Estates and Ancillary	1,333
Total	24,883

Tax Assurance for Off-payroll Engagements

Table 1: For all off-Payroll engagements as of 31 March 2026, for more than £245 per day

No. of existing Engagements as of 31 March 2026	2
Of which, the number that have existed:	
for less than one year at time of reporting	0
for between one and two years at time of reporting	1
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

Table 2: For all new off-Payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

Number of new engagements between 1 April 2025 and 31 March 2026	2
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	2
No. engaged directly (via contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Exit Packages and Severance Payments (Audited position)

9.5 Reporting of other compensation schemes - exit packages						
9.5.1 Exit Packages Costs and Numbers						
	2025-26	2025-26	2025-26	2025-26	2024-25	
Exit packages cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Number of departures where special payments have been made	Total number of exit packages	
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	
less than £10,000	0	0	0	0	1	
£10,000 to £25,000	0	0	0	0	0	
£25,000 to £50,000	0	0	0	0	0	
£50,000 to £100,000	0	3	3	3	0	
£100,000 to £150,000	0	1	1	1	0	
£150,000 to £200,000	0	0	0	0	0	
more than £200,000	0	0	0	0	0	
Total	0	4	4	4	1	
	2025-26	2025-26	2025-26	2025-26	2024-25	
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages	
	£	£	£	£	£	
less than £10,000	0	0	0	0	7,500	
£10,000 to £25,000	0	0	0	0	0	
£25,000 to £50,000	0	0	0	0	0	
£50,000 to £100,000	0	204,086	204,086	204,086	0	
£100,000 to £150,000	0	108,975	108,975	108,975	0	
£150,000 to £200,000	0	0	0	0	0	
more than £200,000	0	0	0	0	0	
Total	0	313,061	313,061	313,061	7,500	
Total Exit Costs Paid in Year			Total paid in year		Total paid in year	
			2025-26		2024-25	
			£		£	
Exit costs paid in year			204,086		7,500	
Total			204,086		7,500	

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).



Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The figures above are consolidated amounts.

The Health Board has approved four VERS in 2025-26.

Additional requirement as per FreM

£0 exit costs were paid in 2025-26, relating to 2024-25 (the year of departure).

Senedd Cymru / Welsh Parliamentary Accountability and Audit Report 2025/26

Regularity of Expenditure

Regularity of Expenditure Regularity is the requirement for all items of expenditure and receipts to be dealt with in accordance with the legislation authorising them, any applicable delegated authority and the rules of Government Accounting.

Aneurin Bevan University Health Board ensures that the funding provided by Welsh Ministers has been expended for the purposes intended by Welsh Ministers and that the resources authorised by Welsh Ministers to be used have been used for the purposes for which the use was authorised.

The Health Board's Chief Executive is the Accountable Officer and ensures that the financial statements are prepared in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, the Chief Executive is required to:

- observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
- prepare them on a going concern basis on the presumption that the services of the Health Board will continue in operation.

Fees and charges

Where the Health Board undertakes activities that are not funded directly by the Welsh Government the Health Board receives income to cover its costs which will offset expenditure reported under programme areas. Miscellaneous Income can be seen in Note 4 (page XX) of the Annual Accounts 2025/26. When charging for this activity the Health Board has complied with the cost allocation and charging requirements set out in HM Treasury guidance.

The Health Board incurred costs amounting to £0.470m for the provision of the statutory audit by Audit Wales for the period 2025/26.

Managing public money

This is the required Statement for Public Sector Information Holders as referenced in the Directors' Report. In line with other Welsh NHS bodies, the Health Board has adopted standing financial instructions which enforce the principles outlined in HM Treasury guidance 'Managing Public Money' which sets out the main principles for dealing with resources in the UK public sector. As a result, the Health Board should have complied with the cost allocation and charging requirements of this guidance. The

Health Board has not been made aware of any instances where this has not been done.

Remote Contingent Liabilities

This disclosure was introduced for the first time in 2015-16. It shows those contingent liabilities that are deemed to be extremely remote and have not been previously disclosed within the normal contingent liability note within the accounts.

The 2025/26 remote contingent liabilities consist of 1 medical negligence case and 1 GP Indemnity case (3 medical negligence cases and 1 personal injury case in 2024/25). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

Nicola Prygodzicz
Chief Executive

Date: XX July 2026

THE CERTIFICATE AND REPORT OF THE AUDITOR GENERAL FOR WALES TO THE SENEDD

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Local Health Board for the year ended 31 March 2026 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Local Health Board as at 31 March 2026 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matters described in the Basis for Qualified Regularity Opinion section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Local Health Board's financial statements because the Health Board has breached its resource limit by spending £75.233 million over the amount that it was authorised to spend in the three-year period 2023-2024 to 2025-2026. This spend constitutes irregular expenditure.

Further detail is set out in my Report on **page xx**

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Aneurin Bevan University Local Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise

explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report, or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;

- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and
- assessing the Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the audited entity's head of internal audit, and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board's policies and procedures concerned with:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals;
 - Obtaining an understanding of Aneurin Bevan University Local Health Board's framework of authority as well as other legal and regulatory frameworks that the Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Board;
 - Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business;

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant

audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

Please see my Report on pages x to y.

Adrian Crompton
Auditor General for Wales
26 June 2026

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Local Health Board (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2026 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion and the failure of the second financial duty. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2025-26, the Health Board failed to meet both the first and the second financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Boards by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2023-24 to 2025-26.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £5,703.840 million by £75.233 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (ie spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. This duty is an essential foundation to the delivery of sustainable quality health services. A Health Board will be deemed to have met this duty for 20245-26 if it submitted a 2025-2028 plan approved by its Board

to the Welsh Ministers, who were required to review and consider approval of the plan.

As shown in Note 2.3 to the Financial Statements, the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2025-2028.

Adrian Crompton
Auditor General for Wales
26 June 2026

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Aneurin Bevan University Health Board Final Accounts for 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: REPORTING OFFICER:	Robert Jones, Assistant Director of Finance (Financial Systems and Services)

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

Ar Gyfer Penderfyniad/For Decision

To give assurance to the Committee along with the Head of Internal Audit Opinion and the Audit Wales audit of annual accounts report, to enable the Committee to recommend that the Board approve the Aneurin Bevan University Health Board 2025/26 Annual Accounts.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Annual Accounts for 2025/26 are attached to this paper.

There have been no changes from the draft accounts that affect the performance of any of the Health Boards's duties reported to the Committee on the 19th of May.

Audit Wales have confirmed they intend to give an unqualified opinion on the Aneurin Bevan University Health Board 2025/26 Financial Statements. They will qualify the regularity opinion as the Health Board has not achieved its statutory target to break even over a three-year period.

The final position as at 31 March 2026 shows a year end deficit of £18.282m and combined with the outcomes for 2023/24 and 2024/25, a three-year deficit of £75.233m.

A number of classification type adjustments have been made during the audit. These are included in Appendix 1 attached.



The Committee are asked to note that the accounts have been satisfactorily completed, and along with the audit of annual accounts report from Audit Wales and the Head of Internal Audit Opinion, recommend approval of the Accounts by the Board at the meeting on 24th June.

At the time of writing this report there are still some minor audit queries outstanding, with Audit Wales also conducting a final review of the audit and Final Accounts. A further update on the outstanding queries will be presented at the meeting.

Cefndir / Background

See above.

Asesiad / Assessment

This report provides the Committee with details of amendments actioned from the draft accounts to the final accounts on completion of the Audit, with confirmation that no adjustments have been made between Draft and Final Accounts which impact the 2025/26 reported position of the Health Board.

At the time of writing, Audit Wales are following up a couple of minor queries - an update will be provided at the Committee.

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to endorse the Aneurin Bevan University Health Board annual accounts for 2025/26 for approval by the Board on 24th June 2026.

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	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
	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/	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.

2025/26 ANNUAL ACCOUNTS –**Appendix 1**

Adjustments Actioned from Draft to Final Annual Accounts for 2025/26

Note No.	Issue	Impact On Fin. Target
	Adjustments Actioned – impact on financial target.	£0k
	None Identified	
	Adjustments Actioned – No impact on financial target	
2.3	Following a review, it was agreed to update the narrative within the note to accurately reflect the correct chronology of the IMTP approval process. As per correspondence from WG Ministers, the IMTP for 2025-28 was approved in June 2025, however this was revoked in December 2025, due to the financial deficit position of the Health Board reported during 2025/26.	None
3.2	Re-classification of Expenditure between Other NHS and Private Provider, totalling £9,499k. Upon internal review following Draft Accounts submission, expenditure with a Supplier incorrectly identified as Other NHS, when in fact it should be classified as Private Provider.	None
4	Re-classification of Income between Other NHS, Local Authority and Other Income, totalling £1,013k. Upon internal review following Draft Accounts submission, income identified as Other NHS should be classified as Other Income. Additionally income originally identified as Other Income should be classified as Local Authorities income.	None
4	Breakdown of Other Income disclosure at the bottom of Note 4 only identified one of the two subjective codes used for Salary Sacrifice. £7,520k reclassified from "Other" to "Salary Sacrifice & Fleet Vehicles".	None
9.6.1	Draft Accounts had amounts in Fair Pay Disclosure table as £000s. The Manual for Accounts requested a change to reporting for 2025/26, so that presented figures should be in £s. Final Accounts have been amended to reflect the correct signage.	None
11	Supporting narrative for Note 11, includes details on Valuations. Original narrative disclosure omitted information for the	None

	Emergency Department extension and 2 nd MRI installation at the Grange University Hospital. Updated narrative disclosure now includes this detail.	
15	Draft Account amounts for Non-Current Receivables - Welsh Risk Pool Reimbursement did not break down the figures between Secondary Health Sector and Primary Sector. All receivables (£140,823k) were categorised as Secondary Health Sector, where £405k should be classified as Primary Sector.	None
29	Following submission of the Draft Accounts, Welsh Government requested that the Health Board acknowledge the WHC pay circular in relation to Board Members remuneration. Following narrative included within disclosure note. <i>"Subsequent to the reporting date, the LHB received confirmation from the Welsh Government of changes to remuneration rates for NHS Wales public appointees, approved prior to 31 March 2026 and effective from 1 January 2026. The financial impact has been recognised in these financial statements."</i>	None
30	Within Note 30. Related Party Transactions £385k was included within the agreement of balances however were omitted from the note. Adjusted to include. Final Accounts amounts agree to LMS Matrices for all reporting bodies.	None
30	Disclosure relating to declaration of interest omitted from Draft Accounts for Richard Clark has been added in Final Accounts following the confirmation of his continued role as Company Secretary for Torfaen Voluntary Alliance in 2025/26. Expenditure: £360k Creditor: £1.2k	None
32	Memorandum Figures for the GWICES Pooled Budget which were not received in advance of Draft Account submission have now been received from Torfaen CBC and populated in Note 32 of the Final Accounts.	None
32	Memorandum Figures for the CHC Pooled Budget which were not received in advance of Draft Account submission have now been received from Torfaen CBC and populated in Note 32 of the Final Accounts.	None
	Adjustment to other returns	

LFR 5	Amount included for Personal Injury Benefit – Unwinding of Discount on Sheet 5 of Financial Return, totalling £93k. In addition, Arisings amount reduced from £744k to £651k.	None
LMS	Debtor and Income values for Monmouthshire County Council incorrectly categorised as values with Neath Port Talbot Council. Updated LMS now correctly Debtor and Income values with Monmouthshire County Council.	None
REMUNERATION REPORT & PENSIONS BENEFITS		
	Additional Disclosure included below the main table, identifying the Gross Salary for each member who has received Salary Sacrifice deductions in the year.	None
	Additional narrative disclosure included in relation to the Secondment of James Calvert (former Medical Director) to Welsh Government	None

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD

FOREWORD

These accounts have been prepared by the Local Health Board under schedule 9 section 178 Para 3(1) of the National Health Service (Wales) Act 2006 (c.42) in the form in which the Welsh Ministers have, with the approval of the Treasury, directed.

Statutory background

Performance Management and Financial Results

Welsh Health Circular WHC/2016/054 replaces WHC/2015/014 'Statutory and Administrative Financial Duties of NHS Trusts and Local Health Boards' and further clarifies the statutory financial duties of NHS Wales bodies and is effective for 2025-26. The annual financial duty has been revoked and the statutory breakeven duty has reverted to a three year duty, with the first assessment of this duty in 2016-17.

Local Health Boards in Wales must comply fully with the Treasury's Financial Reporting Manual to the extent that it is applicable to them. As a result, the primary statement of in-year income and expenditure is the Statement of Comprehensive Net Expenditure, which shows the net operating cost incurred by the Local Health Board which is funded by the Welsh Government. This funding is allocated on receipt directly to the General Fund in the Statement of Financial Position.

Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3 year period, that its aggregate expenditure does not exceed its aggregate approved limits.

The Act came into effect from 1st April 2014 and under the Act the first assessment of the 3 year rolling financial duty took place at the end of 2016-17.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £000	2024-25 £000
Expenditure on Primary Healthcare Services	3.1	366,848	351,914
Expenditure on healthcare from other providers	3.2	574,590	527,203
Expenditure on Hospital and Community Health Services	3.3	1,253,030	1,177,190
		2,194,468	2,056,307
Less: Miscellaneous Income	4	(151,708)	(136,606)
LHB net operating costs before interest and other gains and losses		2,042,760	1,919,701
Investment Revenue	5	(16)	(16)
Other (Gains) / Losses	6	44	(41)
Finance costs	7	816	777
Net operating costs for the financial year		2,043,604	1,920,421

Details of the Health Board's performance against its revenue and capital allocations over the last three financial periods are provided in Note 2 on page 28.

The notes on pages 8 to 79 form part of these accounts.

Other Comprehensive Net Expenditure

	2025-26 £000	2024-25 £000
Net (gain) / loss on revaluation of property, plant and equipment	(56,727)	(15,174)
Net (gain)/loss on revaluation of right of use assets	0	0
Net (gain) / loss on revaluation of intangible assets	0	(42)
Net (gain) loss on revaluation of financial assets	0	0
Net (gain)/ loss on revaluation of PPE & Intangible assets held for sale	0	0
Net (gain)/loss on revaluation of financial assets held for sale	0	0
Impairment and reversals	0	0
(Gain)/Loss on other reserve movements	0	0
Transfers between reserves	0	0
Release of reserves to SoCNE	0	0
Transfers (to) / from other NHS Wales bodies	(36)	0
Reclassification adjustment on disposal of available for sale financial assets	0	0
Other comprehensive net expenditure for the year	(56,763)	(15,216)
Total comprehensive net expenditure for the year	1,986,841	1,905,205

The notes on pages 8 to 79 form part of these accounts.

Statement of Financial Position as at 31 March 2026

		31 March 2026 £000	31 March 2025 £000
	Notes		
Non-current assets			
Property, plant and equipment	11	987,707	927,547
Right of Use Assets	11.3	15,890	18,121
Intangible assets	12	3,095	4,999
Trade and other receivables	15	142,398	105,883
Other financial assets	16	605	607
Total non-current assets		1,149,695	1,057,157
Current assets			
Inventories	14	9,794	10,433
Trade and other receivables	15	174,870	167,160
Other financial assets	16	116	60
Cash and cash equivalents	17	5,551	4,823
		190,331	182,476
Non-current assets classified as "Held for Sale"	11	0	0
Total current assets		190,331	182,476
Total assets		1,340,026	1,239,633
Current liabilities			
Trade and other payables	18	(217,347)	(204,826)
Other financial liabilities	19	0	0
Provisions	20	(100,292)	(98,570)
Total current liabilities		(317,639)	(303,396)
Net current assets/ (liabilities)		(127,308)	(120,920)
Non-current liabilities			
Trade and other payables	18	(15,050)	(16,314)
Other financial liabilities	19	0	0
Provisions	20	(145,467)	(109,154)
Total non-current liabilities		(160,517)	(125,468)
Total assets employed		861,870	810,769
Financed by :			
Taxpayers' equity			
General Fund		612,644	610,494
Revaluation reserve		249,226	200,275
Total taxpayers' equity		861,870	810,769

The financial statements on pages 2 to 7 were approved by the Board on 24 June 2026 and signed on its behalf by:

Chief Executive and Accountable Officer Date: 24 June 2026

The notes on pages 8 to 79 form part of these accounts.

Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2026

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2025-26			
Balance as at 31 March 2025	610,494	200,275	810,769
NHS Wales Transfer	0	0	0
RoU Asset Transitioning Adjustment	0	0	0
Impact of IFRS 16 on PPP/PFI Liability	0	0	0
Balance at 1 April 2025	610,494	200,275	810,769
Net operating cost for the year	(2,043,604)		(2,043,604)
Net gain/(loss) on revaluation of property, plant and equipment	0	56,727	56,727
Net gain/(loss) on revaluation of right of use assets	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale	0	0	0
Net gain/(loss) on revaluation of financial assets held for sale	0	0	0
Impairments and reversals	0	0	0
Net gain/(loss) on other reserve movements	0	0	0
Transfers between reserves	7,776	(7,776)	0
Release of reserves to SoCNE		0	0
Transfers (to) / from other NHS Wales bodies	36	0	36
Reclassification adjustment on disposal of available for sale financial assets	0	0	0
Total recognised income and expense for 2025-26	(2,035,792)	48,951	(1,986,841)
Net Welsh Government funding	1,981,900		1,981,900
Notional Welsh Government Funding	56,042		56,042
Balance at 31 March 2026	612,644	249,226	861,870

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) has applied. However, the NHS Business Services Authority continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £56,007K
Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £35K

The notes on pages 8 to 79 form part of these accounts.

Statement of Changes in Taxpayers' Equity

For the year ended 31 March 2025

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Changes in taxpayers' equity for 2024-25			
Balance at 31 March 2024	581,378	189,324	770,702
NHS Wales Transfer	0	0	0
RoU Asset Transitioning Adjustment	422	0	422
Impact of IFRS 16 on PPP/PFI Liability	0	0	0
Balance at 1 April 2024	581,800	189,324	771,124
Net operating cost for the year	(1,920,421)		(1,920,421)
Net gain/(loss) on revaluation of property, plant and equipment	0	15,174	15,174
Net gain/(loss) on revaluation of right of use assets	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	42	42
Net gain/(loss) on revaluation of financial assets	0	0	0
Net gain/(loss) on revaluation of PPE and Intangible assets held for sale	0	0	0
Net gain/(loss) on revaluation of financial assets held for sale	0	0	0
Impairments and reversals	0	0	0
Net gain/(loss) on other reserve movements	0	0	0
Transfers between reserves	4,265	(4,265)	0
Release of reserves to SoCNE	0	0	0
Transfers (to) / from other NHS Wales bodies	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0
Total recognised income and expense for 2024-25	(1,916,156)	10,951	(1,905,205)
Net Welsh Government funding	1,893,053		1,893,053
Notional Welsh Government Funding	51,797		51,797
Balance at 31 March 2025	610,494	200,275	810,769

Notional Welsh Government funding line includes 9.4% staff employer pension and Pensions Annual Allowance Charge Compensation Scheme (PAACCS) costs paid centrally by Welsh Government.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Notional Welsh Government funding split:

Notional 9.4% staff employer pension £51,784K

Pensions Annual Allowance Charge Compensation Scheme (PAACCS) £13K

The notes on pages 8 to 79 form part of these accounts.

Statement of Cash Flows for year ended 31 March 2026

	2025-26 £000	2024-25 £000
Cash Flows from operating activities		
Net operating cost for the financial year	(2,043,604)	(1,920,421)
Movements in Working Capital	27 (31,754)	8,153
Other cash flow adjustments	28 175,515	110,857
Provisions utilised	20 (35,123)	(22,996)
Net cash outflow from operating activities	(1,934,966)	(1,824,407)
Cash Flows from investing activities		
Purchase of property, plant and equipment	(42,183)	(61,328)
Proceeds from disposal of property, plant and equipment	193	116
Purchase of intangible assets	(135)	(2,271)
Proceeds from disposal of intangible assets	0	0
Payment for other financial assets	0	0
Proceeds from disposal of other financial assets	0	0
Payment for other assets	0	0
Proceeds from disposal of other assets	0	0
Net cash inflow/(outflow) from investing activities	(42,125)	(63,483)
Net cash inflow/(outflow) before financing	(1,977,091)	(1,887,890)
Cash Flows from financing activities		
Welsh Government funding (including capital)	1,981,900	1,893,053
Capital receipts surrendered	0	0
Capital grants received	0	0
Capital element of payments in respect of finance leases and on-SoFP PFI Schemes	0	0
Capital element of payments in respect of on-SoFP PFI	(125)	(639)
Capital element of payments in respect of Right of Use Assets	(3,956)	(3,846)
Cash transferred (to)/ from other NHS bodies	0	0
Net financing	1,977,819	1,888,568
Net increase/(decrease) in cash and cash equivalents	728	678
Cash and cash equivalents (and bank overdrafts) at 1 April 2025	4,823	4,145
Cash and cash equivalents (and bank overdrafts) at 31 March 2026	5,551	4,823

The notes on pages 8 to 79 form part of these accounts.

Notes to the Accounts

1. Accounting policies

The Minister for Health and Social Services has directed that the financial statements of Local Health Boards (LHBs) in Wales shall meet the accounting requirements of the NHS Wales Manual for Accounts. Consequently, the following financial statements have been prepared in accordance with the 2025-26 Manual for Accounts. The accounting policies contained in that manual follow the 2025-26 Financial Reporting Manual (FReM) in accordance with international accounting standards in conformity with the requirements of the Companies Act 2006, to the extent that they are meaningful and appropriate to the NHS in Wales.

Where the LHB Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the LHB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the LHB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Income and funding

The main source of funding for the LHBs are allocations (Welsh Government funding) from the Welsh Government within an approved cash limit, which is credited to the General Fund of the LHB. Welsh Government funding is recognised in the financial period in which the cash is received.

Non-discretionary funding outside the Revenue Resource Limit is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, or ophthalmic services identified by the Welsh Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the Revenue Resource Limit.

Funding for the acquisition of fixed assets received from the Welsh Government is credited to the General Fund.

Miscellaneous income is income which relates directly to the operating activities of the LHB and is not funded directly by the Welsh Government. This includes payment for services uniquely provided by the LHB for the Welsh Government such as funding provided to agencies and non-activity costs incurred by the LHB in its provider role. Income received from LHBs transacting with other LHBs is always treated as miscellaneous income.

From 2018-19, IFRS 15 Revenue from Contracts with Customers has been applied, as interpreted and adapted for the public sector, in the FReM. It replaces the previous standards IAS 11 Construction Contracts and IAS 18 Revenue and related IFRIC and SIC interpretations. The potential amendments identified as a result of the adoption of IFRS 15 are significantly below materiality levels.

Income is accounted for applying the accruals convention. Income is recognised in the period in which services are provided. Where income had been received from third parties for a specific activity to be delivered in the following financial year, that income will be deferred. Only non-NHS income may be deferred.

1.4. Employee benefits

1.4.1. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2. Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2025-26. From 1st April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA the NHS Pensions Agency) from 6.3% to 9.4%.

However, NHS Wales' organisations are required to account for their staff employer contributions of 23.78% in full and on a gross basis, in their annual accounts. Payments made on their behalf by Welsh Government are accounted for on a notional basis. For detailed information see the Other Note within these accounts.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Wales organisation commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme this is disclosed. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the NHS Wales organisation's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs.

1.4.3. NEST Pension Scheme

An alternative pensions scheme for employees not eligible to join the NHS Pensions scheme has to be offered. The NEST (National Employment Savings Trust) Pension scheme is a defined contribution scheme and therefore the cost to the NHS body of participating in the scheme is equal to the contributions payable to the scheme for the accounting period.

1.5. Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.6. Property, plant and equipment

1.6.1. Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the NHS Wales organisation;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2. Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for services or for administrative purposes are stated in the Statement of Financial Position (SoFP) at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use

- Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. NHS Wales' organisations have applied these new valuation requirements from 1st April 2009.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

In 2022-23 a formal revaluation exercise was applied to land and properties. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure.

References in IAS 36 to the recognition of an impairment loss of a revalued asset being treated as a revaluation decrease to the extent that the impairment does not exceed the amount in the revaluation surplus for the same asset, are adapted such that only those impairment losses that do not result from a clear consumption of economic benefit or reduction of service potential (including as a result of loss or damage resulting from normal business operations) should be taken to the revaluation reserve. Impairment losses that arise from a clear consumption of economic benefit should be taken to the Statement of Comprehensive Net Expenditure (SoCNE).

From 2015-16, IFRS 13 Fair Value Measurement must be complied with in full. However, IAS 16 and IAS 38 have been adapted for the public sector context which limits the circumstances under which a valuation is prepared under IFRS 13. Assets which are held for their service potential and are in use should be measured at their current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the assets remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. Where there is no single class of asset that falls within IFRS 13, disclosures should be for material items only.

In accordance with the adaptation of IAS 16 in table 6.2 of the FReM, for non-specialised assets in operational use, current value in existing use is interpreted as market value for existing use which is defined in the RICS Red Book as Existing Use Value (EUV).

Assets which were most recently held for their service potential but are surplus should be valued at current value in existing use, if there are restrictions on the NHS organisation or the asset which would prevent access to the market at the reporting date. If the NHS organisation could access the market then the surplus asset should be used at fair value using IFRS 13. In determining whether such an asset which is not in use is surplus, an assessment should be made on whether there is a clear plan to bring the asset back into use as an operational asset. Where there is a clear plan, the asset is not surplus and the current value in existing use should be maintained. Otherwise the asset should be assessed as being surplus and valued under IFRS13.

Assets which are not held for their service potential should be valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale. Where an asset is not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and it does not meet the IAS 40 and IFRS 5 criteria, these assets are surplus and are valued at fair value using IFRS 13.

1.6.3. Subsequent expenditure

Subsequent expenditure that enhances an asset beyond its original specification is capitalised as directly attributable cost. Expenditure that restores an asset to its original specification is also capitalised; where identifiable, the carrying value of the component replaced is written out and charged to the Statement of Comprehensive Net Expenditure (SoCNE).

In line with national protocol set out in the capital accounting chapter of the Manual for Accounts (agreed with Audit Wales and the Welsh Government), and to mitigate limitations in identifying replaced components, NHS Wales organisations obtain valuation evidence to ensure asset carrying values are not materially overstated. This includes in-year good housekeeping revaluations (prior to being brought into use) for All Wales Capital Schemes and for Discretionary Building Schemes with spend greater than £0.5m. Any write-downs arising are charged to operating expenses.

In 2025-26, the valuation approach was updated to include a District Valuer (DV) desktop review for material schemes that include replacement or backlog maintenance but do not meet the criteria for a good housekeeping valuation (generally schemes costing over £500k and linked to a specific block or blocks). The DV desktop review classifies schemes as enhancing or non-enhancing. Non-enhancing schemes are impaired on transfer from assets under construction (AUC) to the relevant property, plant and equipment category.

1.7. Intangible assets

1.7.1. Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Wales organisation; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use.
- the intention to complete the intangible asset and use it.
- the ability to use the intangible asset.
- how the intangible asset will generate probable future economic benefits.
- the availability of adequate technical, financial and other resources to complete the intangible asset and use it.
- the ability to measure reliably the expenditure attributable to the intangible asset during its

1.7.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8. Depreciation, amortisation and impairments

Freehold land, assets under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS Wales Organisation expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Wales organisation and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and estimated useful lives.

At each reporting period end, the NHS Wales organisation checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Impairment losses that do not result from a loss of economic value or service potential are taken to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the SoCNE. Impairment losses that arise from a clear consumption of economic benefit are taken to the SoCNE. The balance on any revaluation reserve (up to the level of the impairment) to which the impairment would have been charged under IAS 36 are transferred to retained earnings. Right of use (ROU) asset impairments are reflected in ROU liability.

1.9. Research and Development

Research and development expenditure is charged to operating costs in the year in which it is incurred, except insofar as it relates to a clearly defined project, which can be separated from patient care activity and the benefits from which can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SoCNE on a systematic basis over the period expected to benefit from the project.

1.10 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the

within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the SoCNE. On disposal, the balance for the asset on the revaluation reserve, is transferred to the General Fund.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead it is retained as an operational asset and its economic life adjusted. The asset is derecognised when it is scrapped or demolished.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

IFRS 16 leases is effective across public sector from 1st April 2022. The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

In the transition to IFRS 16 a number of elections and practical expedients offered in the standard have been employed. These are as follows: The entity has applied the practical expedient offered in the standard per paragraph C3 to apply IFRS 16 to contracts or arrangements previously identified as containing a lease under the previous leasing standards IAS 17 leases and IFRIC 4 determining whether an arrangement contains a lease and not to those that were identified as not containing a lease under previous leasing standards.

On initial application the LHB has measured the right of use assets for leases previously classified as operating leases per IFRS 16 C8 (b)(ii), at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

No adjustments have been made for operating leases in which the underlying asset is of low value per paragraph C9 (a) of the standard.

The transitional provisions have not been applied to operating leases whose terms end within 12 months of the date of initial application per paragraph C10 (c) of IFRS 16.

Hindsight is used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease in accordance with C10 (e) of IFRS 16.

Due to transitional provisions employed the requirements for identifying a lease within paragraphs 9 to 11 of IFRS 16 are not employed for leases in existence at the initial date of application. Leases entered into on or after the 1st April 2022 will be assessed under the requirements of IFRS 16.

There are further expedients or election that have been employed by the LHB in applying IFRS 16.

These include:

- the measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16
- the measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16

The LHB will not apply IFRS 16 to any new leases of intangible assets, applying the treatment described in section 1.7 instead.

List any other expedients employed by the entity (such as low value 5(b) or 15 on componentisation HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The LHB is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 the LHB has assessed that in all other respects these arrangements meet the definition of a lease under the standard.

The LHB is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.11.1 Aneurin Bevan University LHB as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The LHB employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset the LHB applies a revised rate to the remaining lease liability.

Where existing leases are modified the LHB must determine whether the arrangement constitutes a separate lease and apply the standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by the LHB.

1.11.2 Aneurin Bevan University LHB as lessor

A lessor shall classify each of its leases as an operating or finance lease. A lease is classified as finance lease when the lease substantially transfers all the risks and rewards incidental to ownership of an underlying asset. Where substantially all the risks and rewards are not transferred, a lease is classified as an operating lease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the LHB's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the LHB's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Where the LHB is an intermediate lessor, being a lessor and a lessee regarding the same underlying asset, classification of the sublease is required to be made by the intermediate lessor considering the term of the arrangement and the nature of the right of use asset arising from the head lease.

On transition the LHB has reassessed the classification of all of its continuing subleasing arrangements to include peppercorn leases.

1.12. Inventories

Whilst it is accounting convention for inventories to be valued at the lower of cost and net realisable value using the weighted average or "first-in first-out" cost formula, it should be recognised that the NHS is a special case in that inventories are not generally held for the intention of resale and indeed there is no market readily available where such items could be sold. Inventories are valued at cost and this is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.13. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. In the Statement of Cash flows (SoCF), cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the cash management.

1.14. Provisions

Provisions are recognised when the LHB has a present legal or constructive obligation as a result of a past event, it is probable that the LHB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the discount rate supplied by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the LHB has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the LHB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.14.1. Clinical negligence and personal injury costs

The Welsh Risk Pool Services (WRPS) operates a risk pooling scheme which is co-funded by the Welsh Government with the option to access a risk sharing agreement funded by the participative NHS Wales bodies. The risk sharing option was implemented in both 2024-25 and 2025-26. The WRPS is hosted by

1.14.2. Future Liability Scheme (FLS) - General Medical Practice Indemnity (GMPI)

The FLS is a state backed scheme to provide clinical negligence General Medical Practice Indemnity (GMPI) for providers of GMP services in Wales.

In March 2019, the Minister issued a Direction to Velindre University NHS Trust to enable Legal and Risk Services to operate the Scheme. The GMPI is underpinned by new secondary legislation, The NHS (Clinical Negligence Scheme) (Wales) Regulations 2019 which came into force on 1st April 2019.

GMP Service Providers are not direct members of the GMPI FLS, their qualifying liabilities are the subject of an arrangement between them and their relevant LHB, which is a member of the scheme. The qualifying reimbursements to the LHB are not subject to the £25,000 excess.

1.15. Financial Instruments

From 2018-19 IFRS 9 Financial Instruments has applied, as interpreted and adapted for the public sector, in the FReM. The principal impact of IFRS 9 adoption by NHS Wales' organisations, was to change the calculation basis for bad debt provisions, changing from an incurred loss basis to a lifetime expected credit loss (ECL) basis.

All entities applying the FReM recognised the difference between previous carrying amount and the carrying amount at the beginning of the annual reporting period that included the date of initial application in the opening general fund within Taxpayer's equity.

1.16. Financial assets

Financial assets are recognised on the SoFP when the LHB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The accounting policy choice allowed under IFRS 9 for long term trade receivables, contract assets which do contain a significant financing component (in accordance with IFRS 15), and lease receivables within the scope of IAS 17 has been withdrawn and entities should always recognise a loss allowance at an amount equal to lifetime Expected Credit Losses. All entities applying the FReM should utilise IFRS 9's simplified approach to impairment for relevant assets.

IFRS 9 requirements required a revised approach for the calculation of the bad debt provision, applying the principles of expected credit loss, using the practical expedients within IFRS 9 to construct a provision matrix.

1.16.1. Financial assets are initially recognised at fair value

Financial assets are classified into the following categories: financial assets 'at fair value through SoCNE'; 'held to maturity investments'; 'available for sale' financial assets, and 'loans and receivables'. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.2. Financial assets at fair value through SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through SoCNE. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.16.3 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.4. Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to the SoCNE on de-recognition.

1.16.5. Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the SOFP date, the LHB assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the SoCNE and the carrying amount of the asset is reduced directly, or through a provision of impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the SoCNE to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17. Financial liabilities

Financial liabilities are recognised on the SOFP when the LHB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1. Financial liabilities are initially recognised at fair value

Financial liabilities are classified as either financial liabilities at fair value through the SoCNE or other financial liabilities.

1.17.2. Financial liabilities at fair value through the SoCNE

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the SoCNE. The net gain or loss incorporates any interest earned on the financial asset.

1.17.3. Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18. Value Added Tax (VAT)

Most of the activities of the NHS Wales organisation are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19. Foreign currencies

Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the SoCNE. At the SoFP date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the reporting date.

1.20. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Wales organisation has no beneficial interest in them. Details of third party assets are given in the Notes to the accounts.

1.21. Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the SoCNE on an accruals basis, including losses which would have been made good through insurance cover had the LHB not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which is prepared on a cash basis.

The LHB accounts for all losses and special payments gross (including assistance from the WRP).

The LHB accrues or provides for the best estimate of future pay-outs for certain liabilities and discloses all other potential payments as contingent liabilities, unless the probability of the liabilities becoming payable is remote.

All claims for losses and special payments are provided for where the probability of settlement of an individual claim is over 50%. Where reliable estimates can be made, incidents of clinical negligence against which a claim has not, as yet, been received are provided in the same way. Expected reimbursements from the WRP are included in debtors. For those claims where the probability of settlement is between 5- 50%, the liability is disclosed as a contingent liability.

1.22. Pooled budgets

The NHS Wales organisation has entered into pooled budgets with Local Authorities. Under the arrangements funds are pooled in accordance with section 33 of the NHS (Wales) Act 2006 for specific activities defined in the Pooled budget Note 32.

The pool budget is hosted by one NHS Wales's organisation. Payments for services provided are accounted for as miscellaneous income. The NHS Wales organisation accounts for its share of the assets, liabilities, income and expenditure from the activities of the pooled budget, in accordance with the pooled budget arrangement.

Monmouthshire County Council - Monnow Vale Health and Social Care Unit

Funds are pooled for the provision of health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs. The pool is hosted by Aneurin Bevan University Local Health Board. The financial operation of the pool is governed by a pooled budget agreement between the Local Health Board and Monmouthshire County Council. The income from Monmouthshire County Council is recorded as Local Authority Income in these accounts.

Expenditure for services provided under the arrangement is recorded under the appropriate expense headings in these accounts.

The property in which the unit is housed has been provided by a Private Finance Partner; the contract with the PFI partner is for 30 years and is categorised as an on balance sheet PFI scheme with the HB recognising 72% of the property - see Note 32 of these accounts for further details.

The five Local Authorities in Gwent and ABUHB- Gwent Wide Integrated Community Equipment Service

Funds are pooled for the provision of an efficient and effective GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partner localities. The pool is hosted by Torfaen County Borough Council. The Health Board makes a financial contribution to the scheme but does not account for the schemes expenditure or assets/liabilities generated by this expenditure.

The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Torfaen County Borough Council, are accounted for as expenditure within these accounts.

Monmouthshire County Council - Mardy Park Rehabilitation Centre

Funds are pooled for the provision of care to individuals who have rehabilitation needs. The LHB has entered into a pooled budget with Monmouthshire County Council. The pool is hosted by Monmouthshire County Council.

The five Local Authorities in Gwent and ABUHB - Gwent Frailty Programme

Funds are pooled for the purpose of establishing a consistent service across Gwent. The pool is hosted by Caerphilly County Borough Council, as lead commissioner. The financial operation of the pool is governed by a pooled budget agreement between the bodies listed above and the Health Board. Payments for services provided by the host body, Caerphilly County Borough Council, are accounted for as expenditure within these accounts. Additional information is provided in Note 32.

The five Local Authorities in Gwent and ABUHB – A pooled Fund for Care Home Accommodation functions for Older People

Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The overarching strategic aim of this Agreement is: -

- To ensure coordinated arrangements for ensuring an integrated approach across the Partnership to the commissioning and arranging for Care Home Accommodation for Older People.
- To ensure provision of high quality, cost effective Care Home Accommodation which meets local health and social care needs, through the establishment of a pooled fund.
- To develop a managed market approach to the supply of quality provision to meets the needs of Older People Care Home Accommodation.

Funds are pooled for the provision and commissioning of specified services for older people (>65 years of age) in a care home setting in Gwent. The pool has been hosted by Torfaen County Borough Council since August 2018.

The Health Board makes a financial contribution to the scheme equivalent to actual expenditure incurred in commissioning related placements in homes during the year, but in addition does incur minimal costs associated with a share of the services provided by the host organisation and these are accounted for as expenditure within these accounts.

1.23. Critical Accounting Judgements and key sources of estimation uncertainty

In the application of the accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or the period of the revision and future periods if the revision affects both current and future periods.

1.24. Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the SoFP date, that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Significant estimations are made in relation to on-going clinical negligence and personal injury claims. Assumptions as to the likely outcome, the potential liabilities and the timings of these litigation claims are provided by independent legal advisors. Any material changes in liabilities associated with these claims would be recoverable through the Welsh Risk Pool.

Significant estimations are also made for continuing care costs resulting from claims post 1st April 2003. An assessment of likely outcomes, potential liabilities and timings of these claims are made on a case by case basis. Material changes associated with these claims would be adjusted in the period in which they are revised.

Estimates are also made for contracted primary care services. These estimates are based on the latest payment levels.

1.24.1. Provisions

The LHB provides for legal or constructive obligations for clinical negligence, personal injury and defence costs that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation.

Claims are funded via the Welsh Risk Pool Services (WRPS) which receives an annual allocation from Welsh Government to cover the cost of reimbursement requests submitted to the bi-monthly WRPS Committee. Following settlement to individual claimants by the NHS Wales organisation, the full cost is recognised in year and matched to income (less a £25K excess) via a WRPS debtor, until reimbursement has been received from the WRPS Committee.

1.24.2. Probable & Certain Cases – Accounting Treatment

A provision for these cases is calculated in accordance with IAS 37. Cases are assessed and divided into four categories according to their probability of settlement;

Remote	Probability of Settlement	0 – 5%
	Accounting Treatment	Remote Contingent Liability.
Possible	Probability of Settlement	6% - 49%
	Accounting Treatment	Defence Fee - Provision * Contingent Liability for all other estimated expenditure
Probable	Probability of Settlement	50% - 94%
	Accounting Treatment	Full Provision
Certain	Probability of Settlement	95% - 100%
	Accounting Treatment	Full Provision

** Personal injury cases - Defence fee costs are provided for at 100%.*

The provision for probable and certain cases is based on case estimates of individual reported claims received by Legal & Risk Services within NHS Wales Shared Services Partnership.

The solicitor will estimate the case value including defence fees, using professional judgement and from obtaining counsel advice. Valuations are then discounted for the future loss elements using individual life expectancies and the Government Actuary's Department actuarial tables (Ogden tables) and Personal Injury Discount Rate of 0.5%.

Future liabilities for certain & probable cases with a probability of 95%-100% and 50%- 94% respectively are held as a provision on the balance sheet. Cases typically take a number of years to settle, particularly for high value cases where a period of development is necessary to establish the full extent of the injury caused.

The Health Board has provided for some £237m (£199m 2024/25) within note 20 in respect of potential clinical negligence and personal injury claims and associated defence fees. These provisions have been arrived at on the advice of NHS Wales Shared Services Partnership - Legal & Risk Services. Given the nature of such claims this figure could be subject to significant change in future periods. However, the potential financial effect of such uncertainty is mitigated by the fact that the LHB's ultimate liability in respect of individual cases is capped at £0.025m, with amounts above this excess level being reimbursed by the Welsh Risk Pool.

The Health Board has estimated a liability of £0.869m (£0.379m 2024/25) in respect of retrospective claims for Continuing Health Care funding. The estimated provision is based upon an assessment of the likelihood of claims meeting criteria for continuing health care and the actual costs incurred by individuals in care homes. The provision is based on information made available to the Health Board at the time of these accounts and could be subject to significant change as outcomes are determined.

Aneurin Bevan University Local Health Board has reviewed its portfolio of outstanding claims for continuing healthcare and made an assessment of likely financial liability based on an estimated success factor, eligibility factor and expected weekly average costs of claims. The assumptions have been derived by reviewing a sample of claims.

Primary care expenditure includes estimates for areas which are paid in arrears and not finalised at the time of producing the accounts. These estimates relate to GMS Quality Assurance and Improvement Framework, GMS Enhanced Services, and pharmacy estimates, which are based on an assessment of likely final performance.

1.25 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities to be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined to be included.

Within the Provisions Note (note 20) the amount relating to Early Retirements and Permanent Injury benefits has been discounted using the PES (2024) Post Employment Benefits Liabilities Real Rate in Excess of CPI of 2.95%.

1.26 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The LHB therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.26.1. Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.26.2. PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the LHB's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.26.3. PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised.

Prior year treatment

It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the SoCNE.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the SoCNE.

1.26.4 Impact of IFRS 16 on on-balance sheet PFI/PPP Schemes as from 1st April 2023.

On-balance sheet PPP arrangements should be based on IFRS 16 accounting principles from 2023-24.

When measuring the liability for on-balance sheet PPP contracts containing capital payments linked to a price index IFRS 16 requires that a lessee shall remeasure the lease liability where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments. The lessee shall remeasure the lease liability to reflect those revised lease payments only when there is a change in the cash flows.

Initial remeasurement - the future PPP liability will need to be remeasured at 1st April 2023 to include the actual indexation-linked changes to payments for the capital/infrastructure element which have taken effect in the cash flows since the PPP agreement commenced. This should use a cumulative catch-up approach, where the cumulative effect is recognised as an adjustment to the opening balance of retained earnings.

Subsequent measurement - The PPP liability will continue to require remeasurements whenever cash payments change in response to indexation movements as set out in the individual PPP contract. The double entry for the subsequent liability remeasurement should be Debit Finance Cost, Credit PPP liability.

The liability does not include estimated future indexation linked increases.

1.26.5. Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the LHB's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.26.6. Assets contributed by the LHB to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the LHB's SoFP.

1.26.7. Other assets contributed by the LHB to the operator

Assets contributed (e.g. cash payments, surplus property) by the LHB to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the LHB, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Wales organisation through the asset being made available to third party users.

Other PFI arrangements off Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Nevill Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Joint PFI contract

The LHB has entered into an agreement to share a facility, provided by a Private Finance Partner, with Monmouthshire County Council to match the agreement with the Private Finance Partner. The arrangement is treated as a PFI arrangement and the total obligation is included as a liability of the LHB. The contribution towards the unitary charge committed by Monmouthshire County Council is treated as a financial asset. The future contribution was measured initially at the same amount as the fair value of the share of the PFI asset and is subsequently measured as a finance lease.

1.27. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the LHB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.28. Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

Where transfer of function is between LHBs the gain or loss resulting from the assets and liabilities transferring is recognised in the SoCNE and is disclosed separately from the operating costs.

1.29. Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM.

IFRS14 Regulatory Deferral Accounts - Not UK endorsed. Applies to first time adopters of IFRS after 1st January 2016. Therefore not applicable.

IFRS 18 Presentation and Disclosure in Financial Statements - Application required for accounting periods beginning on or after 1st January 2027. Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - Application required for accounting periods beginning on or after 1st January 2027. Standard is not yet UK endorsed and not yet adopted by

1.30. Accounting standards issued that have been adopted early

During 2025-26 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.31. Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the LHB has established that as it is the corporate trustee of the Aneurin Bevan University LHB NHS Charitable Fund, it is considered for accounting standards compliance to have control of the Aneurin Bevan University LHB NHS Charitable Fund as a subsidiary.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Aneurin Bevan University LHB NHS Charitable Fund or its independence in its management of charitable funds.

Whilst there is a requirement to consolidate the results of the Aneurin Bevan University LHB NHS Charitable Fund within the statutory accounts of the LHB. The LHB has with the agreement of the Welsh Government adopted the IAS 27 (10) exemption to consolidate.

Welsh Government as the ultimate parent of the Local Health Boards will disclose the Charitable Accounts of Local Health Boards in the Welsh Government Consolidated Accounts.

Details of the transactions with the charity are included in the related parties' notes.

2. Financial Duties Performance

The National Health Service Finance (Wales) Act 2014 came into effect from 1st April 2014. The Act amended the financial duties of Local Health Boards under section 175 of the National Health Service (Wales) Act 2006. From 1st April 2014 section 175 of the National Health Service (Wales) Act places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years;
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, to secure compliance with the duty under section 175 (1) while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

The first assessment of performance against the 3 year statutory duty under section 175 (1) was at the end of 2016-17, being the first 3 year period of assessment.

Welsh Health Circular WHC/2016/054 "Statutory and Financial Duties of Local Health Boards and NHS Trusts" clarifies the statutory financial duties of NHS Wales bodies effective from 2016-17.

2.1 Revenue Resource Performance

Annual financial performance

	2023-24	2024-25	2025-26	Total
	£000	£000	£000	£000
Net operating costs for the year	1,818,468	1,920,421	2,043,604	5,782,493
Less general ophthalmic services expenditure and other non-cash limited expenditure	599	(1,693)	(2,349)	(3,443)
Less unfunded revenue consequences of bringing PFI schemes onto SoFP	29	(29)	23	23
Less any non funded revenue consequences of IFRS 16	0	0	0	0
Total operating expenses	1,819,096	1,918,699	2,041,278	5,779,073
Revenue Resource Allocation	1,769,330	1,911,514	2,022,996	5,703,840
Under /(over) spend against Allocation	(49,766)	(7,185)	(18,282)	(75,233)

Aneurin Bevan University LHB has not met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2023-24 to 2025-26.

The Health Board received £18.3m cash-only support from Welsh Government during 2025-26 with the accumulated cash-only support for 2023-24 to 2025-26 as at 31 March 2026 being £75.6m. This support has been provided by Welsh Government to assist the Health Board with making payments and suppliers; there is no requirement for this funding to be repaid.

2.2 Capital Resource Performance

	2023-24	2024-25	2025-26	Total
	£000	£000	£000	£000
Gross capital expenditure	62,681	72,066	45,821	180,568
Add: Losses on disposal of donated assets	1	0	6	7
Less NBV on disposal of property, plant and equipment, right of use and intangible assets	(5,845)	(1,534)	(366)	(7,745)
Adjustment for transfers (to)/from NHS Trusts	0	(45)	0	(45)
Less capital grants received	0	0	0	0
Less donations received	(136)	(78)	(203)	(417)
Less IFRS16 Peppercorn income	0	0	0	0
Less initial recognition of RoU Asset Dilapidations	0	0	0	0
Charge against Capital Resource Allocation	56,701	70,409	45,258	172,368
Capital Resource Allocation	56,742	70,475	45,305	172,522
(Over) / Underspend against Capital Resource Allocation	41	66	47	154

Aneurin Bevan University LHB has met its financial duty to break-even against its Capital Resource Limit over the 3 years 2023-24 to 2025-26.

2.3 Duty to prepare a 3 year integrated plan

The NHS Wales Planning Framework for the period 2025-2028 issued to LHBs placed a requirement upon them to prepare and submit balanced Integrated Medium-Term Plans to the Welsh Government.

The LHB submitted a balanced IMTP for the period 2025-28, in accordance with the NHS Wales Planning Framework in March 2025. This plan was approved by Cabinet Secretary for Health and Social Care on 30th June 2025.

This approval was revoked in December 2025, due to the emerging financial deficit position of the Health Board reported during 2025/26. Therefore the Health Board did not have an approved financial plan for the period 2025/26.

The Minister for Health and Social Services extant approval

Status
Date

Aneurin Bevan University LHB has therefore not met its statutory duty to have an approved financial plan.

2.4 Creditor payment

The LHB is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The LHB has achieved the following results:

	2025-26	2024-25
Total number of non-NHS bills paid	302,142	301,118
Total number of non-NHS bills paid within target	293,413	294,215
Percentage of non-NHS bills paid within target	97.1%	97.7%

The LHB has met the target.

3. Analysis of gross operating costs

3.1 Expenditure on Primary Healthcare Services

	Cash limited £000	Non-cash limited £000	2025-26 Total £000	2024-25 Total £000
General Medical Services	140,047		140,047	132,671
Pharmaceutical Services	37,718	(8,322)	29,396	29,224
General Dental Services	45,761		45,761	44,444
General Ophthalmic Services	6,580	10,671	17,251	15,075
Other Primary Health Care expenditure	3,715		3,715	4,729
Prescribed drugs and appliances	130,678		130,678	125,771
Total	364,499	2,349	366,848	351,914

Return of excess funds from primary care contractors are included in the figures above

Included within other notes to the accounts

Additional Primary Care Expenditure	Positive	0	0
Additional Primary Care Income	Negative	(13,172)	(5,843)
Overall total		353,676	346,071

The General Medical Services expenditure includes £18,194k (2024/25 £11,699k) in relation to staff salaries, the General Dental Services expenditure includes £2,757k (2024/25 £2,155k) in relation to staff salaries, the Prescribed Drugs & Appliances expenditure includes £309k (2024/25 £352k) in relation to staff salaries, and the General Ophthalmic Services includes £156k (2024/25 £88k) in relation to staff salaries.

3.2 Expenditure on healthcare from other providers

	2025-26 £000	2024-25 £000
Goods and services from other NHS Wales Health Boards	66,288	64,362
Goods and services from other NHS Wales Trusts	60,101	54,658
Goods and services from Welsh Special Health Authorities	0	0
Goods and services from other non Welsh NHS bodies	13,560	14,400
Goods and services from NHSW JCC	232,273	218,320
Local Authorities	39,911	41,544
Voluntary organisations	11,777	10,849
NHS Funded Nursing Care	13,053	11,817
Continuing Care	110,957	99,904
Private providers	26,298	10,942
Specific projects funded by the Welsh Government	0	0
Other	372	407
Total	574,590	527,203

Local Authorities expenditure relates to the following bodies:

	2025-26 £'000	2024-25 £'000
Blaenau Gwent County Borough Council	3,381	3,644
Caerphilly County Borough Council	17,379	17,632
Monmouthshire County Council	4,753	4,947
Newport City Council	7,138	8,548
Torfaen County Borough Council	7,168	6,876
Gloucestershire County Council	92	(103)
	39,911	41,544

3.3 Expenditure on Hospital and Community Health Services

	2025-26	2024-25
	£000	£000
Directors' costs	2,802	2,741
Operational Staff costs	910,435	843,137
Single lead employer Staff Trainee Cost	45,228	43,004
Collaborative Bank Staff Cost	0	0
Supplies and services - clinical	154,058	143,559
Supplies and services - general	18,199	20,917
Consultancy Services	649	481
Establishment	7,196	6,438
Transport	1,467	1,542
Premises	41,322	46,305
External Contractors	0	0
Depreciation	45,804	42,231
Depreciation Right of Use assets (RoU)	4,116	3,896
Amortisation	1,960	1,964
Fixed asset impairments and reversals (Property, plant & equipment)	(5,687)	1,817
Fixed asset impairments and reversals (RoU Assets)	0	0
Fixed asset impairments and reversals (Intangible assets)	0	0
Impairments & reversals of financial assets	0	0
Impairments & reversals of non-current assets held for sale	0	0
Audit fees	470	443
Other auditors' remuneration	0	0
Losses, special payments and irrecoverable debts	8,725	3,065
Research and Development	0	0
Expense related to short-term leases	168	367
Expense related to low-value asset leases (excluding short-term leases)	980	973
Other operating expenses	15,138	14,310
Total	1,253,030	1,177,190

The Health Board Spent £3.3m (£2.8m 2024-25) on Research and Development. The majority of this spend relates to staff £2.7m (£2.2m 2024-25) which along with the non-staff spend is reflected under the various headings within note 3.3. During 2025-26 Research and Development income received was £3.1m (£2.6m 2024-25).

3.4 Losses, special payments and irrecoverable debts: charges to operating expenses

	2025-26	2024-25
	£000	£000
Increase/(decrease) in provision for future payments:		
Clinical negligence;		
Secondary care	63,373	2,814
Primary care	1,199	49
Redress Secondary Care	32	180
Redress Primary Care	0	0
Personal injury	639	547
All other losses and special payments	5,271	1,062
Defence legal fees and other administrative costs	2,284	1,414
Gross increase/(decrease) in provision for future payments	72,798	6,066
Contribution to Welsh Risk Pool	0	0
Premium for other insurance arrangements	0	0
Irrecoverable debts	594	73
Less: income received/due from Welsh Risk Pool	(64,667)	(3,074)
Total	8,725	3,065

	2025-26	2024-25
	£	£
Permanent injury included within personal injury £:	(221,402)	(472,029)

4. Miscellaneous Income

	2025-26 £000	2024-25 £000
Local Health Boards	25,547	24,380
NHSW Joint Commissioning Committee	15,082	14,774
NHS Wales trusts	19,921	17,702
Welsh Special Health Authorities	2,245	1,404
Foundation Trusts	45	97
Other NHS England bodies	2,487	2,975
Other NHS Bodies	49	21
Local authorities	21,283	21,289
Welsh Government	5,510	3,729
Welsh Government Hosted bodies	0	0
Non NHS:		
Prescription charge income	3	3
Dental fee income	5,742	6,130
Private patient income	0	0
Overseas patients (non-reciprocal)	316	365
Injury Costs Recovery (ICR) Scheme	1,401	1,323
Other income from activities	2,777	2,528
Patient transport services	0	0
Education, training and research	21,848	19,086
Charitable and other contributions to expenditure	1,596	1,394
Receipt of NWSSP Covid centrally purchased assets	0	0
Receipt of Covid centrally purchased assets from other organisations	0	0
Receipt of donated assets	203	78
Receipt of Government granted assets	0	0
Right of Use Grant (Peppercorn Lease)	0	0
Non-patient care income generation schemes	144	155
NHS Wales Shared Services Partnership (NWSSP)	0	0
Deferred income released to revenue	0	0
Right of Use Asset Sub-leasing rental income	0	0
Contingent rental income from finance leases	0	0
Rental income from operating leases	477	467
Other income:		
Provision of laundry, pathology, payroll services	96	82
Accommodation and catering charges	3,532	3,349
Mortuary fees	410	422
Staff payments for use of cars	674	673
Business Unit	0	0
Scheme Pays Reimbursement Notional	4	81
Other	20,316	14,099
Total	151,708	136,606
Other income Includes;		
Salary Sacrifice Schemes & Fleet Vehicles	9,603	7,772
VAT recoveries re Business Activities and Contracted Out Services	946	986
Income from Managed Practices	5,633	0
Other	4,134	5,341
Total	20,316	14,099

Injury Cost Recovery (ICR) Scheme income

	2025-26 %	2024-25 %
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	24.62	24.45

5. Investment Revenue

	2025-26 £000	2024-25 £000
Rental revenue :		
PFI Finance lease income		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue :		
Bank accounts	0	0
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	16	16
Total	16	16

6. Other gains and losses

	2025-26 £000	2024-25 £000
Gain/(loss) on disposal of property, plant and equipment	(45)	41
Gain/(loss) on disposal other than by sale of right of use assets	1	0
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of assets held for sale	0	0
Gain/(loss) on disposal of financial assets	0	0
Change on foreign exchange	0	0
Change in fair value of financial assets at fair value through SoCNE	0	0
Change in fair value of financial liabilities at fair value through SoCNE	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	(44)	41

7. Finance costs

	2025-26 £000	2024-25 £000
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under Right of Use Leases	442	353
Interest on obligations under PFI contracts;		
main finance cost	89	132
contingent finance cost	0	0
Impact of IFRS 16 on PPP/PFI contracts	107	147
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	638	632
Provisions unwinding of discount	178	145
Other finance costs	0	0
Total	816	777

8. Future charges to Statement of Comprehensive Net Expenditure (SoCNE)

LHB as lessee

As at 31st March 2026 the Health Board had 0 leases agreements in place for the leases of premises; 488 arrangements in respect of equipment and 265 in respect of vehicles, with 0 property, 100 equipment and 55 vehicle leases having expired in year.

	2025-26	2025-26	2025-26	2024-25
	Low Value & Short Term	Other	Total	Total
Payments recognised as an expense				
	£000	£000	£000	£000
Minimum lease payments	1,186	0	1,186	1,363
Contingent rents	0	0	0	0
Sub-lease payments	0	0	0	0
Total	1,186	0	1,186	1,363
Total future minimum lease payments				
Payable	£000	£000	£000	£000
Not later than one year	1,391	0	1,391	820
Between one and five years	963	0	963	803
After 5 years	0	0	0	0
Total	2,354	0	2,354	1,623

LHB as lessor

	2025-26	2024-25
Rental revenue	£000	£000
Rent	477	467
Contingent rents	0	0
Total revenue rental	477	467
Total future minimum lease payments		
Receivable	£000	£000
Not later than one year	306	290
Between one and five years	1,157	1,085
After 5 years	942	789
Total	2,405	2,164

9. Employee benefits and staff numbers

9.1 Employee costs	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	684,814	1,358	22,042	34,909	0	2,841	745,964	702,130
Social security costs	88,244	0	0	4,873	0	0	93,117	70,709
Employer contributions to NHS Pension Scheme	136,161	0	0	5,446	0	0	141,607	130,925
Other pension costs	17	0	0	0	0	0	17	229
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Total	909,236	1,358	22,042	45,228	0	2,841	980,705	903,993
Charged to capital							767	802
Charged to revenue							979,938	903,191
							980,705	903,993
Net movement in accrued employee benefits (untaken staff leave)							80	(38)

The staff under the 'Other' heading relate to Agency Medical Staff who are paid via a direct engagement scheme which commenced in January 2020.

9.2 Average number of employees

	Permanent Staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Collaborative Bank Staff	Other	Total	2024-25
	Number	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	2,800	8	11	0	0	0	2,819	2,722
Medical and dental	890	5	39	447	0	13	1,394	1,339
Nursing, midwifery registered	4,180	0	111	0	0	0	4,291	4,121
Professional, Scientific, and technical staff	455	0	10	0	0	0	465	433
Additional Clinical Services	2,910	0	23	0	0	0	2,933	2,903
Allied Health Professions	981	5	14	0	0	0	1,000	982
Healthcare Scientists	258	0	2	0	0	0	260	257
Estates and Ancillary	1,081	0	25	0	0	0	1,106	1,054
Students	3	0	0	0	0	0	3	6
Total	13,558	18	235	447	0	13	14,271	13,817

9.3. Retirements due to ill-health

	2025-26	2024-25
Number	15	16
Estimated additional pension costs £	962,243	1,456,012

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. These additional pension costs have been calculated on an average basis and will be borne by the NHS Pension Scheme.

9.4 Employee benefits

The Health Board does not have an employee benefit scheme.

9.5 Reporting of other compensation schemes - exit packages

9.5.1 Exit Packages Costs and Numbers

	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures	Total number of exit packages	Number of departures where special payments have been made	Total number of exit packages
	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only	Whole numbers only
less than £10,000	0	0	0	0	1
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	3	3	0	0
£100,000 to £150,000	0	1	1	0	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	4	4	0	1

	2025-26	2025-26	2025-26	2025-26	2024-25
Exit packages cost band (including any special payment element)	Cost of compulsory redundancies	Cost of other departures	Total cost of exit packages	Cost of special element included in exit packages	Total cost of exit packages
	£	£	£	£	£
less than £10,000	0	0	0	0	7,500
£10,000 to £25,000	0	0	0	0	0
£25,000 to £50,000	0	0	0	0	0
£50,000 to £100,000	0	204,086	204,086	204,086	0
£100,000 to £150,000	0	108,975	108,975	108,975	0
£150,000 to £200,000	0	0	0	0	0
more than £200,000	0	0	0	0	0
Total	0	313,061	313,061	313,061	7,500

Total Exit Costs Paid in Year	Total paid in year	Total paid in year
	2025-26	2024-25
	£	£
Exit costs paid in year	204,086	7,500
Total	204,086	7,500

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Voluntary Early Release Scheme (VERS).

Where the LHB has agreed early retirements, the additional costs are met by the LHB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

The figures above are consolidated amounts.

The Health Board has approved 4 VERS in 2025-26.

Additional requirement as per FReM
£0 exit costs were paid in 2025-26, relating to 2024-25 (the year of departure).

9.5 Reporting of other compensation schemes - exit packages continued

9.5.2 Analysis of other departures

	2025-26	2025-26
	Agreements	Total value of
Type of other departures	Number	agreements
		£
Voluntary redundancies including early retirement contractual costs	4	313,061
Contractual payments in lieu of notice*	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring Welsh Government Approval**	0	0
Other please specify	0	0
Total	4	313,061

This disclosure provides detail for the number and value of exit packages agreed in the year.

The figures above are consolidated amounts.

9.6 Fair Pay disclosures

9.6.1 Remuneration Relationship

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/employee in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

Total Pay and benefits	£'000			£'000		
Chief Executive Total pay and benefits range	245-250			240-245		
Highest paid Director Total pay and benefits range	245-250			240-245		
	2025-26	2025-26	2025-26	2024-25	2024-25	2024-25
	£	£		£	£	
	Chief			Chief		
Total pay and benefits mid-point	Executive	Employee	Ratio	Executive	Employee	Ratio
25th percentile pay ratio	247,500	29,758	8.3:1	247,500	29,484	8.2:1
Median pay	247,500	38,364	6.5:1	247,500	37,030	6.5:1
75th percentile pay ratio	247,500	49,046	5.0:1	247,500	48,530	5.0:1
Salary component of total pay and benefits						
25th percentile pay ratio	247,500	29,758		247,500	29,484	
Median pay	247,500	38,364		247,500	37,030	
75th percentile pay ratio	247,500	49,046		247,500	48,530	
	Highest Paid			Highest Paid		
Total pay and benefits mid-point	Director	Employee	Ratio	Director	Employee	Ratio
25th percentile pay ratio	247,500	29,758	8.3:1	247,500	29,484	8.2:1
Median pay	247,500	38,364	6.5:1	247,500	37,030	6.5:1
75th percentile pay ratio	247,500	49,046	5.0:1	247,500	48,530	5.0:1
Salary component of total pay and benefits						
25th percentile pay ratio	247,500	29,758		247,500	29,484	
Median pay	247,500	38,364		247,500	37,030	
75th percentile pay ratio	247,500	49,046		247,500	48,530	

In 2025-26 14 (2024-25, 15) employees received remuneration in excess of the highest-paid director.

Remuneration for all staff ranged from £17k to £371k (2024-25, £17k to £459k).

The all staff range includes directors with the exception of the highest paid CEO Director as appropriate and excludes the non-executive directors and excludes pension benefits of all employees

Financial Year Summary

The 2025-26 pay ratio is comparable with 2024-25 with minimal variation.

The median pay ratio for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole.

9.6.2 Percentage Changes	2024-25	2023-24
	to	to
	2025-26	2024-25
	%	%
% Change from previous financial year in respect of Chief Executive		
Salary and allowances	2	7
Performance pay and bonuses	0	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances	2	7
Performance pay and bonuses	0	0
Average % Change from previous financial year in respect of employees takes as a whole		
Salary and allowances	1	5
Performance pay and bonuses	0	0

9.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts.

These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2025-26 tax year (2024-25 £6,240 and £50,270).

Restrictions on the annual contribution limits were removed on 1st April 2017.

10. Public Sector Payment Policy - Measure of Compliance

10.1 Prompt payment code - measure of compliance

The Welsh Government requires that Health Boards pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the Health Board financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery.

	2025-26	2025-26	2024-25	2024-25
NHS	Number	£000	Number	£000
Total bills paid	5,354	456,451	5,193	433,942
Total bills paid within target	4,994	450,167	4,770	425,567
Percentage of bills paid within target	93.3%	98.6%	91.9%	98.1%
Non-NHS				
Total bills paid	302,142	738,419	301,118	700,384
Total bills paid within target	293,413	715,779	294,215	676,799
Percentage of bills paid within target	97.1%	96.9%	97.7%	96.6%
Total				
Total bills paid	307,496	1,194,870	306,311	1,134,326
Total bills paid within target	298,407	1,165,946	298,985	1,102,366
Percentage of bills paid within target	97.0%	97.6%	97.6%	97.2%

10.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2025-26	2024-25
	£	£
Amounts included within finance costs (note 7) from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	207	114,172
Total	207	114,172

11.1 Property, plant and equipment

2025-26

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2025	79,198	797,467	2,582	49,689	118,390	380	38,655	4,588	1,090,949
Indexation	2,105	59,514	168	0	0	0	0	0	61,787
Additions									
- purchased	0	9,484	56	16,981	10,363	0	6,514	67	43,465
- donated	0	13	0	0	190	0	0	0	203
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	52	0	0	0	52
Reclassifications	0	54,142	0	(54,142)	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	396	39,287	152	0	0	0	0	0	39,835
Impairments	0	(35,282)	0	(382)	0	0	0	0	(35,664)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(65)	0	0	(4,705)	(21)	(800)	(264)	(5,855)
At 31 March 2026	81,699	924,560	2,958	12,146	124,290	359	44,369	4,391	1,194,772
Depreciation at 1 April 2025	0	63,141	488	0	73,408	374	24,087	1,904	163,402
Indexation	0	5,011	49	0	0	0	0	0	5,060
Transfer from/into other NHS bodies	0	0	0	0	16	0	0	0	16
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	2,812	11	0	0	0	0	0	2,823
Impairments	0	(4,339)	0	0	0	0	0	0	(4,339)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(65)	0	0	(4,551)	(21)	(800)	(264)	(5,701)
Provided during the year	0	27,266	102	0	12,636	6	5,337	457	45,804
At 31 March 2026	0	93,826	650	0	81,509	359	28,624	2,097	207,065
Net book value at 1 April 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Net book value at 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707
Net book value at 31 March 2026 comprises :									
Purchased	78,511	828,705	2,308	12,146	42,198	0	15,700	2,267	981,835
Donated	3,188	1,813	0	0	501	0	45	27	5,574
Government Granted	0	216	0	0	82	0	0	0	298
At 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707
Asset financing :									
Owned	81,699	826,498	2,308	12,146	42,781	0	15,745	2,294	983,471
On-SoFP PPP/PFI contracts	0	4,236	0	0	0	0	0	0	4,236
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2026	81,699	830,734	2,308	12,146	42,781	0	15,745	2,294	987,707

The net book value of land, buildings and dwellings at 31 March 2026 comprises :

	£000
Freehold	909,975
Long Leasehold	4,762
Short Leasehold	4
	914,741

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.

0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11.1 Property, plant and equipment

2024-25

	Land £000	Buildings, excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2024	75,111	750,899	2,390	40,777	117,063	281	39,458	3,953	1,029,932
Indexation	666	5,342	15	0	0	0	0	0	6,023
Additions									
- purchased	0	3,509	149	46,201	7,691	0	5,427	624	63,601
- donated	0	17	0	0	42	0	19	0	78
- government granted	0	0	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	(45)	0	(45)
Reclassifications	0	37,289	0	(37,289)	(60)	0	16	44	0
Revaluations	3,288	6,243	0	0	0	0	0	0	9,531
Reversal of impairments	133	14,644	28	0	0	0	0	0	14,805
Impairments	0	(17,994)	0	0	0	0	0	0	(17,994)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(2,482)	0	0	(6,346)	99	(6,220)	(33)	(14,982)
At 31 March 2025	79,198	797,467	2,582	49,689	118,390	380	38,655	4,588	1,090,949
Depreciation at 1 April 2024	0	43,143	395	0	67,276	269	24,508	1,524	137,115
Indexation	0	374	6	0	0	0	0	0	380
Transfer from/into other NHS bodies	0	0	0	0	0	0	(11)	0	(11)
Reclassifications	0	0	0	0	(16)	0	16	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	403	1	0	0	0	0	0	404
Impairments	0	(1,776)	0	0	0	0	0	0	(1,776)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	(2,482)	0	0	(6,306)	99	(6,219)	(33)	(14,941)
Provided during the year	0	23,479	86	0	12,454	6	5,793	413	42,231
At 31 March 2025	0	63,141	488	0	73,408	374	24,087	1,904	163,402
Net book value at 1 April 2024	75,111	707,756	1,995	40,777	49,787	12	14,950	2,429	892,817
Net book value at 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Net book value at 31 March 2025 comprises :									
Purchased	76,108	732,430	2,094	49,689	44,378	6	14,503	2,652	921,860
Donated	3,090	1,697	0	0	463	0	65	32	5,347
Government Granted	0	199	0	0	141	0	0	0	340
At 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547
Asset financing :									
Owned	79,198	730,440	2,094	49,689	44,982	6	14,568	2,684	923,661
On-SoFP PPP/PFI contracts	0	3,886	0	0	0	0	0	0	3,886
PFI residual interests	0	0	0	0	0	0	0	0	0
At 31 March 2025	79,198	734,326	2,094	49,689	44,982	6	14,568	2,684	927,547

The net book value of land, buildings and dwellings at 31 March 2025 comprises :

	£000
Freehold	811,217
Long Leasehold	4,390
Short Leasehold	11
	815,618

Valuers 'material uncertainty', in valuation. The disclosure relates to the materiality in the valuation report not that of the underlying account.

0

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHBs are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between Knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

11. Property, plant and equipment (continued)

Disclosures:

(i) Donated Assets

Assets totalling £203k were purchased via Charitable Funds donations during the year.

(ii) Valuations

The LHBs land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The LHB is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

In 2025-26, indexation has been applied to land and buildings based on indices received from the Valuation Office Agency and as agreed in the Technical Update Note 01 issued by Welsh Government on 24th September 2025. No indexation has been applied to equipment.

In addition, in 2025-26 there have been separate revaluations for seven assets under construction coming into use. These include Nevill Hall Satellite Radiotherapy Unit, the ward D7E upgrade, pharmacy robot installation and new decontamination unit at Royal Gwent Hospital, the Emergency Department extension and 2nd MRI installation at the Grange University Hospital and boiler replacement upgrade at St Cadoc's Hospital.

Further to these revaluations, an exercise was undertaken by the Valuation Office Agency to assess the TEF and REFIT estates programmes for enhancing and non-enhancing expenditure in 2025-26. Any non-enhancing expenditure has been impaired from the asset values as at 31st March 2026. This assessment covers work to take place in 2026-27 when a similar impairment impact will be expected.

(iii) Asset Lives

Property, plant and equipment is depreciated using the following asset lives:

- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment between 5-15 years.

(iv) Compensation

There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

(v) Write Downs

There have not been any write downs in the period.

(vi) Open Market Value

The Health Board does not hold any property where the value is materially different from its open market value.

(vii) Assets Held for Sale or sold in the period

There are no assets held for sale or sold in the period.

(viii) IFRS 13 Fair value measurement

11. Property, plant and equipment

11.2 Non-current assets held for sale

	Land	Buildings, including dwelling	Other property, plant and equipment	Intangible assets	Other assets	Total
	£000	£000	£000	£000	£000	£000
Balance brought forward 1 April 2025	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2026	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Balance brought forward 1 April 2024	0	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0
Add reversal of impairment of assets held for sale	0	0	0	0	0	0
Less impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance carried forward 31 March 2025	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings within the note. Most leases are individually insignificant, however, four are significant in their own right (>£1m):

- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,086k
- Brynmawr Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,956k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2026: £1,840k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2026: £1,903k

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2025-26									
Cost or valuation at 1 April 2025	658	15,466	0	0	9,029	944	1,822	0	27,919
Additions	0	700	0	0	1,058	338	0	0	2,096
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(345)	0	0	(453)	(134)	0	0	(932)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	(128)	0	0	0	0	0	0	(128)
At 31 March 2026	658	15,693	0	0	9,634	1,148	1,822	0	28,955
Depreciation at 1 April 2025	132	3,885	0	0	4,181	532	1,068	0	9,798
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	(345)	0	0	(370)	(134)	0	0	(849)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	44	1,881	0	0	1,535	318	338	0	4,116
At 31 March 2026	176	5,421	0	0	5,346	716	1,406	0	13,065
Net book value at 1 April 2025	526	11,581	0	0	4,848	412	754	0	18,121
Net book value at 31 March 2026	482	10,272	0	0	4,288	432	416	0	15,890
RoU Asset Total Value Split by Lessor									
	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercorn Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercorn Leases	472	258	0	0	0	0	0	0	730
Other Public Sector Market Value Leases	10	1,155	0	0	0	0	0	0	1,165
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	8,859	0	0	4,288	432	416	0	13,995
Total	482	10,272	0	0	4,288	432	416	0	15,890

11.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most leases are individually insignificant, however, six are significant in their own right (>£1m):

- Blaenavon Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £1,213k
- Brynmawr Primary Care Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £2,117k
- Rhymney Integrated H&SC Resource Centre (LHB lease) held under Land & Buildings NBV at 31 March 2025: £2,078k
- Ty Gwent held under Land & Buildings NBV at 31 March 2025: £1,092k
- Biochemistry Managed Service Contract held under Plant & Machinery NBV at 31 March 2025: £2,172k
- NHH Energy scheme (previously classified as an off balance sheet PFI scheme) held under Plant & Machinery NBV at 31 March 2025: £1,411k

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
2024-25									
Cost or valuation at 1 April 2024	813	12,180	0	0	9,058	860	2,045	0	24,956
Additions	0	4,151	0	0	1,818	184	0	0	6,153
Transfer from/into other NHS bodies	0	(57)	0	0	0	0	0	0	(57)
Disposals other than by sale	(155)	(808)	0	0	(1,847)	(100)	(223)	0	(3,133)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
At 31 March 2025	658	15,466	0	0	9,029	944	1,822	0	27,919
Depreciation at 1 April 2024	196	2,968	0	0	3,138	339	945	0	7,586
Recognition	0	0	0	0	0	0	0	0	0
Transfers from/into other NHS bodies	0	(12)	0	0	0	0	0	0	(12)
Disposals other than by sale	(155)	(513)	0	0	(681)	(100)	(223)	0	(1,672)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
De-recognition	0	0	0	0	0	0	0	0	0
Provided during the year	91	1,442	0	0	1,724	293	346	0	3,896
At 31 March 2025	132	3,885	0	0	4,181	532	1,068	0	9,798
Net book value at 1 April 2024	617	9,212	0	0	5,920	521	1,100	0	17,370
Net book value at 31 March 2025	526	11,581	0	0	4,848	412	754	0	18,121
RoU Asset Total Value Split by Lessor									
	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
NHS Wales Peppercom Leases	0	0	0	0	0	0	0	0	0
NHS Wales Market Value Leases	0	0	0	0	0	0	0	0	0
Other Public Sector Peppercom Leases	516	277	0	0	0	0	0	0	793
Other Public Sector Market Value Leases	10	1,046	0	0	0	0	0	0	1,056
Private Sector Peppercom Leases	0	0	0	0	0	0	0	0	0
Private Sector Market Value Leases	0	10,258	0	0	4,848	412	754	0	16,272
Total	526	11,581	0	0	4,848	412	754	0	18,121

11.3 Right of Use Assets continued
Quantitative disclosures

	2025-26	2025-26	2025-26	2025-26	2024-25
Maturity analysis	Land	Buildings	Other	Total	Total
Contractual undiscounted cash flows relating to lease liabilities	£000	£000	£000	£000	£000
Less than 1 year	0	1,831	1,398	3,229	4,091
2-5 years	1	4,957	2,551	7,509	7,633
> 5 years	11	4,999	1,225	6,235	7,291
Less finance charges allocated to future periods	(2)	(1,390)	(387)	(1,779)	(1,878)
Total	10	10,397	4,787	15,194	17,137
Lease Liabilities (net of irrecoverable VAT)				2025-26	2024-25
Current				2,865	3,708
Non-Current				12,329	13,429
Total				15,194	17,137
Amounts Recognised in Statement of Comprehensive Net Expenditure				2025-26	2024-25
Depreciation				4,116	3,896
Impairment				0	0
Variable lease payments not included in lease liabilities - Interest expense				442	353
Sub-leasing income				(3)	(2)
Expense related to short-term leases				168	367
Expense related to low-value asset leases (excluding short-term leases)				980	973
Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)					
Interest expense				(442)	(353)
Repayments of principal on leases				(3,956)	(3,846)
Total				(4,398)	(4,199)

12. Intangible non-current assets

2025-26

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2025	3,118	0	5,086	0	0	1,041	9,245
Revaluation	0	0	0	0	0	0	0
Reclassifications	318	0	901	0	0	(1,219)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	159	0	(281)	0	0	178	56
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(45)	0	(1,390)	0	0	0	(1,435)
Gross cost at 31 March 2026	3,550	0	4,316	0	0	0	7,866
Amortisation at 1 April 2025	2,052	0	2,194	0	0	0	4,246
Revaluation	0	0	0	0	0	0	0
Reclassifications	(142)	0	142	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	540	0	1,420	0	0	0	1,960
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(45)	0	(1,390)	0	0	0	(1,435)
Amortisation at 31 March 2026	2,405	0	2,366	0	0	0	4,771
Net book value at 1 April 2025	1,066	0	2,892	0	0	1,041	4,999
Net book value at 31 March 2026	1,145	0	1,950	0	0	0	3,095
NBV at 31 March 2026							
Purchased	1,145	0	1,950	0	0	0	3,095
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2026	1,145	0	1,950	0	0	0	3,095

12. Intangible non-current assets 2024-25

	Software (purchased)	Software (internally generated)	Licences and trademarks	Patents	Development expenditure- internally generated	Assets under Construction	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2024	3,531	0	2,924	0	0	1,063	7,518
Revaluation	0	0	27	0	0	0	27
Reclassifications	21	0	158	0	0	(179)	0
Reversal of impairments	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Additions- purchased	15	0	2,064	0	0	157	2,236
Additions- internally generated	0	0	0	0	0	0	0
Additions- donated	0	0	0	0	0	0	0
Additions- government granted	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(449)	0	(87)	0	0	0	(536)
Gross cost at 31 March 2025	3,118	0	5,086	0	0	1,041	9,245
Amortisation at 1 April 2024	1,800	0	1,033	0	0	0	2,833
Revaluation	0	0	(15)	0	0	0	(15)
Reclassifications	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0
Provided during the year	701	0	1,263	0	0	0	1,964
Reclassified as held for sale	0	0	0	0	0	0	0
Transfer from/into other NHS bodies	0	0	0	0	0	0	0
Disposals	(449)	0	(87)	0	0	0	(536)
Amortisation at 31 March 2025	2,052	0	2,194	0	0	0	4,246
Net book value at 1 April 2024	1,731	0	1,891	0	0	1,063	4,685
Net book value at 31 March 2025	1,066	0	2,892	0	0	1,041	4,999
NBV at 31 March 2025							
Purchased	1,066	0	2,892	0	0	1,041	4,999
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Internally generated	0	0	0	0	0	0	0
Total at 31 March 2025	1,066	0	2,892	0	0	1,041	4,999

Additional Disclosures re Intangible Assets

Disclosures:

(i) Donated Assets

Aneurin Bevan University LHB has not received any donated intangible assets during the year.

(ii) Recognition

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

(iii) Asset Lives

The Useful Economic Lives (UEL) of intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL unless known to differ, with the UEL of any internally generated software being based on the professional judgement of Health Board professionals and finance staff.

(iv) Additions during the period

Intangible assets acquired during the period amounted to £0.056m; this primarily related to software renewals offset by the release of a VAT provision in relation to software licences purchased in 2024/25.

(v) Disposals during the period

Fully amortised software and licences with a GBV of £1.435m were disposed of as no longer in use, during the year.

vi) Transfers into other NHS Bodies

Aneurin Bevan University LHB has not received any intangible assets transferred from another NHS body.

13 . Impairments

	2025-26 Property, plant & equipment £000	2025-26 Right of Use Assets £000	2025-26 Intangible assets £000	2025-26 Held for sale assets £000	2025-26 Financial Assets £000	2025-26 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	0	0	0	0	0	0
Abandonment in the course of construction	382	0	0	0	0	382
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	30,943	0	0	0	0	30,943
Reversal of Impairments	(37,012)	0	0	0	0	(37,012)
Total of all impairments	(5,687)	0	0	0	0	(5,687)

Analysis of impairments charged to reserves in year :

Impairments charged to the Statement of Comprehensive Net Expenditure	(5,687)	0	0	0	0	(5,687)
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	(5,687)	0	0	0	0	(5,687)

	2024-25 Property, plant & equipment £000	2024-25 Right of Use Assets £000	2024-25 Intangible assets £000	2024-25 Held for sale assets £000	2024-25 Financial Assets £000	2024-25 Total Asset Impairment £000
Impairments arising from :						
Loss or damage from normal operations	236	0	0	0	0	236
Abandonment in the course of construction	0	0	0	0	0	0
Over specification of assets (Gold Plating)	0	0	0	0	0	0
Loss as a result of a catastrophe	0	0	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Changes in market price	0	0	0	0	0	0
Others (specify)	15,982	0	0	0	0	15,982
Reversal of Impairments	(14,401)	0	0	0	0	(14,401)
Total of all impairments	1,817	0	0	0	0	1,817

Analysis of impairments charged to reserves in year :

Impairments charged to the Statement of Comprehensive Net Expenditure	1,817	0	0	0	0	1,817
Impairments as a result of revaluation/indexation charged to Revaluation Reserve	0	0	0	0	0	0
Impairments as a result of a loss of economic value or service potential Charged to Revaluation Reserve	0	0	0	0	0	0
Right of Use (RoU) asset impairments reflected in RoU Liability	0	0	0	0	0	0
Total	1,817	0	0	0	0	1,817

2025-26	Impairment amount £000	Reason for impairment £000	Nature of Asset £000	Valuation basis £000	Charge to SoCNE £000	Charge to reserve £000
Nevill Hall Satellite Radiotherapy Unit	13,325	Assets Valued on Coming Into Use	Operational	Fair Value	13,325	0
ED Extension, GUH	8,685	Assets Valued on Coming Into Use	Operational	Fair Value	8,685	0
Decontamination Unit, RGH	2,788	Assets Valued on Coming Into Use	Operational	Fair Value	2,788	0
St Woolos Hospital	2,780	Building Closures	Operational	Fair Value	2,780	0
Targeted Estates Fund Non-Enhancing	1,009	Valuer Desktop Review of TEF complete schemes	Operational	Fair Value	1,009	0
2nd MRI Suite, GUH	975	Assets Valued on Coming Into Use	Operational	Fair Value	975	0
Pharmacy Robot, RGH	392	Assets Valued on Coming Into Use	Operational	Fair Value	392	0
Boiler Replacement Works, SCH	378	Assets Valued on Coming Into Use	Operational	Fair Value	378	0
REFIT Non-Enhancing Works, HB Wic	327	Valuer Desktop Review of REFIT complete schemes	Operational	Fair Value	327	0
D7E Ward Refurb, RGH	284	Assets Valued on Coming Into Use	Operational	Fair Value	284	0
NHH Cancer Centre AUC	382	Abandonment in the course of construction	Under Construction	Fair Value	382	0
Total Impairment	31,325				31,325	0
Reversal of Impairments						
Grange University Hospital	(19,067)		Operational	Indexation	(19,067)	0
Royal Gwent Hospital	(5,725)		Operational	Indexation	(5,725)	0
Ysbytty Aneurin Bevan	(3,712)		Operational	Indexation	(3,712)	0
Nevill Hall Hospital	(2,795)		Operational	Indexation	(2,795)	0
19 Hills HWBC	(1,794)	Indexation - reversal of	Operational	Indexation	(1,794)	0
St Cadocs Hospital	(1,270)	impairment in previous	Operational	Indexation	(1,270)	0
Bevan HWBC	(1,072)	years	Operational	Indexation	(1,072)	0
Ysbyty Ystrad Fawr	(671)		Operational	Indexation	(671)	0
Llanfrechfa Grange	(432)		Operational	Indexation	(432)	0
Various Community	(78)		Operational	Indexation	(78)	0
Indexation - Land	(396)		Operational	Indexation	(396)	0
Total Reversal of Impairments	(37,012)				(37,012)	0
Net credit to SoCNE	(5,687)				(5,687)	0

14.1 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	3,203	3,753
Consumables	6,332	6,430
Energy	259	250
Work in progress	0	0
Other	0	0
Total	9,794	10,433
Of which held at realisable value	0	0

14.2 Inventories recognised in expenses

	31 March 2026 £000	31 March 2025 £000
Inventories recognised as an expense in the period	0	0
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	0	0

The Health Board does not purchase any stock or assets with the intention to sell, and as such the above is a nil return.

15. Trade and other Receivables

Current	31 March 2026 £000	31 March 2025 £000
Welsh Government	2,654	2,406
NHSW JCC Joint Commissioning Committee	458	478
Welsh Health Boards	3,501	3,753
Welsh NHS Trusts	9,407	7,109
Welsh Special Health Authorities	913	1,037
Non - Welsh Trusts	0	0
Other NHS	577	1,426
2019-20 Scheme Pays - Welsh Government Reimbursement	690	686
Welsh Risk Pool Claim reimbursement		
NHS Wales Secondary Health Sector	128,261	125,057
NHS Wales Primary Sector FLS Reimbursement	1,785	883
NHS Wales Redress	268	422
Other	269	412
Local Authorities	4,426	5,617
Other receivables	12,149	10,929
Provision for irrecoverable debts	(2,448)	(2,015)
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	11,821	8,960
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	0	0
Intangibles capital receivables	0	0
Other capital prepayments	139	0
Sub total	174,870	167,160
Non-current		
Welsh Government	0	0
NHSW JCC Joint Commissioning Committee	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Non - Welsh Trusts	0	0
Other NHS	0	0
2019-20 Scheme Pays - Welsh Government Reimbursement	0	0
Welsh Risk Pool Claim reimbursement;		
NHS Wales Secondary Health Sector	140,418	104,507
NHS Wales Primary Sector FLS Reimbursement	405	10
NHS Wales Redress	0	0
Other	0	0
Local Authorities	0	0
Other receivables	1,575	1,366
Provision for irrecoverable debts	0	0
Pension Prepayments NHS Pensions	0	0
Pension Prepayments NEST	0	0
Other prepayments	0	0
Other accrued income	0	0
Right of Use capital receivables	0	0
Capital Receivables		
Tangibles capital receivables	0	0
Intangibles capital receivables	0	0
Other capital prepayments	0	0
Sub total	142,398	105,883
Total	317,268	273,043

The great majority of trade undertaken by the Health Board is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £3.420m (£3.286m in 2024-25).

15. Trade and other Receivables (continued)

Receivables past their due date but not impaired

	31 March 2026 £000	31 March 2025 £000
By up to three months	1,109	1,420
By three to six months	561	142
By more than six months	1,750	1,724
	<u>3,420</u>	<u>3,286</u>

Expected Credit Losses (ECL) / Provision for impairment of receivables

Balance at 1 April	(2,015)	(1,942)
Transfer to other NHS Wales body	0	0
Amount written off during the year	(68)	0
Amount recovered during the year	0	0
(Increase) / decrease in receivables impaired	(318)	(58)
Bad debts recovered during year	(47)	(15)
Balance at 31 March	<u>(2,448)</u>	<u>(2,015)</u>

In determining whether a debt should be impaired, consideration is given to the age of the debt, historic collectability rates and the results of actions already taken including referral to the Health Board's credit agencies.

Receivables VAT

Trade receivables	1,558	1,295
Other	120	137
Total	<u>1,678</u>	<u>1,432</u>

16. Other Financial Assets

	Current		Non-current	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Financial assets				
Shares and equity type investments				
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Deposits	0	0	0	0
Loans at amortised cost	0	0	0	0
Derivatives	0	0	0	0
Other (Specify)				
Held to maturity investments at amortised costs	0	0	0	0
At fair value through SOCNE	0	0	0	0
Available for sale at FV	0	0	0	0
Capital Financial Assets				
Loans at amortised cost	37	36	380	417
Right of Use Asset Finance Sublease	79	24	225	190
Total	116	60	605	607

RoU Sub-leasing income Recognised in Statement of Comprehensive Net Expenditure	2025-26	2024-25
RoU Sub-leasing income	(3)	(2)

17. Cash and cash equivalents

	2025-26	2024-25
	£000	£000
Balance at 1 April	4,823	4,145
Net change in cash and cash equivalent balances	728	678
Balance at 31 March	5,551	4,823
Made up of:		
Cash held at GBS	5,530	4,801
Commercial banks	0	0
Cash in hand	21	22
Cash and cash equivalents as in Statement of Financial Position	5,551	4,823
Bank overdraft - GBS	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in Statement of Cash Flows	5,551	4,823

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are;

Lease Liabilities (ROUA) -£1.943m
Lease Liabilities (short-term and low value leases) £0.731m
PFI liabilities: -£0.148m

The movement relates to cash, no comparative information is required by IAS 7 in 2025-26.

18. Trade and other payables

Current	31 March 2026 £000	31 March 2025 £000
Welsh Government	0	12
NHSW Joint Commissioning Committee	6,253	3,785
Welsh Health Boards	5,952	5,590
Welsh NHS Trusts	3,446	3,954
Welsh Special Health Authorities	28	61
Other NHS	7,092	7,336
Taxation and social security payable / refunds	19,585	17,338
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	0	0
Non-NHS payables - Revenue	67,697	59,008
Local Authorities	16,472	16,397
Overdraft	0	0
Rentals due under operating leases	0	0
Pensions: staff	13,243	11,571
Non NHS Accruals	74,918	77,652
Deferred Income:		
Deferred Income brought forward	0	0
Deferred Income Additions	18	0
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	0	0
Other creditors	0	0
Payments on account	(10,705)	(10,711)
Impact of IFRS 16 on SoFP PFI contracts	134	122
Right of Use asset payables	2,865	3,708
Capital asset payables		
Tangibles - Payables	10,187	8,766
Intangibles - Payables	33	112
Obligations under finance leases, HP contracts	0	0
Imputed finance lease element of on SoFP PFI contracts	129	125
PFI assets – deferred credits	0	0
Capital Payments on account	0	0
Sub Total	217,347	204,826
Non-current		
Welsh Government	0	0
NHSW Joint Commissioning Committee	0	0
Welsh Health Boards	0	0
Welsh NHS Trusts	0	0
Welsh Special Health Authorities	0	0
Other NHS	0	0
Taxation and social security payable / refunds	0	0
Refunds of taxation by HMRC	0	0
VAT payable to HMRC	0	0
Other taxes payable to HMRC	0	0
NI contributions payable to HMRC	0	0
Non-NHS payables - Revenue	0	0
Local Authorities	0	0
Overdraft	0	0
Rentals due under operating leases	0	0
Pensions: staff	0	0
Non NHS Accruals	0	0
Deferred Income :		
Deferred Income brought forward	0	0
Deferred Income Additions	0	0
Transfer to / from current/non current deferred income	0	0
Released to SoCNE	0	0
Other creditors	0	0
PFI assets –deferred credits	0	0
Payments on account	0	0
Impact of IFRS 16 on SoFP PFI contracts	1,386	1,421
Right of Use asset payables	12,329	13,429
Capital asset payables		
Capital Creditors - Tangibles	0	0
Capital Creditors - Intangibles	0	0
Obligations under finance leases, HP contracts	0	0
Imputed finance lease element of on SoFP PFI contracts	1,335	1,464
PFI assets – deferred credits	0	0
Capital Payments on account	0	0
Sub Total	15,050	16,314
Total	232,397	221,140

It is intended to pay all invoices within the 30 day period directed by the Welsh Government.

The LHB aims to pay all invoices within the 30 day period directed by the Welsh Government.

The Capital Payables - Tangibles figure includes balances that have been agreed with Welsh NHS Trusts, as part of the Agreement of Balances process, totalling £25k (2024-25, £52K).

18. Trade and other payables (continued).

Amounts falling due more than one year are expected to be settled as follows:	31 March	31 March
	2026	2025
	£000	£000
Between one and two years	2,091	2,601
Between two and five years	5,576	5,136
In five years or more	7,383	8,577
Sub-total	15,050	16,314

19. Other financial liabilities

Financial liabilities	Current		Non-current	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Financial Guarantees:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Derivatives at fair value through SoCNE	0	0	0	0
Other:				
At amortised cost	0	0	0	0
At fair value through SoCNE	0	0	0	0
Total	0	0	0	0

20. Provisions

	At 1 April 2025	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2026
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
Clinical negligence:-									
Secondary care	90,650	(28,931)	1,170	31,556	37,291	(26,555)	(13,942)	0	91,239
Primary care	746	0	(40)	0	892	(54)	(63)	0	1,481
Redress Secondary care	159	0	78	0	123	(198)	(91)	0	71
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	49	0	0	0	523	(287)	(12)	0	273
All other losses and special payments	915	0	0	0	5,271	(5,271)	0	0	915
Defence legal fees and other administration	1,445	0	0	426	1,842	(1,356)	(552)		1,805
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	400			261	205	(381)	(188)	85	382
2019-20 Scheme Pays - Reimbursement	33			0	24	(36)	0	0	21
Restructuring	0			0	0	0	0	0	0
Other	3,102		0	0	580	(3)	(319)	0	3,360
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,071		0	0	745	(778)	(293)	0	745
Total	98,570	(28,931)	1,208	32,243	47,496	(34,919)	(15,460)	85	100,292
Non Current									
Clinical negligence:-									
Secondary care	100,721	0	(1,620)	(31,556)	73,729	(233)	(4,774)	0	136,267
Primary care	0	0	0	0	370	0	0	0	370
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,169	0	0	0	128	(316)	0	93	3,074
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,754	0	0	(426)	1,121	(321)	(127)		2,001
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,479			(261)	0	0	0	0	2,218
2019-20 Scheme Pays - Reimbursement	652			0	16	0	0	0	668
Restructuring	0			0	0	0	0	0	0
Other	379		0	0	775	(112)	(173)	0	869
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	109,154	0	(1,620)	(32,243)	76,139	(982)	(5,074)	93	145,467
TOTAL									
Clinical negligence:-									
Secondary care	191,371	(28,931)	(450)	0	111,020	(26,788)	(18,716)	0	227,506
Primary care	746	0	(40)	0	1,262	(54)	(63)	0	1,851
Redress Secondary care	159	0	78	0	123	(198)	(91)	0	71
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,218	0	0	0	651	(603)	(12)	93	3,347
All other losses and special payments	915	0	0	0	5,271	(5,271)	0	0	915
Defence legal fees and other administration	3,199	0	0	0	2,963	(1,677)	(679)		3,806
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,879			0	205	(381)	(188)	85	2,600
2019-20 Scheme Pays - Reimbursement	685			0	40	(36)	0	0	689
Restructuring	0			0	0	0	0	0	0
Other	3,481		0	0	1,355	(115)	(492)	0	4,229
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,071		0	0	745	(778)	(293)	0	745
Total	207,724	(28,931)	(412)	0	123,635	(35,901)	(20,534)	178	245,759

Expected timing of cash flows:

	In year to 31 March 2027	Between 1 April 2027 31 March 2031	Thereafter	Total
				£000
Clinical negligence:-				
Secondary care	91,239	136,267	0	227,506
Primary care	1,481	370	0	1,851
Redress Secondary care	71	0	0	71
Redress Primary care	0	0	0	0
Personal injury	273	3,074	0	3,347
All other losses and special payments	915	0	0	915
Defence legal fees and other administration	1,805	2,001	0	3,806
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	382	2,218	0	2,600
2019-20 Scheme Pays - Reimbursement	21	668	0	689
Restructuring	0	0	0	0
Other	3,360	869	0	4,229
Capital provisions				
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	745	0	0	745
Total	100,292	145,467	0	245,759

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2026/27 it will receive £92,619k and in 2027/28 and beyond £137,742k from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £869k. The estimation method used to calculate the provision for 2025/26 is consistent with the methodology used in 2024/25. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions have also been made for Ancillary Staff Banked Annual Leave Payments, GP Annual Leave, Dental Contractors Overachievement, PACS Onerous Contract and Scheme Pays.

20. Provisions (continued)

	At 1 April 2024	Structured settlement cases transferred to Risk Pool	Transfer of provisions to creditors	Transfer between current and non-current	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2025
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
Clinical negligence:-									
Secondary care	64,140	(3,887)	1,586	34,629	28,319	(18,490)	(15,647)	0	90,650
Primary care	791	0	0	0	91	(94)	(42)	0	746
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	159
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	37	0	0	0	162	(136)	(14)	0	49
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	915
Defence legal fees and other administration	1,954	0	0	(419)	1,244	(939)	(395)		1,445
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	397			107	418	(405)	(189)	72	400
2019-20 Scheme Pays - Reimbursement	7			0	26	0	0	0	33
Restructuring	0			0	0	0	0	0	0
Other	2,511		0	0	1,699	0	(1,108)	0	3,102
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,727		0	0	524	(1,115)	(65)	0	1,071
Total	71,827	(3,887)	1,589	34,317	33,871	(21,613)	(17,606)	72	98,570
Non Current									
Clinical negligence:-									
Secondary care	142,027	0	0	(34,629)	20,546	(706)	(26,517)	0	100,721
Primary care	0	0	0	0	0	0	0	0	0
Redress Secondary care	0	0	0	0	0	0	0	0	0
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,027	0	0	0	466	(330)	(67)	73	3,169
All other losses and special payments	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	1,017	0	0	419	732	(247)	(167)		1,754
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,586			(107)	0	0	0	0	2,479
2019-20 Scheme Pays - Reimbursement	597			0	55	0	0	0	652
Restructuring	0			0	0	0	0	0	0
Other	393		0	0	249	(100)	(163)	0	379
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	0		0	0	0	0	0	0	0
Total	149,647	0	0	(34,317)	22,048	(1,383)	(26,914)	73	109,154
TOTAL									
Clinical negligence:-									
Secondary care	206,167	(3,887)	1,586	0	48,865	(19,196)	(42,164)	0	191,371
Primary care	791	0	0	0	91	(94)	(42)	0	746
Redress Secondary care	263	0	3	0	326	(287)	(146)	0	159
Redress Primary care	0	0	0	0	0	0	0	0	0
Personal injury	3,064	0	0	0	628	(466)	(81)	73	3,218
All other losses and special payments	0	0	0	0	1,062	(147)	0	0	915
Defence legal fees and other administration	2,971	0	0	0	1,976	(1,186)	(562)		3,199
Pensions relating to former directors	0			0	0	0	0	0	0
Pensions relating to other staff	2,983			0	418	(405)	(189)	72	2,879
2019-20 Scheme Pays - Reimbursement	604			0	81	0	0	0	685
Restructuring	0			0	0	0	0	0	0
Other	2,904		0	0	1,948	(100)	(1,271)	0	3,481
Capital provisions									
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0	0
Other Capital Provisions	1,727		0	0	524	(1,115)	(65)	0	1,071
Total	221,474	(3,887)	1,589	0	55,919	(22,996)	(44,520)	145	207,724

The expected timing of cash flows are based on best available information; but they could change on the basis of individual case changes. The claims outstanding with the Welsh Risk Pool are based on best estimates of settlement of claims provided by the Health Board's legal advisors. The Health Board estimates that in 2025/26 it will receive £91,146k and in 2026/27 and beyond £101,877k from the Welsh Risk Pool in respect of clinical negligence and personal injury payments.

Other provisions include: Continuing Healthcare Independent Review Panel (IRP) & Ombudsman claims £379K. The estimation method used to calculate the provision for 2024/25 is consistent with the methodology used in 2023/24. In the continuing absence of detailed assessment information the Health Board has used a mixture of actual assessments and the application of an expected success factor and average weekly costs to determine whether an individual claimant provision would be established.

Other provisions include an amount for Ancillary Staff Banked Annual Leave Payments, potential VAT payment to HMRC and Capital provision. The total Health Board provision also includes an amount of £164K which relates to 22 Redress cases where offers have been made to the families but not yet

Provision (Continued)

Pensions tax annual allowance – Scheme Pays arrangements 2019/20

In accordance with a Ministerial Direction issued on 18 December 2019, the Welsh Government have taken action to support circumstances where pensions tax rules are impacting upon clinical staff who want to work additional hours, and have determined that:

Clinical staff who are members of the NHS Pension Scheme and who, as a result of work undertaken in the 2019-20 tax year, face a tax charge on the growth of their NHS pension benefits, may opt to have this charge paid by the NHS Pension Scheme, with their pension reduced on retirement.

Welsh Government, on behalf of the Aneurin Bevan University Health Board, will pay the members who opt for reimbursement of their pension, a corresponding amount on retirement, ensuring that they are fully compensated for the effect of the deduction.

This scheme will be funded directly by the Welsh Government to the NHS Business Services Authority Pension Division, the administrators on behalf of the Welsh claimants.

Clinical staff had until 31 March 2022 to opt for this scheme and the ability to make changes up to 31 July 2026.

The Health Board have included a Scheme Pay provision of £689,932 (£685,920, 2024-25) as notified by Welsh Government within these accounts.

21. Contingencies

21.1 Contingent liabilities

	2025-26 £'000	2024-25 £'000
Provisions have not been made in these accounts for the following amounts :		
Legal claims for alleged medical or employer negligence:-		
Secondary care	294,957	305,930
Primary care	3,371	1,470
Redress Secondary care	0	63
Redress Primary care	0	0
Doubtful debts		0
Equal Pay costs	0	0
Defence costs	3,744	4,364
Continuing Health Care costs	1,368	1,388
Other	0	0
Total value of disputed claims	303,440	313,215
Less amounts recoverable in the event of claims being successful	(298,507)	(307,921)
Net contingent liability	4,933	5,294

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them. The value of legal claims has decreased by £9.8m from the value of legal claims in 2024-25, while the number of claims has also decreased from 252 in 2024-25 to 248 in 2025-26.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Continuing Healthcare Cost uncertainties

The Health Board continues to review claims for reimbursement of retrospective care payments (IRPs). As a consequence, there has been a movement in the level of provision and uncertainty including in these Accounts.

Note 20 sets out the £0.869m provision made for probable continuing care costs relating to 80 outstanding phase 9, 10 and 11 claims received by 31st March 2026. This compares with the 2024/25 provision of £0.379m and 69 outstanding phase 9 and 10 claims.

Note 21.1 also sets out the £1.368m contingent liability for possible additional continuing care costs relating to those claims if they are all settled and in full, a slight reduction to the £1.388m reported for 2024/25.

There are 13 new claims (4 - Phase 10, 9 - Phase 11), which have been received whereby the assessment process remains incomplete, as we are still awaiting full details to support the claims. The assessment process is highly complex and involves a multi-disciplinary teams and for those reasons can take many months. At this stage, the Health Board does not have enough information to make a judgement on the likely success or otherwise of these claims, however, they may result in additional costs to

21.2 Remote Contingent liabilities

	2025-26 £000	2024-25 £000
Guarantees	0	0
Indemnities	148	428
Letters of Comfort	0	0
Total	148	428

The 2025-26 remote contingent liabilities consist of 1 medical negligence case and 1 GP Indemnity case (3 medical negligence cases and 1 personal injury case in 2024-25). Should these cases progress the majority of the costs incurred, in excess of £25k per case attributable to the Health Board, will be recovered from the Welsh Risk Pool.

21.3 Contingent assets

	2025-26 £000	2024-25 £000
	0	0
Total	0	0

22. Capital commitments

Contracted capital commitments at 31 March

The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	2025-26 £000	2024-25 £000
Property, plant and equipment	12,498	12,365
Right of Use Assets	0	0
Intangible assets	0	14
Total	12,498	12,379

23. Losses and special payments

Losses and special payments are charged to the Statement of Comprehensive Net Expenditure in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore, the payments in this note for settlement and claimant costs are prepared on a cash basis.

Gross loss to the Exchequer

23.1 Number of cases and associated amounts paid out during the financial year

	Amounts paid out during period to 31 March 2026	
	Number of cases	£
Clinical negligence:-		
Secondary Care	109	26,787,957
Primary Care	4	53,848
Redress Secondary Care	16	197,628
Redress Primary Care	0	0
Personal injury	37	602,422
All other losses and special payments	53	5,271,499
Total	219	32,913,354

23.2 Analysis of number of cases and associated amounts paid out during the financial year

Case Type	In year cases in excess of £300,000		Cumulative amount
	L&R Case reference number	£	£
Cases in excess of £300,000:			
Medical Negligence	SSPLR141196	537,000	647,000
Medical Negligence	SSPLR132790	391,844	1,276,844
Medical Negligence	SSPLR144801	4,000,000	4,300,000
Medical Negligence	SSPLR144158	7,368,254	7,664,500
Medical Negligence	SSPLR120834	700,000	1,150,000
Medical Negligence	SSPLR142702	454,296	454,296
Medical Negligence	SSPLR145803	332,301	332,301
Medical Negligence	SSPLR149401	325,000	325,000
Medical Negligence	SSPLR144378	5,203,000	5,538,000
Medical Negligence	SSPLR136706	865,585	925,585
Medical Negligence	SSPLR147877	360,000	360,000
Sub-total	Number of cases 11	£ 20,537,280	£ 22,973,526
All other cases paid in year	208	12,376,074	23,360,488
Total cases paid in year	219	32,913,354	46,334,014

23.3 Analysis of number of cases and associated amounts where no payments were made in financial year

	Number of cases	£
Cumulative amount up to £300k	101	4,769,316
Cumulative amount greater than £300k	13	19,146,807
Total	114	23,916,123

24. Right of Use lease obligations**24.1 Obligations (as lessee)****Amounts payable under right of use asset leases:****2025-26**

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2026	2026	2026	2026
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	1,831	1,398	3,229
Between one and five years	1	4,957	2,551	7,509
After five years	11	4,999	1,225	6,235
Less finance charges allocated to future periods	(2)	(1,390)	(387)	(1,779)
Minimum lease payments	10	10,397	4,787	15,194
Included in:				
Current borrowings	0	1,566	1,299	2,865
Non-current borrowings	10	8,831	3,488	12,329
	10	10,397	4,787	15,194
Present value of minimum lease payments				
Within one year	0	1,566	1,299	2,865
Between one and five years	1	4,212	2,328	6,541
After five years	9	4,619	1,160	5,788
Present value of minimum lease payments	10	10,397	4,787	15,194
Included in:				
Current borrowings	0	1,566	1,299	2,865
Non-current borrowings	10	8,831	3,488	12,329
	10	10,397	4,787	15,194

2024-25

	LAND	BUILDINGS	OTHER	TOTAL
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Minimum lease payments				
Within one year	0	1,853	2,238	4,091
Between one and five years	1	5,078	2,554	7,633
After five years	11	6,147	1,133	7,291
Less finance charges allocated to future periods	(2)	(1,645)	(231)	(1,878)
Minimum lease payments	10	11,433	5,694	17,137
Included in:				
Current borrowings	0	1,567	2,141	3,708
Non-current borrowings	10	9,866	3,553	13,429
	10	11,433	5,694	17,137
Present value of minimum lease payments				
Within one year	0	1,567	2,141	3,708
Between one and five years	1	4,241	2,436	6,678
After five years	9	5,625	1,117	6,751
Present value of minimum lease payments	10	11,433	5,694	17,137
Included in:				
Current borrowings	0	1,567	2,141	3,708
Non-current borrowings	10	9,866	3,553	13,429
	10	11,433	5,694	17,137

24.2 Right of Use Assets receivables (as lessor)

The Health Board has two Right of Use Assets lease receivables, as a lessor, at the balance sheet date.

Amounts receivable under right of use assets :

	31 March 2026 £000	31 March 2025 £000
Gross Investment in leases		
Within one year	87	26
Between one and five years	166	106
After five years	65	92
Less finance charges allocated to future periods	(12)	(9)
Minimum lease payments	306	215
Included in:		
Current financial assets	81	25
Non-current financial assets	225	190
	306	215
Present value of minimum lease payments		
Within one year	81	25
Between one and five years	161	100
After five years	64	90
Less finance charges allocated to future periods	0	0
Present value of minimum lease payments	306	215
Included in:		
Current financial assets	81	25
Non-current financial assets	225	190
	306	215

25. Private Finance Initiative contracts

25.1 PFI schemes off-Statement of Financial Position

The LHB has one PFI Scheme that was previously classified as off-statement of financial position. The scheme related to the provision of replacement heating and lighting systems within Neville Hall hospital. The scheme commenced in 2000 for a period of 25 years. Since the introduction of IFRS 16 in 2022/23, the off-statement of Financial Position PFI has been recognised as a Right of use Asset.

Commitments under off-SoFP PFI contracts	Off-SoFP PFI contracts	Off-SoFP PFI contracts
	31 March 2026 £000	31 March 2025 £000
Total payments due within one year	0	0
Total payments due between 1 and 5 years	0	0
Total payments due thereafter	0	0
Total future payments in relation to PFI contracts	0	0
Total estimated capital value of off-SoFP PFI contracts	0	0

25.2 PFI schemes on-Statement of Financial Position

Capital value of scheme included in Fixed Assets Note 11	£000
Contract start date:	4,236
Contract end date:	Mar-04
	Mar-36

Monnow Vale Health and Social Care Facility - a new health and social care facility. This scheme commenced in 2006 with unitary charge payments being made for a period of 30 years from 2006. The obligation for the scheme is £2,984k. In 2025/26, the liability for the scheme was increased by £107k due to the IFRS16 requirement to reflect the impact of RPI increases within the scheme obligation.

Total obligations for on-Statement of Financial Position PFI contracts due:

2025-26	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2026 £000	31 March 2026 £000	31 March 2026 £000	31 March 2026 £000
Total payments due within one year	129	134	82	761
Total payments due between 1 and 5 years	553	573	253	3,042
Total payments due thereafter	782	813	128	3,803
Total future payments in relation to PFI contracts	1,464	1,520	463	7,606

2024-25	On SoFP PFI Capital element	On SoFP PFI IFRS 16 impact	On SoFP PFI Imputed interest	On SoFP PFI Service charges
	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000	31 March 2025 £000
Total payments due within one year	125	122	86	735
Total payments due between 1 and 5 years	538	521	274	2,938
Total payments due thereafter	926	900	174	4,407
Total future payments in relation to PFI contracts	1,589	1,543	534	8,080

	31/03/2026 £000
Total present value of obligations for on-SoFP PFI contracts	11,053

25.3 Charges to expenditure	2025-26	2024-25
	£000	£000
Service charges for On Statement of Financial Position PFI contracts (excl interest costs)	722	2,764
Total expense for Off Statement of Financial Position PFI contracts	0	0
The total charged in the year to expenditure in respect of PFI contracts	722	2,764

The LHB is committed to the following annual charges

PFI scheme expiry date:	£000	£000
Not later than one year	0	0
Later than one year, not later than five years	0	0
Later than five years	761	735
Total	761	735

The estimated annual payments in future years will vary from those which the Health Board is committed to make during the next year by the impact of movement in the Retail Prices Index.

25.4 Number of PFI contracts

	Number of on SoFP PFI contracts	Number of off SoFP PFI contracts
Number of PFI contracts	1	0
Number of PFI contracts which individually have a total commitment > £500m	0	0

The LHB has one on-going PFI contract as at 31/03/26. As detailed in note 25.2, two of the LHB's PFI contracts concluded durin

25.5 Public Private Partnerships

The Health Board did not have any Public Private Partnerships during the year

26. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. The Health Board is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The Health Board has limited powers to invest and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Health Board in undertaking its activities.

Currency risk

The Health Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the United Kingdom and Sterling based. The Health Board does not have any overseas operations. The Health Board therefore has low exposure to currency rate fluctuations.

Interest rate risk

Health Boards are not permitted to borrow and the Health Board therefore has low exposure to interest rate fluctuations.

Credit risk

As the majority of the Health Board's funding derives from funds voted by the Welsh Government the Health Board has low exposure to credit risk.

Liquidity risk

The Health Board is required to operate within cash limits set by the Welsh Government for the financial year and draws down funds from the Welsh Government as the requirement arises. The Health Board is not, therefore, exposed to significant liquidity risks.

27. Movements in working capital

	2025-26 £000	2024-25 £000
(Increase)/decrease in inventories	639	(589)
(Increase)/decrease in trade and other receivables - non-current	(36,513)	38,243
(Increase)/decrease in trade and other receivables - current	(7,766)	(30,588)
Increase/(decrease) in trade and other payables - non-current	(1,264)	426
Increase/(decrease) in trade and other payables - current	12,521	2,664
Total	(32,383)	10,156
Adjustment for accrual movements in fixed assets - creditors	(1,217)	(1,599)
Adjustment for accrual movements in fixed assets - debtors	103	(34)
Adjustment for accrual movements in right of use assets - creditors	1,943	(800)
Adjustment for accrual movements in right of use assets - debtors	90	(25)
Other adjustments	(290)	455
	(31,754)	8,153

Other Adjustments include:

- £778K - Arising Capital Provisions Not Included Elsewhere
- £452K - Utilised Capital Provisions Not Included Elsewhere
- £36k - Movement in Fixed Asset Debtors

28. Other cash flow adjustments

	2025-26 £000	2024-25 £000
Depreciation	49,920	46,127
Amortisation	1,960	1,964
(Gains)/Loss on Disposal	44	(41)
Impairments and reversals	(5,687)	1,817
Release of PFI deferred credits	0	0
NWSSP Covid assets issued debited to expenditure but non-cash	0	0
Covid assets received credited to revenue but non-cash	0	0
Donated assets received credited to revenue but non-cash	(203)	(78)
Government Grant assets received credited to revenue but non-cash	0	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non cash	0	0
Non-cash movements in right of use assets	(45)	25
Non-cash movements in provisions	73,484	9,246
Other movements	56,042	51,797
Total	175,515	110,857

Other movements of £56,042K (2024-25 £51,797K) is made up of notional funding received for:

- LHB notional 9.4% Staff Employer Pension Contribution: £56,007K
- the 2019-20 Pensions Annual Allowance Charge Compensation Scheme (PAACCS): £35K

which are both funded directly to the NHSBA Pensions Division by Welsh Government.

29. Events after the Reporting Period

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 24 June 2026; post the date the financial statements were certified by the Auditor General for Wales.

Subsequent to the reporting date, the Health Board received confirmation from the Welsh Government of changes to remuneration rates for NHS Wales public appointees, approved prior to 31 March 2026 and effective from 1 January 2026. The financial impact has been recognised in these financial statements.

30. Related Party Transactions

The Welsh Government is regarded as a related party of the Health Board. During the year the Health Board had a significant number of material revenue and capital transactions with either the Welsh Government or with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Parties	2025-26		As at 31st March 2026	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Welsh Government	7	7,434	0	2,654
Betsi Cadwaladr University Health Board	110	25	17	2
Cardiff & Vale University Health Board	46,700	3,639	3,654	1,167
Cwm Taf University Health Board	19,304	4,188	1,836	907
Hywel Dda University Health Board	549	425	8	32
Powys Teaching Health Board	231	16,015	0	1,189
Swansea Bay University Health Board	2,508	1,254	438	204
Public Health Wales NHS Trust	883	6,231	149	929
Velindre NHS Trust	121,499	14,684	3,036	8,312
Welsh Ambulance Services NHS Trust	691	387	287	166
NHS Wales Joint Commissioning Committee (WHSSC)	232,406	15,082	6,253	458
Digital Health and Care Wales (DHCW)	8,485	2,085	1	261
Health Education and Improvement Wales (HEIW)	142	19,022	27	651
	433,515	90,471	15,706	16,932

In addition the LHB has had significant number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions are with the following:-

Government Body	2025-26		As at 31st March 2026	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Blaenau Gwent County Borough Council	4,622	1,116	2,326	66
Caerphilly County Borough Council	19,096	14,673	5,063	3,461
Monmouthshire County Council	6,865	1,866	2,244	511
Newport City Council	10,440	2,335	3,106	173
Torfaen County Borough Council	10,734	1,447	3,269	154
	51,757	21,437	16,008	4,365

The LHB has also had significant material transactions with the following:

Aneurin Bevan Local Health Board Charitable Fund	2025-26		As at 31st March 2026	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
	16	1,596	16	209

A number of the LHB's Board members have interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2025-26		As at 31st March 2026	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Helen Cunningham	Blaenau Gwent County Borough Council	Elected Member	4,622	1,116	2,326	66
Penny Jones	Monmouthshire County Council	Councillor	6,865	1,866	2,244	511
	Welsh Government	Daughter is a Member of the Senedd	7	7,434	0	2,654
Peter Carr	Digital Health & Care Wales	Chair of National LIMS 2.0 Programme Board	8,485	2,085	1	261
	Torfaen County Borough Council	Elected Member, Deputy Leader and Executive Member for Children, Families and Education	10,734	1,447	3,269	154
Richard Clark	Torfaen Voluntary Alliance	Company Secretary and Trustee	361	0	1	0

31. Third Party assets

The LHB held £41,184 cash at bank and in hand at 31 March 2026 (31st March 2025, £33,690) which relates to monies held by the LHB on behalf of patients. Cash held in patient Investment Accounts amounted to £0 at 31st March 2026 (31st March 2025, £0). This has been excluded from the Cash and Cash equivalents figure reported in the accounts.

In addition the LHB had located on its premises a significant quantity of consignment stock. This stock remains the property of the supplier until it is used. The value of consignment stock at 31 March 2026 amounted to £3.7m (£3.5m as at 31st March 2025).

32. Pooled budgets

The Health Board has five pooled budgets. The specific accounting treatment of each pooled budget is covered within Accounting Policies note 1.22.

Monnow Vale Health and Social Care Unit

The Health Board has entered into a pooled budget with Monmouthshire County Council. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 to provide health and social care inpatient, outpatient, clinic and day care facilities to individuals who have medical, social, community or rehabilitation needs and a memorandum note to the accounts provides details of the joint income and expenditure. The asset value of property, plant & equipment is £5,883K which is split 72% Aneurin Bevan Health Board and 28% Monmouthshire County Council. The costs incurred under the pooled budget is declared in the memorandum trading account.

	Cash	Own Contribution	Grants	2025/26 £000	2024/25 £000
Pooled Budget contributions					
Aneurin Bevan University Health Board	-	3,127	-	3,127	2,965
Monmouthshire County Council	454	981	-	1,435	1,382
Total Pooled Budget contributions for the year	454	4,108	-	4,562	4,347
Expenditure					
Aneurin Bevan Health Board	-	3,401		3,401	3,271
Monmouthshire County Council	644	898		1,542	1,501
Total Expenditure for the year	644	4,299	0	4,943	4,772
Net Surplus/(Deficit) on the Pooled Budget for the Year	(190)	(191)	0	(381)	(425)

Gwent Wide Integrated Community Equipment Service

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen County Borough Councils, for the provision of an effective integrated GWICES (Gwent Wide Integrated Community Equipment Service) to service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the joint equipment store in the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is £1,323K for 2025/26 (£1,289K in 2024/25).

	2025/26 £000	2024/25 £000
Pooled Budget contributions		
Blaenau Gwent County Borough Council	424	379
Caerphilly County Borough Council	730	635
Monmouthshire County Borough Council	581	518
Newport City Council	619	537
Torfaen County Borough Council	1072	989
Aneurin Bevan University Health Board	1323	1,264
CRT	224	161
Contribution to Lead Commissioner - LAs	151	123
Contribution to Lead Commissioner - UHB	30	25
Reserve	8	155
Total Pooled Budget contributions for the year	5,161	4,787
Expenditure		
Staff Costs	181	149
Non Staff Expenditure	4980	4,638
Total Expenditure for the year	5,161	4,787
Net Surplus/(Deficit) on the Pooled Budget for the Year	0	0

Mardy Park Rehabilitation Centre

The Health Board has entered into a pooled budget arrangement with Monmouthshire County Council. Under the arrangement funds are pooled under Section 33 of the NHS (Wales) Act 2006 to provide care to individuals who have rehabilitation needs. The pool is hosted by Monmouthshire County Council and the LHBs contribution is £283K for 2025/26 (£278K in 2024/25).

	2025/26 £000	2024/25 £000
Pooled Budget contributions		
Monmouthshire County Borough Council	375	368
Aneurin Bevan University Health Board	283	278
Total Pooled Budget contributions for the year	658	646
Expenditure		
Staff Costs	453	421
Premises	112	92
Transport	-	6
Supplies & Services	26	32
Other Expenditure	35	45
Total Expenditure for the year	626	596
Net Surplus/(Deficit) on the Pooled Budget for the Year	32	50

32. Pooled budgets (continued)

Gwent Frailty Programme

The Health Board has entered into a pooled budget with 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision of a Gwent wide integrated health and social care Frailty service, for service users who are resident in the partners' localities. Under the arrangement funds are pooled under section 33 of the NHS (Wales) Act 2006 for the purpose of establishing a consistent service for the Gwent area. The Health Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. The LHB's contribution is **£10,677K** for 2025/26 (£10,320K in 2024/25).

	2025/26 £000	2024/25 £000
Pooled Budget contributions		
Blaenau Gwent County Borough Council	756	689
Caerphilly County Borough Council	2,372	2,349
Monmouthshire County Borough Council	1,794	1,628
Newport City Council	2,080	2,148
Torfaen County Borough Council	881	833
Aneurin Bevan University Health Board	10,677	10,320
Total Pooled Budget contributions for the year	18,560	17,967

Expenditure

Reimbursements to Local Authorities from Pooled Fund:

Blaenau Gwent County Borough Council	180	159
Caerphilly County Borough Council	1,886	1,940
Monmouthshire County Borough Council	1,492	1,442
Newport City Council	2,091	2,131
Torfaen County Borough Council	759	680

Reimbursements to ABUHB from Pooled Fund 11,414 11,006

Central Costs	812	777
Total Expenditure for the year	18,634	18,135

Net Surplus/(Deficit) on the Pooled Budget for the Year (74) (168)

Continuing Healthcare - Older People in Care Homes

The Health Board has entered into a pooled budget with the 5 Local Authorities in the Gwent area, namely Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen County Councils, for the provision and commissioning of certain specialised services for older people (>65 years of age) in a care home setting in Gwent. Statutory Directions issued under section 169 of the Social Services and Wellbeing (Wales) Act 2014 required Partnership Bodies to enter into partnership arrangements and for the establishment and maintenance of pooled funds from April 2018, for the exercise of their Care Home Accommodation Functions.

The pool was established in August 2018 and is hosted by Torfaen County Borough Council. Under the arrangement, the Health Board makes a financial contribution equivalent to related expenditure in commissioning related placements in homes during the year. The LHB's contribution is **£46,803K** for 2025/26 (£43,955K in 2024/25).

	2025/26 £000	2024/25 £000
Pooled Budget contributions		
Blaenau Gwent County Borough Council	12,573	11,303
Caerphilly County Borough Council	37,498	34,641
Monmouthshire County Borough Council	17,677	15,255
Newport City Council	31,264	29,117
Torfaen County Borough Council	16,754	15,983
Aneurin Bevan University Health Board	46,803	43,955
Total Pooled Budget contributions for the year	162,569	150,254

Expenditure

Gwent Local Authority Residential Homes	21,382	20,193
Other Elderly Frail Residential Care	15,484	14,817
Other EMI Residential Care	32,874	29,968
Elderly Frail Funded Nursing Care	35,003	32,863
EMI Funded Nursing Care	24,732	21,264
Elderly frail Continuing Health Care	9,778	8,908
EMI Continuing Health Care	23,016	21,942
Step Up/ Step Down	238	237
Lead Commissioner Costs	62	62
Total Expenditure for the year	162,569	150,254

Net Surplus/(Deficit) on the Pooled Budget for the Year 0 0

33. Operating segments

Accounting standard IFRS 8 defines an operating segment as a component of an entity:

IFRS 8 requires bodies to report information about each of its operating segments.

Whilst the organisation is structured into divisions, the performance management and the allocation of resources flow from the Board of Aneurin Bevan University Health Board.

There are no hosted services within the health board. Divisions do not manage capital programmes, have any autonomy in relation to balance sheets or produce discrete accounts.

For the purposes of IFRS 8 it is therefore deemed that there is no requirement to report any operating segments

34. Other Information

34.1. 9.4% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1st April 2025 to 31st March 2026. This has been calculated from actual Welsh Government expenditure for the 9.4% staff employer pension contributions between April 2025 and February 2026 alongside Health Board data for March 2026.

Transactions include notional expenditure in relation to the 9.4% paid to NHSBSA by Welsh Government and notional funding to cover that expenditure as follows:

	2025-26 £000	2024-25 £000
Statement of Comprehensive Net Expenditure for the year ended 31 March 2026		
Expenditure on Primary Healthcare Services	1,220	780
Expenditure on healthcare from other providers	0	0
Expenditure on Hospital and Community Health Services	54,787	51,004
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026		
Net operating cost for the year	56,007	51,784
Notional Welsh Government Funding	56,007	51,784
Statement of Cash Flows for year ended 31 March 2026		
Net operating cost for the financial year	56,007	51,784
Other cash flow adjustments	56,007	51,784
2.1 Revenue Resource Performance		
Revenue Resource Allocation	56,007	51,784
3. Analysis of gross operating costs		
3.1 Expenditure on Primary Healthcare Services		
General Medical Services	1,111	684
Pharmaceutical Services	0	0
General Dental Services	99	85
Other Primary Health Care expenditure	10	11
3.2 Expenditure on healthcare from other providers		
	0	0
	0	0
3.3 Expenditure on Hospital and Community Health Services		
Directors' costs	190	166
Staff costs	52,444	50,838
Single Lead Employer staff trainee costs	2,153	0
9.1 Employee costs		
Permanent Staff		
Employer contributions to NHS Pension Scheme	56,007	51,784
Charged to capital	0	0
Charged to revenue	56,007	51,784
18. Trade and other payables		
Current		
Pensions: staff	0	0
28. Other cash flow adjustments		
Other movements	56,007	51,784

The Department of Health and Social Care (DHSC) 2023-24 consultation on the NHS Pension Scheme confirmed that the transitional approach that has operated since 2019-20 for employer contributions will continue in 2024-25. From 1 April 2024 an employer rate of 23.7% (23.78% inclusive of the administration charge) will apply. However, the NHS Business Services Authority will continue to only collect 14.38% from NHS Wales employers under their normal monthly payment process to the NHS Pension Scheme. This has resulted in an increase in the central payments made by Welsh Government from 6.3% to 9.4%.

Other

34.2 IFRS 17 - Insurance Contract Disclosures

The outcome of the contract review for a range of income contract types applicable to the organisation, did not identify any insurance contracts that fall within the scope of IFRS 17.

STATEMENT OF FINANCIAL POSITION

(Signage as per provision note disclosure)	£000
Liability for incurred claims @ 1 April 2025	0
Liability for remaining payments @ 31 March 2026	0
	0
Arising during year	0
Utilised	0
Reversed unused	0
Movement in Discount Rates	0
	0

STATEMENT OF COMPREHENSIVE NET EXPENDITURE

(Signage as per income and expenditure note disclosure)	£000
Insurance Income	0
Insurance expenditure	0

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

LOCAL HEALTH BOARDS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2011 and subsequent financial years in respect of the Local Health Boards (LHB)¹, in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the LHB shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year in which the accounts are being prepared, and has been applied by the Welsh Government and detailed in the NHS Wales LHB Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the LHB for the year ended 31 March 2011 and subsequent years shall comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied by the Welsh Assembly Government, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2011 and subsequent years, the account of the LHB shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive of the LHB.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst

Dated :

¹ Please see regulation 3 of the 2009 No.1559 (W.154); NATIONAL HEALTH SERVICE, WALES; The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009.

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

24 June 2026

Representations regarding the 2025/26 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Health Board for the year ended 31 March 2026 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
 - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
 - make judgements and estimates on a reasonable basis;
 - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and

Bwrdd Iechyd Prifysgol Aneurin Bevan

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- prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Health Board will continue in operation.
- ensuring the regularity of any expenditure and other transactions incurred.
- the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by Aneurin Bevan University Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 24 June 2026.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Nicola Prygodzicz
Chief Executive
24 June 2026

Signed by:
Andrew Morgan OBE
Chair of the Health Board
24 June 2026

Head of Internal Audit Opinion & Annual Report 2025/26

Aneurin Bevan University Health Board



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Report status:	Final
Draft report issued:	April 2026
Final report issued:	June 2026
Author:	Stephen Chaney
Audit, Risk and Assurance Committee:	June 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, Digital Health and Care Wales 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 • Discharge Planning
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 • Cancer Referral Rates • Satellite Radiotherapy – NHH (Draft Report) • Falls Management (Draft Report) • Benefits Realisation (excluding digital) (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 Agreed Actions • Public Health • Estates Assurance - Space Utilisation

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 5.8) 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 findings 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 agreed management actions 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, three were allocated Substantial Assurance, fifteen 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 Agreed Actions**– For this advisory review, we considered whether a sample of 2024/25 agreed management actions were implemented in a timely manner, with supporting evidence. We also assessed the accuracy of the Audit 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 provided **reasonable assurance** that the governance and strategic oversight of risk and assurance were 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** - The audit of discharge planning concluded **substantial assurance** over the reporting of key discharge metrics and information. Overall arrangements for recording, monitoring and reporting discharge data were well established and effective.

Financial Governance and Management

We have undertaken one review 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.

The audit provided **reasonable assurance** on the arrangements in place.

Quality & Safety

We have undertaken three reviews in this area.

- **Falls Management (draft report)** – The audit of inpatient falls management concluded **reasonable assurance**, confirming that a sound policy framework and

monitoring arrangements were in place, but with several areas requiring improvement. These included policy documentation updates, the delivery of falls training, documentation completeness and incident reporting (including discrepancies between Datix and weekly data), and weaknesses in the timeliness and completeness of investigations.

- **Safeguarding** – The **reasonable assurance** 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** – The audit of cancer referral rates concluded **reasonable assurance**, finding that overall arrangements for managing suspected cancer referrals broadly aligned with national guidance and expectations, with GP referral conversion rates (7.8%) consistent with the all-Wales average. However, the report highlights areas for improvement, including the absence of formal Health Board procedures incorporating referral guidance, limited training for administrative staff, and a lack of consistent recording and analysis of referrals rejected during screening.

Information Governance & Security

We have undertaken two 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.

- **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 (**reasonable assurance**) 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) (draft report)** – The audit concluded **reasonable assurance** over benefits realisation arrangements for non-digital programmes at the Health Board, finding that governance and processes generally operate effectively—particularly in larger, formal programmes where benefits are clearly defined and aligned to strategic objectives. However, there is no consistent corporate-wide framework, leading to variation in how benefits are identified, monitored, and reported, and limiting the ability to obtain a comprehensive, organisation-wide view of realised benefits.
- **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** – This 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 three reviews in this area.

- **Overseas Recruitment** – The audit of overseas recruitment concluded **reasonable assurance**, but we identified data quality and record-keeping weaknesses. Key issues included inconsistencies between ESR and the visa tracker (a variance of 319 staff),

inaccurate or incomplete visa records, and errors such as duplicate entries and outdated information, largely due to insufficient reconciliation processes.

- **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 were strengthened during delivery, with the Project Board established later than ideal but is 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.
- **Radiotherapy Satellite Centre – NHH (draft report)** - The audit focused on the delivery and management arrangements established jointly by the Health Board and Velindre University NHS Trust to progress the development of the Regional Radiotherapy Satellite Centre at Nevill Hall Hospital. The facility is now open and fully operational, with patients benefiting from the scanning and treatments that are available. Overall, the project has been successfully delivered i.e. within the agreed budget allocation, albeit with a six-month delay from the original completion date. There were findings raised over the lack of a signed service level agreement, unresolved defects / actions to be completed and discrepancies in the recording of financial costs. Therefore, we provided **reasonable assurance**.
- **Estates Assurance – Space Utilisation** – This advisory review aimed to evaluate how effectively the Health Board manages and controls space utilisation, with the goal of supporting efficiency, cost reduction, and improved patient care. Space utilisation surveys completed to date within the Health Board indicate an average utilisation of approximately 25% within admin and clerical office space as reviewed. If reflective of the wider estate, this suggests significant potential for improved efficiency and cost savings through better use and rationalisation of existing space. We highlighted the need for a strategic utilisation framework, improved governance, and enhanced data-driven decision-making, especially as the Health Board invests in monitoring technology and refreshes its Estates Strategy.

2.5 Approach to Previously Agreed Management Actions

As part of our Follow-up of Previously Agreed Management Actions 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 tracker.

In addition, Audit Committees monitor the progress in implementing management actions (this is wider than just Internal Audit findings) through their own 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 agreed actions, 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 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 audit findings 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, Risk and Assurance 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;
- Digital Health and Care Wales; 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.
Primary Care Services Ophthalmic	Substantial	To provide assurance that Primary Care Services is maintaining a robust system to facilitate timely and accurate payments to Ophthalmic contractors.
Payroll	Substantial	To evaluate the design and operation of the systems and controls in place within payroll services.
Single Lead Employer	Reasonable	The purpose of this review is to assess compliance with a range of policies and procedures within the service.
Procurement	Reasonable	To review the adequacy and effectiveness of the control arrangements governing Single Tender Actions (STAs) and Declarations of Interest (DOIs).

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 2026/27 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	100%	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	100%	95%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to discussion & draft report [20 working days]	R	50%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	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 24 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

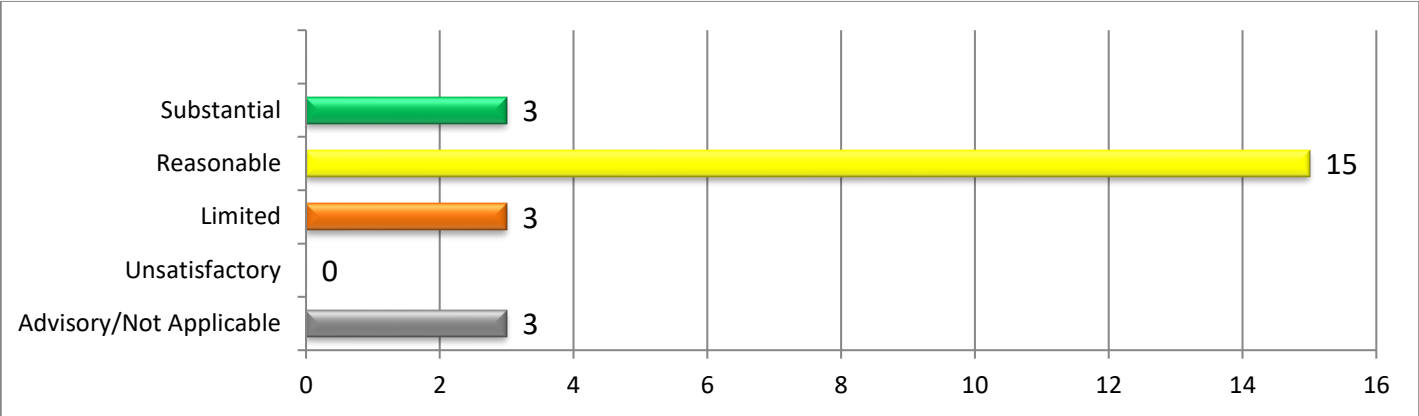


Figure 1 above does not include the audit ratings for the reviews undertaken at NWSSP, DHCW or the NHS Wales Joint Commissioning Committee.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were three audits that did not proceed following preliminary planning and agreement with management. These audits are documented in section 5.8.

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	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.

Review Title	Objective
Discharge Planning	To assess the accuracy, completeness, and reliability of data recorded and reported within the discharge process and ensuring that information is incorporated into an established performance reporting framework.

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.

Review Title	Objective
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.
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 examined the delivery of the project against the key project parameters inc. time, cost and quality. This will be the only audit of the project.
Overseas Recruitment	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.
Cancer Referral Rates	To determine if the referral and application processes within the Health Board are consistent with the rest of NHS Wales.

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.

Review Title	Objective
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
Follow-up of Agreed Actions	To assess whether high priority agreed management actions have been implemented.
Public Health	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.
Estates Assurance - Space Utilisation	To assess the systems and controls in place within the UHB to measure the efficiency and effectiveness

Review Title	Objective
	of space utilisation across the UHB's facilities ensuring the optimal use of available space and identifying opportunities for improvement.

5.7 Draft Audit Reports

The following audits have been substantially completed, with the draft reasonable assurance 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
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.
Satellite Radiotherapy - NHH	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.

5.8 Audits not undertaken

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.

Review Title	Rationale
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.

In addition, at the time of this annual report there were three reviews that were ‘work in progress’, which are detailed below.

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.
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.
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.

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

Mehefin 2026/ June 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 agreed management actions 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](#)



Audit of Accounts Report – Aneurin Bevan UHB

Audit year: 2025-26

Date issued: June 2026

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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 Audit of Accounts Report. The Report summarises the main findings from my audit of your 2025-26 annual report and accounts. My team have already discussed these findings with finance officers.

My team have substantially completed the audit work as set out in my Audit Plan dated March 2026.

The audit is substantially complete, subject to resolving some outstanding queries on testing and receipt of central assurances requested from NWSSP auditors.

Since my Audit Plan, I have updated materiality to reflect the 2025-26 accounts. I

have not identified any new audit risks. My response to previously identified risks is set out in **Appendix 1**.

I am required to provide an opinion on whether the accounts have been properly prepared, give a true and fair view, in all material aspects and whether income and expenditure have been applied to the purposes intended. My proposed audit opinion and basis for it is outlined on page 18.

It is the responsibility of the those charged with governance, ie the Board, to address any matters raised in my report and provide me with a Letter of Representation.

I would like to extend my gratitude to the officers and staff of the Finance and Governance teams for their cooperation throughout the audit process which has been invaluable in completing this audit effectively.

Your audit at a glance



We intend to issue an **unqualified true and fair opinion** and a **qualified regularity opinion** on the accounts.
We are also proposing to issue a **substantive report**.

See [Appendix 4](#)



There are no **other significant matters** to report.

See [Audit findings](#)



There are no **uncorrected misstatements** in the accounts.

See [Audit findings](#)



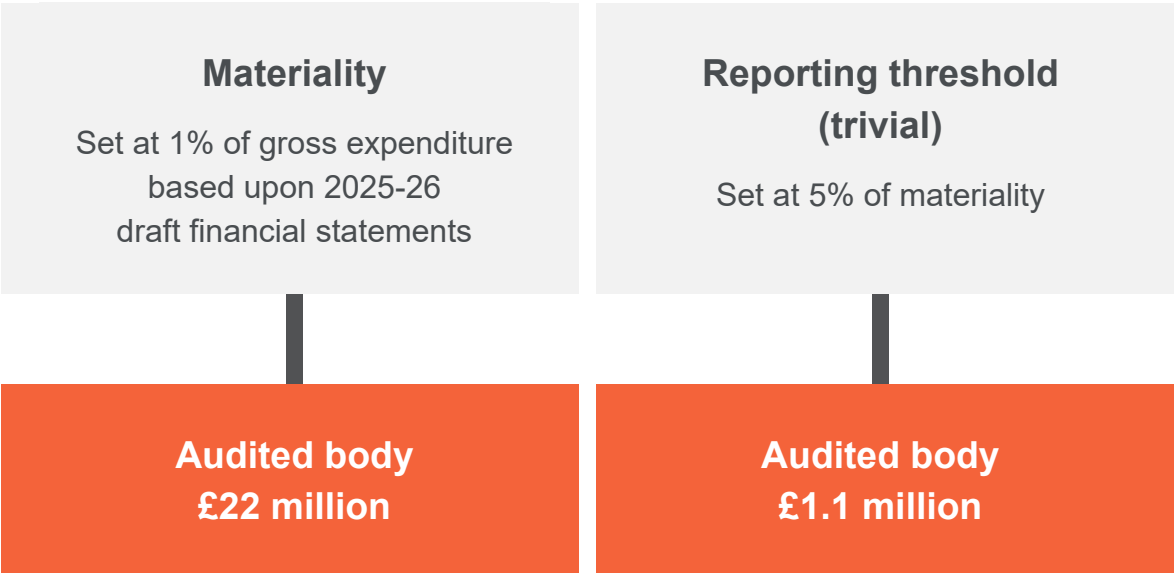
The recommendations arising from our work will be set out in an Accounts Addendum which will be communicated with officers in due course.



We are aiming to certify your accounts on 26 June 2026, ahead of the deadline of 30 June 2026.

Materiality

I use professional judgement to set a materiality threshold to identify and correct misstatements that could affect users’ decisions, considering both financial errors and disclosure requirements according to the applicable accounting framework and laws. My team updates materiality throughout the audit and I include in this report matters that exceed my reporting threshold, as set out below:



There are some areas of the accounts that may be of more importance to the user of the accounts. We confirm lower materiality levels for these:



Audit Findings

Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Uncorrected misstatements

There were no uncorrected misstatements identified in the accounts.

Corrected misstatements

During our audit, we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention.

These are set out in **Appendix 2**.

Other significant issues

International Standard on Auditing 260 requires us to communicate with those charged with governance. We must tell you significant findings from the audit and other matters if they are significant to your oversight of the Health Board's financial reporting process.

There were no such issues identified during the audit.

Proposed audit opinion

Audit opinion

We intend to issue an unqualified true and fair opinion and a qualified regularity opinion following the failure of the Health Board to meet its financial duty to break even against its revenue resource limit over the three years 2023-24 to 2025-26.

We are also proposing to issue a substantive report which explains why our audit opinion in respect of the regularity of expenditure is qualified. This report will also refer to the fact that the Health Board did not meet its financial duty to have an approved three-year integrated medium-term plan for the period 2025-28. The regularity opinion is not qualified for this.

Our proposed audit report is set out in **Appendix 3**.

Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is required by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 4** the contents of which are in line with our standard request for representations.

Audit team and ethical compliance

The main members of my team who carried out the audit work, together with their contact details, are summarised in **Exhibit 1**.

Exhibit 1: My local audit team

Engagement Lead	Richard Harries richard.harries@audit.wales
Audit Manager	Julie Rees julie.rees@audit.wales
Audit Lead	Dafydd Parker dafydd.parker@audit.wales

Compliance with ethical standards

We confirm that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

Appendix 1 – Audit risks and outcomes

My Audit Plan set out the risks of material misstatement and irregularity for the audit of the Health Board’s accounts. **Exhibit 2** lists these audit risks and sets out how they were addressed as part of the audit. No additional audit risks have been identified since that need to be brought to your attention.

Exhibit 2: Audit risks reported previously, work done and outcome

Audit risk	Work done	Outcome
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].	The audit team: • tested the appropriateness of journal entries and other adjustments made in preparing the financial statements; • reviewed accounting estimates for bias; and • evaluated the rationale for any significant transactions outside the normal course of business.	My audit work did not identify any instances of management override of controls.

Audit risk	Work done	Outcome
Failure of first financial duty The Health Board’s first financial duty is to break even over a three-year period. 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.	• 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.	My testing did not identify any material misstatement in the accounts as a whole. However, I do intend to issue a qualified regularity opinion following the failure of the Health Board to meet its first financial duty to break even over the three-year period 2023-24 to 2025-26. I am also proposing to issue a substantive report which explains why our audit opinion in respect of the regularity of expenditure is qualified. This report will also refer to the fact that the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan for the period 2024-2027. The regularity opinion is not qualified for this.

Audit risk	Work done	Outcome
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.	• 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.	My testing identified some disclosure errors – see Appendix 2.

Audit risk	Work done	Outcome
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.	• 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.	My testing did not identify any material errors in the valuation of property assets.

Audit risk	Work done	Outcome
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.	• 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.	My testing identified some disclosure errors – see Appendix 2

Audit risk	Work done	Outcome
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.	• 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.	My testing did not identify any material errors in the accounting for provisions and contingent liabilities.

Appendix 2 – Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention.

Value of correction	Accounts area	Explanation
Narrative	Remuneration and Staff Report – salary and pension disclosures	The gross salary of those individuals in receipt of Salary Sacrifice schemes was added to comply with the manual for accounts.
Narrative	Remuneration and Staff Report – salary and pension disclosures	A footnote was added to refer to the Medical Director’s secondment to the Welsh Government.
Narrative	Note 29 Events after the reporting period	The Health Board received notification from Welsh Government of changes to the remuneration rates for public appointees, approved prior to the year end, effective from 1 January 2026. The financial impact of the has been recognised in the financial statements and Welsh Government have advised that this is also reported as a post balance sheet event.
Amounts due £1.2k Expenditure £360k	Note 30 Related party transactions	Our testing identified one Board members’ related party disclosure had

		not been included in the note to the accounts.
£385k	Note 30 Related party transactions	Corrections required to the related party transactions recorded with nine health and local governments to ensure figures correspond to the balances agreed as part of the agreement of balances process.

Appendix 3 – Proposed audit report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of Aneurin Bevan University Local Health Board for the year ended 31 March 2026 under Section 61 of the Public Audit (Wales) Act 2004.

These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Cash Flow Statement and Statement of Changes in Taxpayers' Equity and related notes, including a summary of material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of affairs of Aneurin Bevan University Local Health Board as at 31 March 2026 and of its net operating costs for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual; and
- have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

Opinion on regularity

In my opinion, except for the matters described in the Basis for Qualified Regularity Opinion section of my report, in all material respects, the expenditure and income in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions

recorded in the financial statements conform to the authorities which govern them.

Basis for Qualified Opinion on regularity

I have qualified my opinion on the regularity of the Aneurin Bevan University Local Health Board's financial statements because the Health Board has breached its resource limit by spending £75.233 million over the amount that it was authorised to spend in the three-year period 2023-2024 to 2025-2026. This spend constitutes irregular expenditure.

Further detail is set out in my Report on page xx

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of financial statements and regularity of public sector bodies in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the Board in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Aneurin Bevan University Local Health Board is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The Chief Executive is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the remuneration report to be audited has been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Ministers' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

In the light of the knowledge and understanding of the Board and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and the other unaudited parts of the Accountability Report, or the Governance Statement.

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:

- I have not received all the information and explanations I require for my audit;
- adequate accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Accountability Report are not in agreement with the accounting records and returns;
- information specified by HM Treasury or Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of Directors and the Chief Executive for the financial statements

As explained more fully in the Statements of Directors' and Chief Executive's Responsibilities, the Directors and the Chief Executive are responsible for:

- maintaining adequate accounting records
- the preparation of financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the annual report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Directors and Chief Executive determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; and

- assessing the Board's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors and Chief Executive anticipate that the services provided by the Board will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service (Wales) Act 2006.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the audited entity's head of internal audit, and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board's policies and procedures concerned with:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of

this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals;

- Obtaining an understanding of Aneurin Bevan University Local Health Board's framework of authority as well as other legal and regulatory frameworks that the Board operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Board;
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business;

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

Please see my **Report on pages x to y.**

Adrian Crompton
Auditor General for Wales
26 June 2026

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Report of the Auditor General to the Senedd

Introduction

Under the Public Audit Wales Act 2004, I am responsible for auditing, certifying and reporting on Aneurin Bevan University Local Health Board (the Health Board's) financial statements. I am reporting on these financial statements for the year ended 31 March 2026 to draw attention to two key matters for my audit. These are the failure against the first financial duty and consequential qualification of my 'regularity' opinion and the failure of the second financial duty. I have not qualified my 'true and fair' opinion in respect of any of these matters.

Financial duties

Health Boards are required to meet two statutory financial duties – known as the first and second financial duties.

For 2025-26, the Health Board failed to meet both the first and the second financial duty.

Failure of the first financial duty

The **first financial duty** gives additional flexibility to Health Boards by allowing them to balance their income with their expenditure over a three-year rolling period. The three-year period being measured under this duty this year is 2023-24 to 2025-26.

As shown in Note 2.1 to the Financial Statements, the Health Board did not manage its revenue expenditure within its resource allocation over this three-year period, exceeding its cumulative revenue resource limit of £5,703.840 million by £75.233 million.

Where a Health Board does not balance its books over a rolling three-year period, any expenditure over the resource allocation (ie spending limit) for those three years exceeds the Health Board's authority to spend and is therefore 'irregular'. In such circumstances, I am required to qualify my 'regularity opinion' irrespective of the value of the excess spend.

Failure of the second financial duty

The **second financial duty** requires Health Boards to prepare and have approved by the Welsh Ministers a rolling three-year integrated medium-term plan. This duty is an essential foundation to the delivery of

sustainable quality health services. A Health Board will be deemed to have met this duty for 2024-25 if it submitted a 2025-2028 plan approved by its Board to the Welsh Ministers, who were required to review and consider approval of the plan.

As shown in Note 2.3 to the Financial Statements, the Health Board did not meet its second financial duty to have an approved three-year integrated medium-term plan in place for the period 2025-2028.

Adrian Crompton

Auditor General for Wales

26 June 2026

Appendix 4 – Letter of representation

[Audited body's letterhead]

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Cardiff
CF10 4BZ

[Date]

Representations regarding the 2025-26 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Aneurin Bevan University Local Health Board for the year ended 31 March 2026 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
 - observe the accounts directions issued by Welsh Ministers, including the relevant accounting and disclosure

requirements and apply appropriate accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;
 - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
 - prepare them on a going concern basis on the presumption that the services of Aneurin Bevan University Local Health Board will continue in operation;
- ensuring the regularity of any expenditure and other transactions incurred;
 - the design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Local Health Board and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;

- the identity of all related parties and all the related party relationships and transactions of which we are aware; and
- our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions.

Representations by Aneurin Bevan University Local Health Board

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Local Health Board on 24 June 2026.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as

we are aware, there is no relevant audit information of which you are unaware.

Signed by:

Chief Executive

Date:

Signed by:

Chair or of the Health Board

Date:

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 latest [audit quality 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	

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We welcome correspondence and telephone calls in Welsh and English.

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



DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Review of the Risk Management Framework
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 Trafodaeth/For Discussion

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report presents the Audit, Risk and Assurance Committee ("the Committee") with the annual review of the Risk Management Framework and supporting documents for review and comment.

Cefndir / Background

In line with recognised best practice, the Risk Management Framework ("the Framework") is subject to regular review to ensure it remains fit for purpose. This review also provides an opportunity to incorporate organisational learning, emerging intelligence and developments in best practice. In recognition of this, the revised Risk Management Framework and supporting documents are attached to this report as follows:

- Appendix A - Risk Management (and Assurance) Framework
- Appendix B – Risk Management Procedure
- Appendix C – Risk Appetite Statement
- Appendix D – Strategic Risk Assessment Template

The Framework was last reviewed and approved by the Audit, Risk and Assurance Committee in April 2025.

Asesiad / Assessment

The revised Risk Management Framework represents a natural evolution of the Health Board's approach, building on the solid foundations established to date and reflecting an increasing organisational focus on assurance and risk maturity.

The inclusion of "Assurance" within the title of the Framework signals a deliberate shift towards strengthening the link between risk management, assurance and decision-making, ensuring that risks are not only identified and managed, but that there is clear, demonstrable evidence regarding the effectiveness of those arrangements.

Learning and Improvement Opportunities

This iteration of the Framework responds to learning identified through the recent Internal Audit review and aligns more closely with the principles set out in the HM Treasury Orange Book and recognised good practice. In particular, it places greater emphasis on clarifying roles and responsibilities, strengthening escalation arrangements, and improving the articulation of the relationship between operational, corporate and strategic risks.

The revised Framework also introduces a structured maturity model, supporting the organisation to better understand its current position and identify clear opportunities for continuous improvement. This provides a more systematic approach to developing risk management capability over time, enabling progress towards a more mature, consistent and embedded risk culture across the Health Board.

To support the continued development of a mature risk management and assurance framework, the suite of risk management documents has been reviewed and streamlined to improve clarity, reduce duplication, and strengthen the link between risk, assurance and decision-making.

The revised structure establishes a clear distinction between governance requirements, operational processes and risk appetite, ensuring each document has a defined purpose and can be updated independently as the organisation's needs evolve.

The revised suite comprises:

1. **Risk Management and Assurance Framework**

Sets out the Health Board's approach to risk management and assurance, including the principles, governance arrangements, roles and responsibilities that underpin effective risk management and support informed decision-making.

2. **Risk Management Procedure**

Provides practical guidance on how risks are identified, assessed, managed, escalated, monitored and reported across the organisation.

3. **Risk Appetite Statement** (*no changes*)

Maintained as a standalone document, the Risk Appetite Statement defines the level of risk the Board is willing to accept in pursuit of its strategic

objectives. Whilst not updated as part of this review, the current operating environment presents an opportunity for the Board to review whether the existing appetite statements and risk thresholds remain aligned to organisational priorities, challenges and strategic ambitions.

4. Strategic Risk Assessment Template

Redesigned to focus on the key strategic controls that the Board is relying upon to manage each strategic risk. Whilst numerous operational controls exist beneath these arrangements, inclusion of all such controls would result in excessive detail and limit the Board's ability to focus on the effectiveness of the principal controls managing the risk.

The revised approach therefore provides targeted assurance by linking strategic controls to evidence of their effectiveness, identified assurance gaps and improvement actions, whilst maintaining the ability to drill down into supporting operational controls where necessary.

Overall, these enhancements strengthen the coherence of the Health Board's risk management arrangements and support a more integrated, transparent and assurance-driven approach to managing risk in support of organisational objectives.

Furthermore, the internal audit review identified a number of opportunities to enhance the maturity of the Health Board's risk management arrangements, including strengthening Executive oversight, improving strategic alignment, enhancing the quality and consistency of risk reporting, and further developing assurance, visibility and risk management capability across the organisation, these have been considered and incorporated within this review with further work planned to complete all recommendations.

Strategic Risk and Assurance Internal Audit Recommendations		
Recommendations from Internal Audit Review	Action	Progress
Streamlining and Maintaining the Risk Framework	*Reviewing and streamlining the Risk Management Framework and supporting documents to remove duplication and improve clarity.	Complete. A streamlined suite of standalone documents is now in place, comprising the Risk Management and Assurance Framework, Risk Management Procedure and Risk Appetite Statement, each supported by appropriate cross-referencing.
	Ensuring documentation continues to reflect best practice and organisational learning.	
Strengthening Strategic Alignment and Focus	Ensuring clear alignment between the SRR, IMTP and the Gwent 35 strategy, with explicit mapping of risks to strategic objectives.	Ongoing. Clear alignment is established between the SRR and IMTP. Further work is underway to strengthen explicit alignment to the Gwent 35 Strategy through enhancements to the risk assessment template

	Refining the SRR to focus on true strategic risks, with operational risks reclassified to the CRR.	Ongoing. A continuous cycle of review and refinement is in place, with risks being re-scoped and, where appropriate, de-escalated to ensure the SRR remains focused on strategic risks, with operational risks appropriately transferred to the CRR. Planned deep dives will further support this refinement.
	Improving clarity of the line of sight from strategy → planning → risk.	Planned. This will be addressed as part of the comprehensive review of individual strategic risk assessments, strengthening the alignment between strategy, planning and risk.
Improving the Quality, Consistency and Clarity of Risk Reporting	Enhancing the SRR template to improve structure, clarity and usability. Addressing variation in user understanding to improve overall quality and consistency	In Progress. The SRR template is being revised to improve clarity, usability and consistency, including strengthening the linkage between controls and corresponding assurances to enhance visibility of control effectiveness.
	Strengthening the linkage between controls, assurances, gaps and actions to improve transparency.	Planned. This will be progressed through the planned programme of strategic risk "deep dives", enabling more detailed review and strengthening of linkages.
	Improving the description and articulation of assurance gaps to avoid ambiguity or misinterpretation.	Planned. This will be addressed alongside the deep dive programme, with a focus on improving the clarity, specificity and consistency of assurance gap articulation.
Enhancing Assurance and Visibility of Risk Management	Introducing structured "deep dives" into key risks within Committee cycles, prioritised by risk exposure.	In Progress. Enhanced reporting has commenced within Committees, with increased focus on risks exceeding appetite to support more targeted scrutiny. A structured programme of deep dives will be further embedded following completion of the strategic risk review, strengthening assurance and visibility.
Strengthening Executive Oversight and Scrutiny	Formalising regular Executive Committee oversight of the Strategic Risk Register (SRR), including quarterly review aligned to Board cycles.	Complete. Formal arrangements are in place for the SRR to be reviewed quarterly by the Executive Committee, aligned to the Board reporting cycle

Building Capability and Consistency in Risk Practice	Delivering targeted training and guidance to risk owners to promote consistent understanding and application of: • Risk assessment standards • Assurance mapping • Identification of meaningful gaps and actions	In Progress. Training is currently delivered on a responsive basis. A structured training programme will be developed to target areas of highest risk exposure and to improve consistency and maturity of risk management practice across the organisation.

*This was a consideration in the Audit Report, not a recommendation for implementation.

In conclusion, the revised Risk Management and Assurance Framework represents a significant step forward in strengthening the Health Board’s approach to risk, assurance and decision-making. It reflects a clear commitment to continuous improvement, learning from internal audit findings and aligning with recognised best practice.

The enhancements set out within this review will support the Health Board to further develop its risk maturity, improve the quality and consistency of risk information, and strengthen assurance to the Board. Collectively, this provides a solid foundation for a more transparent, integrated and assurance-driven approach, enabling the Board and its Committees to exercise effective oversight and support the delivery of strategic objectives.

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is requested to:

- **DISCUSS** and provide feedback on the proposed changes to the Risk Management and Assurance Framework, Risk Management Procedure and Strategic Risk Assessment Template (Board Assurance Framework) prior to submission to the Board for approval in September 2026.
- **REVIEW** the Risk Appetite Statement and provide feedback to inform its consideration by the Board in September 2026, including whether the current appetite statements and thresholds remain appropriate in the context of the Health Board's operating environment and strategic objectives.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

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

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

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

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



Aneurin Bevan University Health Board

Risk Management and Assurance Framework

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1. Introduction

Aneurin Bevan University Health Board (the Health Board) is committed to good governance, patient safety, quality of care, statutory compliance and the delivery of its strategic objectives. Effective risk management is fundamental to the Health Board's governance framework and system of internal control.

Risk management is not a separate activity. It is an integral part of strategy, planning, operational delivery, clinical and corporate decision-making, improvement, transformation, commissioning, partnership working and performance management.

This Framework sets out the Health Board's mature, integrated approach to identifying, assessing, treating, monitoring, reporting and assuring risk. It aligns risk management, risk appetite, risk registers, the Board Assurance Framework and assurance reporting so that risks to objectives are visible, owned, controlled and escalated appropriately.

2. Purpose and Outcomes

The purpose of this Framework is to define how the Health Board will manage uncertainty in pursuit of its objectives, minimising threats and enabling opportunities within agreed appetite and tolerance.

The intended outcomes are:

- a consistent risk language;
- clear accountability for risk ownership and action;
- proportionate escalation and de-escalation;
- transparent Board oversight;
- evidence-based assurance;
- and a risk-aware culture where staff feel able to identify, discuss and learn from risk.

3. Scope

This Framework applies to all Health Board employees, independent members, contractors, secondees, students, volunteers and any person or organisation undertaking work on behalf of the Health Board. It applies to clinical, operational, strategic, programme, project, financial, workforce, compliance, digital, estates, partnership, reputational and emerging risks.

The Framework supports the Health Board's Quality Strategy, Integrated Medium-Term Plan, Performance Management and Accountability Framework, Standing Orders, Standing Financial Instructions and statutory, regulatory and professional obligations.

4. Principles and Risk Culture

The Health Board will apply the following principles to all risk management activity:

- Risk management is integrated into governance, planning, performance, quality, safety and decision-making rather than operated as a standalone process.
- Risk is managed in relation to objectives, outcomes and the interests of patients, service users, staff, communities and partners.
- Risk management is proportionate: the level of analysis, control, assurance and reporting reflects the nature, scale and tolerability of the risk.
- Risk appetite is used actively to guide decisions, prioritise resources and determine whether further action, escalation or acceptance is required.
- Controls and assurances are distinguished clearly: controls reduce risk; assurances provide evidence that controls are designed and operating effectively.
- Risk information is timely, accurate, complete and recorded in Datix as the single source of organisational risk information.
- The Health Board supports a just, learning and psychologically safe culture where risks and control weaknesses can be raised early and acted upon.

5. Risk Governance and Accountability

Risk governance is based on clear ownership, defined escalation routes, regular scrutiny and independent assurance.

The Board retains overall accountability for the effectiveness of risk management and internal control, supported by its committees and Executive Team.

Role / Forum	Core Responsibilities
Board	Set strategic objectives, approve the Framework and Risk Appetite Statement, oversee the Strategic Risk Register and confirm that principal risks are understood and managed within appetite or subject to agreed action.
Audit, Risk and Assurance Committee	Provide independent scrutiny of the effectiveness of risk management, assurance, internal control and governance arrangements; review the Strategic Risk Register / Board Assurance Framework and assurance map.
Board Committees	Scrutinise delegated strategic risks and relevant corporate risks aligned to committee remit; test controls, assurance, gaps, actions, trajectory and appetite alignment.
Chief Executive / Accountable Officer	Ensure an effective system of internal control and risk management is maintained and reflected in the Annual Governance Statement.
Executive Directors	Own strategic and corporate risks within portfolio; ensure risks are assessed, controlled, resourced, reviewed and escalated; ensure divisional arrangements operate effectively.
Director of Corporate Governance	Lead the design, implementation and continuous improvement of the Framework, risk appetite, Board Assurance Framework and corporate risk reporting arrangements.
Head of Corporate Risk and Assurance	Maintain risk methodology, standards, reporting, training, challenge and quality review; support consistent use of Datix and escalation processes.
Risk Owner	Accountable for the risk description, assessment, controls, actions, assurance, appetite alignment, review and reporting of an assigned risk.
Action Owner	Responsible for delivering agreed mitigating actions by target dates and providing evidence of completion or exception reporting.
Risk Leads	Coordinate local risk register quality, support teams, facilitate review meetings and ensure timely escalation or de-escalation.
All staff	Identify, assess, record, manage and escalate risks within their role; comply with controls; report incidents, hazards and control weaknesses.

The Health Board uses a three-lines assurance model to clarify responsibility for managing risk and providing assurance.

Line	Primary Responsibility	Examples of Assurance
First line: operational management	Own and manage risk, operate controls, deliver actions and maintain local risk registers.	Self-assessment, local audits, performance dashboards, quality and safety reviews, control evidence.
Second line: oversight and specialist functions	Set policy and standards, advise, monitor compliance, challenge risk quality and aggregate themes.	Corporate risk review, compliance monitoring, specialist reviews, committee scrutiny, thematic reporting.
Third line: independent assurance	Provide independent and objective assurance on governance, risk management and internal control.	Internal audit, external audit, inspection, regulatory review and independent peer review.

6. Risk Management Process

*To support the effective identification, assessment, management and escalation of risks, the Risk Management Procedure can be accessed **here**. Add link when approved and uploaded.*

The Health Board will apply a consistent risk lifecycle aligned to recognised risk management practice. The lifecycle is iterative: risks are reviewed as objectives, services, controls, evidence and operating conditions change.

1. Establish the context: define the objective, scope, stakeholders, constraints, assumptions, dependencies and relevant appetite theme.
2. Identify the risk: describe the uncertain event or circumstance, its cause, potential consequence and the objective that may be affected.
3. Analyse the risk: assess causes, current controls, likelihood, consequence, inherent risk, current risk and target risk using the approved 5x5 scoring methodology.
4. Evaluate tolerability: compare current and target risk with risk appetite, legal duties, patient safety requirements, control

effectiveness and available assurance.

5. Treat the risk: agree proportionate actions to tolerate, treat, transfer, terminate or take the opportunity, with clear owners, target dates and expected impact.
6. Monitor and review: review controls, action progress, assurance findings, score movement, risk velocity, proximity and whether escalation or de-escalation is required.
7. Communicate and report: ensure relevant teams, committees and the Board receive meaningful risk information that supports decisions and accountability.

Risk descriptions should use a consistent structure:

There is a risk that [event or circumstance] caused by/due to [cause] resulting in [impact on objective, safety, quality, finance, performance, compliance, reputation or people].

Risk owners must consider whether risks are malicious or non-malicious in nature. Malicious risks, such as cyber-attack, fraud, violence or deliberate data compromise, require controls and assurances that differ from non-malicious risks such as human error, equipment failure, demand variation or adverse weather.

7. Risk Appetite and Tolerance

Risk appetite is the amount and type of risk that the Health Board is willing to seek, accept or tolerate in pursuit of its objectives. Risk tolerance is the specific threshold at which a risk is considered within or outside appetite and therefore requires acceptance, treatment, escalation or de-escalation.

Risk appetite must be used when setting strategy, approving business cases, designing services, planning transformation, entering partnerships, reviewing performance, prioritising investment and deciding whether residual risk can be accepted.

Appetite Level	Risk Appetite Description	Tolerance Threshold
Averse	Avoidance of risk exposure where practicable.	Score 5 and below
Minimal	Ultra-safe approach leading to only minimum exposure after controls.	Score 8 and below

Appetite Level	Risk Appetite Description	Tolerance Threshold
Cautious	Preference for safe options while accepting some managed risk exposure.	Score 13 and below
Open	Willing to consider all viable options, subject to controls and assurance, recognising higher exposure may be appropriate.	Score 17 and below
Hungry	Eager to innovate and take higher levels of risk, but only in the right circumstances and with explicit authority.	Score 21 and below

Any risk operating outside the Board's agreed risk appetite must have a documented rationale, named Executive Lead, agreed treatment plan, review frequency, and reporting route. Acceptance of an out-of-appetite risk must be explicit, time-bound, and subject to regular review.

The Health Board has defined six risk appetite themes, which set the level of risk it is willing to accept across different areas of activity. These themes support informed decision-making and help identify risks requiring enhanced management, scrutiny, and oversight where they exceed agreed appetite thresholds.

Further detail can be found at **Appendix A** with the full document available [here](#).

8. Risk Registers and Board Assurance Framework

Datix is the Health Board's single system for recording and maintaining organisational risk information. All risks must be recorded, reviewed and reported using Datix to support consistency, aggregation, scrutiny and auditability.

Register	Purpose	Typical Criteria / Ownership
Strategic Risk Register	Captures principal risks to delivery of strategic priorities and annual objectives, with controls, assurances, gaps and actions.	Owned by Executive Directors and scrutinised by Board and committees. Acts as the Board Assurance Framework.
Corporate Risk Register	Captures significant operational risks requiring Executive Team oversight, cross-organisational coordination or resources beyond divisional control.	Normally score 15 or above, or lower where significance, sensitivity, aggregation or control weakness warrants escalation.

Register	Purpose	Typical Criteria / Ownership
Divisional Risk Registers	Capture risks that exceed directorate or service capability or require divisional ownership, prioritisation and coordination.	Typically score 8-12, but professional judgement applies.
Directorate / Local Risk Registers	Capture operational risks that can be managed within the service, ward, department or directorate.	Typically score 1-6, with escalation where control gaps or trajectory exceed local capacity.
Thematic Risk Registers	Capture specialist risk areas such as health and safety, quality and patient safety, emergency planning, information governance or digital.	Managed by the relevant specialist group or committee with links to operational registers.
Programme and Project Risk Registers	Capture risks to programme or project objectives, benefits, milestones, resources or dependencies.	Managed by project boards; escalated to organisational registers where service delivery, safety, compliance or strategic objectives are threatened.

Escalation is not automatic by score alone. A risk should remain at the level where it can be effectively owned and managed. Escalation is required where the risk exceeds local capability or authority, requires resources or decisions from a higher level, has cross-cutting implications, is outside appetite, or threatens patient safety, statutory compliance, service delivery or strategic objectives.

9. Reporting, Escalation and De-escalation

Risk reporting must provide insight rather than simply list risks. Reports should explain risk movement, material control gaps, assurance gaps, action slippage, appetite position, emerging risks, clusters, cumulative exposure and decisions required.

Forum	Risk Information Received	Minimum Frequency
Board	Strategic Risk Register / Board Assurance Framework, risk appetite exceptions, principal risk movement and assurance gaps.	Each formal Board meeting unless otherwise agreed.
Audit, Risk and Assurance Committee	Whole-system assurance on risk management, internal control, assurance mapping, audit findings and strategic risk.	Each meeting.

Forum	Risk Information Received	Minimum Frequency
Board Committees	Delegated strategic risks and relevant corporate risks aligned to committee remit.	Each meeting.
Executive Committee	Corporate Risk Register, escalations, de-escalations, cross-cutting risks, action exceptions and emerging risks.	At least bi-monthly or as required by risk profile.
Divisional / Directorate Governance Forums	Local and divisional registers, new risks, overdue reviews, action exceptions and escalation decisions.	Monthly or in line with governance cycle.
Project Boards	Project risk registers, dependency risks, benefits risks and service-impact escalations.	At each project board meeting.

Immediate escalation outside the routine cycle is required for risks that present imminent danger, potential serious harm, major service disruption, statutory non-compliance, significant financial exposure, cyber or information compromise, media or public confidence impact, or any matter requiring urgent executive decision.

De-escalation should occur when controls are effective, risk exposure has reduced, actions have been completed, assurance evidence is available, and ownership can safely return to the lower level. The rationale for de-escalation must be recorded in Datix.

10. Assurance Arrangements

Assurance provides evidence that controls are designed appropriately and operating effectively. A mature risk framework distinguishes between controls, gaps in control, sources of assurance and gaps in assurance.

Element	Definition	Minimum Expectation
Controls	Measures that reduce likelihood, consequence or exposure.	Controls are current, specific, owned and capable of being evidenced.
Control gaps	Known weaknesses in design, implementation, coverage or capacity of controls.	Gaps are recorded with actions, owners, dates and expected impact.
Assurances	Evidence that controls exist and are working.	Assurance is mapped across first, second and third lines and linked to each principal risk.

Element	Definition	Minimum Expectation
Assurance gaps	Areas where evidence is insufficient, outdated, incomplete or not independent enough.	Gaps are reported to the relevant committee with planned sources of assurance.

The Strategic Risk Register must identify for each strategic risk:

- strategic objective affected;
- executive owner;
- inherent, current and target scores;
- appetite theme and tolerance threshold;
- key controls; control gaps;
- sources of assurance; assurance gaps;
- actions;
- trajectory; and,
- committee oversight route.

11. Implementation and Embedding

The Corporate Governance Directorate, led by the Director of Corporate Governance, will coordinate implementation of this Framework. Implementation will focus on capability, consistency, cultural adoption, reporting quality and assurance maturity, as set out below:

- Embed risk consideration into strategy, IMTP development, annual planning, quality impact assessment, service change, business cases, financial recovery, procurement, partnership decisions and programme governance.
- Use Datix to maintain a single source of truth and improve the quality, timeliness and consistency of risk data.
- Provide targeted support to teams and services to improve risk descriptions, scoring, controls, actions, assurance and escalation discipline.
- Develop thematic risk analysis and cumulative exposure reporting to identify clusters, dependencies and systemic vulnerabilities.
- Use lessons from incidents, complaints, claims, inquests, audit, inspection, staff feedback and performance intelligence to update risk profiles.

12. Training and Capability

Risk management training will be role-based and proportionate. All staff should understand how to identify, manage and escalate risks relevant to their role. Risk owners, risk leads, senior leaders and Board members require additional capability to discharge their responsibilities effectively.

Audience	Training / Support Requirement
All staff	Awareness of risk identification, incident and hazard reporting, local controls and escalation routes through induction and refresher communications.
Risk owners and action owners	Risk description, scoring, appetite, controls, action planning, assurance, Datix updates and reporting expectations.
Risk leads and governance teams	Register quality review, moderation, escalation, trend analysis, thematic reporting and committee support.
Executive Directors and senior leaders	Strategic risk, risk appetite, risk acceptance, assurance mapping, accountability and decision-making.
Board and committee members	Risk appetite, Board Assurance Framework, scrutiny of controls and assurance, strategic risk oversight and risk culture.

Board members will receive risk management development individually and collectively, including at induction and at least every two years. The Corporate Governance Directorate will provide ongoing advice, coaching and quality review.

13. Monitoring Effectiveness and Continuous Improvement

The effectiveness of the Framework will be assessed through routine oversight by the Board, Audit, Risk and Assurance Committee, Executive Committee and relevant management forums, supported by internal audit, external audit and regulatory findings.

Measure	Indicator of Maturity
Risk register quality	Risks use the agreed cause-event-impact structure; controls and actions are specific; reviews are timely; appetite alignment is recorded.
Action delivery	Mitigating actions are completed on time or subject to clear exception reporting and revised trajectories.

Measure	Indicator of Maturity
Assurance quality	Strategic risks show mapped controls, assurance sources and gaps across the three lines.
Escalation discipline	Escalations and de-escalations are timely, justified and recorded.
Risk appetite use	Reports identify risks outside appetite and decisions explicitly reference risk appetite.
Learning and improvement	Lessons from incidents, audit, inspection, claims and performance intelligence are reflected in risks and controls.
Data quality	Datix contains complete, accurate, current and auditable risk information.

The Framework will be reviewed bi-annually, or sooner where there are material changes in strategy, legislation, regulation, standards, organisational structure, operating environment or the Health Board's risk profile.

14. Supporting Documents

- Risk Management Procedure
- Risk Appetite Statement
- Guidance Note for Risk Assessment and Management
- Guidance for Using the electronic Risk Management System
- Performance Management and Accountability Framework
- Standing Orders and Standing Financial Instructions
- Quality Strategy and Integrated Medium-Term Plan

15. References

- International Organisation for Standardisation, ISO 31000:2018 Risk management - Guidelines.
- HM Treasury, The Orange Book: Management of Risk - Principles and Concepts, May 2023.
- HM Treasury, Risk Appetite Guidance Note, 2021.
- Good Governance Institute, Risk Appetite for NHS Organisations, 2019.

- NHS Wales 5x5 Risk Scoring Matrix and related national guidance.
- Audit Wales structured assessment methodology and NHS Wales governance guidance.
- National Security Risk Assessment and relevant cyber, information governance and emergency planning guidance.

16. Appendices

- Appendix A - Risk Appetite Statement
- Appendix B - Minimum Risk Register Data Standards
- Appendix C - Risk Maturity Model

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Appendix A - Risk Appetite Statement

The Risk Appetite Statement is part of this Framework and should be reviewed at least annually. It supports structured judgement and does not remove the need for professional assessment, executive accountability or Board scrutiny.

Theme	Appetite	Threshold	Statement
Compliance and Safety	Minimal	Score 8 and below	The Health Board has a minimal appetite for risks affecting patient safety, safeguarding, statutory compliance, legal duties or security. Decisions should prioritise harm prevention, compliance and rapid control improvement.
Service Delivery	Open	Score 17 and below	The Health Board is open to managed risk in service delivery where this supports improved access, quality, sustainability or performance and where quality, equality, safety and contingency considerations are explicit.
People	Open	Score 17 and below	The Health Board is open to innovative workforce models, recruitment and wellbeing approaches, provided professional standards, safe staffing, staff experience and culture are protected.
Transformation and Partnership Working	Open	Score 17 and below	The Health Board is open to transformation and collaboration where benefits, governance, accountabilities, dependencies and risk-sharing arrangements are clear.
Financial Sustainability	Cautious	Score 13 and below	The Health Board is cautious in financial risk-taking, balancing value, affordability, quality, safety and statutory duties.
Confidence and Trust	Cautious	Score 13 and below	The Health Board is cautious about risks that could reduce public, staff, partner, regulator or stakeholder confidence, and will emphasise transparency and engagement.

Risks above threshold must be identified as outside appetite and reported with a treatment plan, target position, owner, review frequency and decision required.

Where the Board or an executive forum accepts a risk outside appetite, acceptance must be explicit, time-bound and recorded.

Appendix B - Minimum Risk Register Data Standards

Field	Minimum standard
Risk title	Clear and concise summary of the risk.
Risk description	Uses cause-event-impact structure and links to an objective or outcome.
Risk category and appetite theme	Selected consistently to support aggregation and appetite reporting.
Owner	Named accountable owner with authority to manage or escalate the risk.
Inherent, current and target scores	Assessed using the approved 5x5 matrix with rationale.
Controls	Specific, current controls that are actually in operation.
Control gaps	Known weaknesses in control design, implementation or effectiveness.
Assurances	Evidence that controls are operating, mapped where appropriate across the three lines.
Assurance gaps	Areas where evidence is missing, outdated or insufficiently independent.
Actions	SMART actions with owner, due date, expected impact and status.
Review date and frequency	Frequency reflects score, volatility, proximity, appetite and control strength.
Trajectory and proximity	Direction of travel and likely timing of impact are recorded where relevant.
Escalation / de-escalation rationale	Decision and rationale recorded, including forum and date.

Appendix C - Risk Maturity Model

Maturity level	Characteristics	Evidence
1. Initial	Risk activity is inconsistent, person-dependent and reactive. Registers are incomplete or out of date.	Limited Datix use; weak action tracking; risks not linked to objectives.
2. Developing	Common templates and governance routes exist, but quality and review discipline vary.	Some timely reviews; inconsistent controls and assurance; variable scoring moderation.
3. Established	Consistent process, clear ownership, routine reporting and escalation are in place.	Active registers; committee oversight; risk appetite recorded; action tracking.
4. Managed	Risk information informs decisions, priorities and resource allocation. Assurance gaps and cumulative exposure are visible.	BAF quality reviews; assurance mapping; thematic analysis; improvement plans.
5. Optimising	Risk management is dynamic, predictive and embedded in culture, planning and learning.	KRIs, horizon scanning, scenario analysis, triangulated intelligence and demonstrable continuous improvement.

Risk Management Procedure

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1 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control.

Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

2 SCOPE OF PROCEDURE

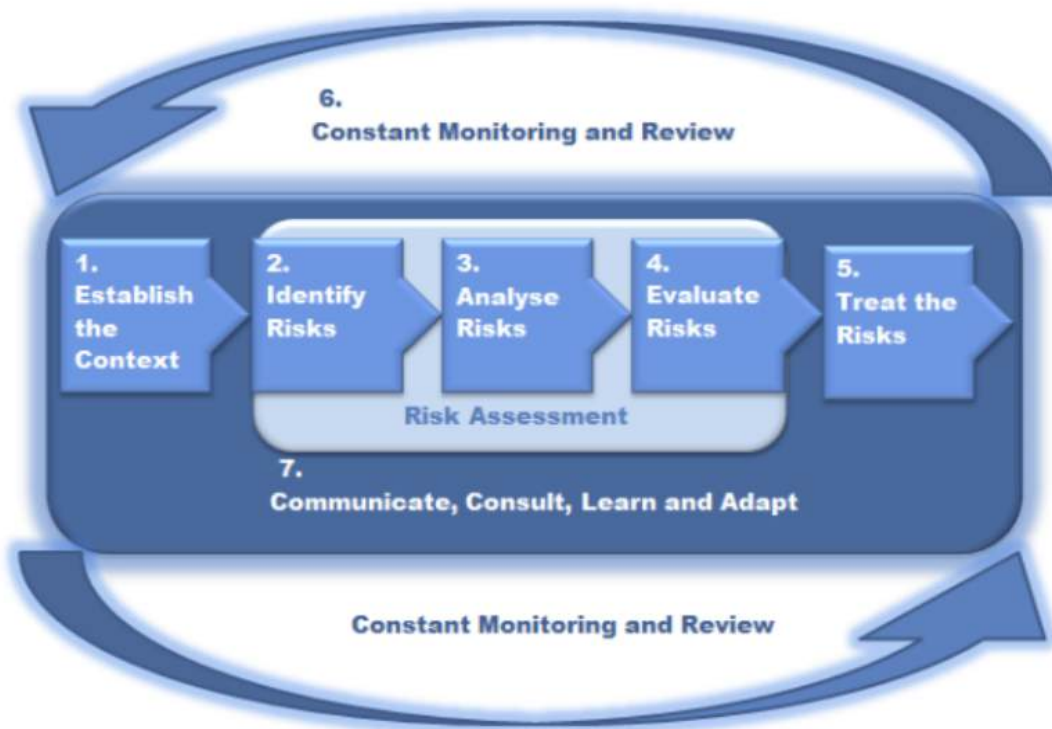
This procedure applies to all staff and services and outlines the process for identifying, assessing, managing, and escalating risks.

3 ROLES AND RESPONSIBILITIES

Employees in all positions are responsible for maintaining risk awareness by identifying and reporting risks to their line manager and/or directors as appropriate.

All areas must conduct ongoing robust risk assessments and escalate risks through the Health Board's governance and escalation route, as outlined below in the Risk Management Process section.

4 RISK MANAGEMENT PROCESS



Step 1: Establish the Context

Before identifying risks, first decide on the scope of the activity, including your objectives, and develop an understanding of your operating environment.

Identify your stakeholders (internal and external) to determine whether they could potentially expose the Health Board to risk, could be exposed to risk, or could assist with risk management.

There are three other elements that are important to consider when establishing the context for a risk assessment:

- External factors (e.g., regulatory, financial, environmental, technological)
- Internal factors (e.g., workforce, capability, culture) Confirm the objectives that could be impacted by risk.
- The risk management context - this defines the goals and objectives of the risks.

Step 2: Identify Risks

The aim of this step is to develop a comprehensive list of future events which could be uncertain but are likely to have an impact (either positively or negatively) on the achievement of the objectives - these are the risks.

It is important to understand the difference between a Risk and an Issue, as these can often get confused. A useful way of remembering the difference is;

- Risks are things that might happen and stop us achieving objectives, or otherwise impact on the success of the Health Board.
- Issues are things that have happened or are currently happening, that are being actively managed.

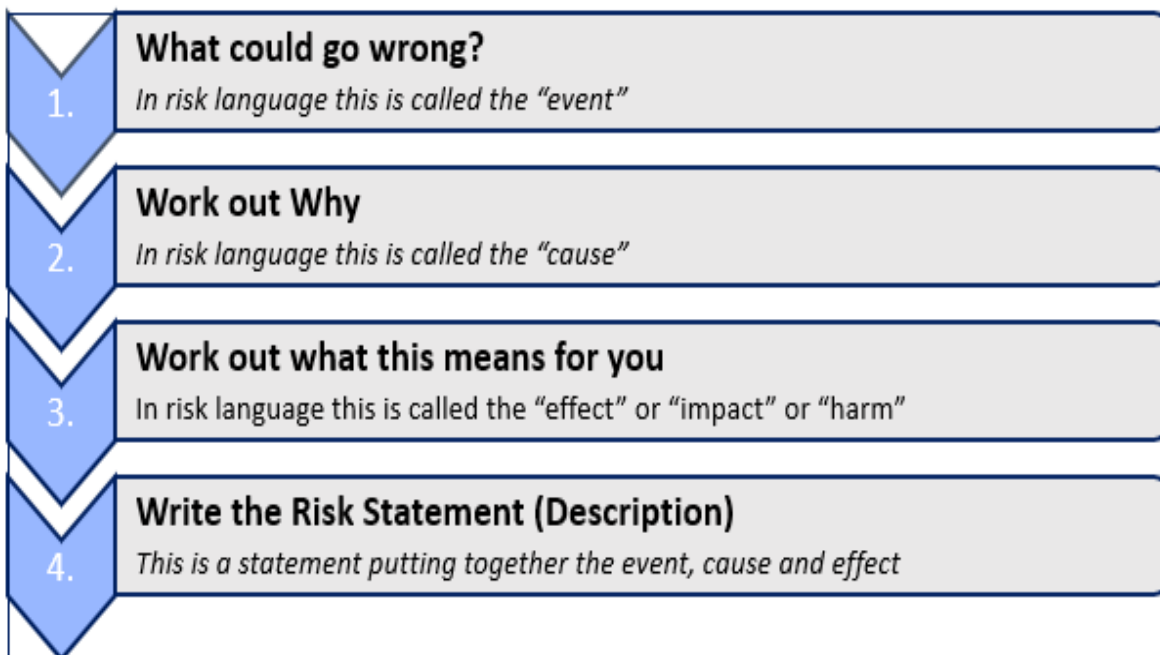
An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

Temporal Proximity	Risk or Issue
Has happened or is currently happening	Issue
Potential to materialise in this financial year	Risk
Potential to materialise in the next financial year	Risk
Potential to materialise in the next 2 -5 years <i>(Dependant if the risk is malicious e.g., Cyber or Fraud (2y) or non-malicious e.g., error, system failure (5y))</i>	Risk

Common techniques for identifying risks are the use of risk categories or linking risks to each objective identified in the context setting phase. Another method is to consider threats and opportunities the Health Board faces and use these to identify relevant risks.

For each risk identified ensure that its source or cause is well understood and documented, including key elements such as the risk event, the potential cause and the potential impact should the risk be realised. A clear risk description is important to ensure corresponding actions for treatment are effective.

The steps below will guide the development of a risk description, examples of this process are included at **Appendix 1**.



Step 3: Analyse Risks

Risk analysis establishes the potential impact of each risk and its likelihood of occurrence. The combination of these two factors determines the severity of the risk, which may be positive or negative.

Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **LIKELIHOOD** and **IMPACT**.

Although there are many ways to achieve this, a common approach is to use a matrix or 'risk heat map'. Consequence and likelihood are plotted on the two axes of the matrix, with each corresponding cell assigned a level of severity.

Risks should be measured at the following three stages.

Stage	Description
INITIAL	This will be the score when the risk is first identified – this will not change
CURRENT	This should reflect the latest level of risk each time that the risk is reviewed.
TARGET	The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions.

The NHS 5 X 5 Risk Scoring Matrix is presented at **Appendix 2**.

Step 4: Evaluate the Risk

Compare risk score against defined thresholds.

Determine:

- Whether the risk is tolerable
- Priority for action
- Consider wider implications (e.g., safety, legal, financial, reputational).

Step 5: Treat the Risk

Risk treatment is the action taken in response to the risk evaluation when additional mitigation activities are agreed upon.

There are five strategies to managing a risk, known as the 5T's (Treat, Tolerate, Transfer, Terminate, Take the Opportunity). Select and implement appropriate mitigation using one or more of the following:

Strategies	
Treat	reduce likelihood or impact
Tolerate	accept risk with justification
Transfer	share risk (e.g., contracts, insurance)
Terminate	stop the activity causing the risk
Take the Opportunity	actively exploiting a risk that has a potential positive outcome

Selecting the most appropriate treatment requires balancing the cost and effort of implementation against the benefits derived from additional risk mitigation.

In some cases, further treatment may be unachievable or unaffordable and the residual risk may need to be accepted and communicated.

Consideration should be given to how external stakeholders can provide support when developing treatment options or if treatments can be implemented collaboratively.

Step 6: Communication and Consultation

Communication and consultation are essential attributes of good risk management.

Discuss risks regularly in team/service meetings.

Ensure:

- Stakeholders are informed
- Actions are tracked
- Updates are recorded
- Use risk information to inform planning and decision-making.

Step 7: Monitoring and Review

Risks change over time and hence risk management will be most effective where it is dynamic and evolving.

Monitoring and review are integral to successful risk management; it is important to articulate who is responsible for conducting monitoring and review activities.

Key objectives of risk monitoring and review include:

- detecting changes in the internal and external environment, including evolving objectives and strategies;
- identifying new or emerging risks;
- ensuring the continued effectiveness and relevance of controls and the implementation of treatment programs;
- obtaining further information to improve the understanding and management of already identified risks; and
- analysing and learning lessons from events, including near-misses, successes, and failures

Monitoring and review can be periodic or in response to trigger events or changing circumstances.

Appendix 2 serves as a guide for conducting periodic risk assessments based on the risk level (severity). The frequency of the review process, however, should be proportional to the rate at which the organisation and its operating environment change.

During review:

- Update scores
- Check effectiveness of controls
- Identify new risks or changes

5 ESCALATION PROCESS

Escalate a risk when:

- It cannot be managed at the current level
- Controls are ineffective
- It exceeds capacity, capability, or authority
- It poses significant risk to service delivery, safety, or objectives

Trigger Points for Escalation

- Score increases into a higher threshold
- Risk remains unresolved over time
- Impact escalates (e.g., patient safety, compliance)
- Cross-organisational implications identified

Project Risk Escalation

- Managed within project governance structures
- Escalate to operational risk registers if:
 - Score ≥ 9
 - Risk threatens service delivery

Appendix 3 demonstrates the process.

IMPORTANT NOTE:

Escalation of a risk to a higher-level risk register does not remove the responsibility to manage the risk at the level at which it manifests. Risk owners and managers must continue to implement and monitor controls, mitigation actions and assurances within their area of responsibility, irrespective of where the risk is recorded.

Risks may only be escalated to a higher-level risk register where there is agreement that the risk cannot be effectively managed within the existing level of authority, control or resources, and that oversight is required at a higher level of the organisation.

As escalation results in the transfer of ownership and accountability to a more senior manager or Executive Lead, escalation must be formally agreed by the receiving risk owner before any amendment is made to the risk management system. Such agreement should normally be obtained through a formal governance forum, such as a Divisional Assurance Meeting, Corporate Assurance Meeting, Executive Committee or other appropriate risk review forum.

Once approval has been obtained, the risk may be formally amended within the risk management system to reflect the new ownership, reporting arrangements and level of oversight. The rationale for escalation and the agreement of the receiving risk owner must be documented within the meeting record and risk management system.

Escalation should not be viewed as a mechanism for transferring responsibility for managing the risk. The originating service, department or division remains responsible for managing the operational causes and consequences of the risk and for implementing agreed mitigating actions within its sphere of control.

"Escalated" does not mean "someone else is dealing with it."

It means:

"Someone more senior now has oversight and accountability, but the people closest to the risk must still manage it."

6 DATIX RISK MANAGEMENT SYSTEM

Risks must be recorded on the Health Board's Risk Management System, Datix. The DatixWeb Risk Module Training Guide is a step-by-step guide to recording and managing risks on Datix and can be accessed via ABPulse.

7 SUPPORTING DOCUMENTS

This document should be read in conjunction with the:

- Risk Management and Assurance Framework
- Risk Appetite Statement
- DatixWeb Risk Module Training Guide

8 TRAINING AND IMPLEMENTATION

Staff must complete risk management training via induction and ongoing programmes. Additional support and guidance available through the

corporate governance function.

9 AUDIT AND REVIEW

This document will be reviewed annually in line with the Risk Management Framework and will be subject to regular auditing to ensure that risk management practices are effectively embedded across the Health Board

10 APPENDICES

Appendix 1 - Risk Statement Examples

Appendix 2 – NHS Wales Risk Scoring Matrix (5x5 Model)

Appendix 3 – Risk Escalation Process

Appendix 4 - Risk Assessment Template Strategic/Corporate

Appendix 5 - Risk Assessment Template Divisional/Directorate

11 APPENDIX 1: Risk Statement Examples

1. What could go wrong?	2. What could be the cause of this?	3. What would be the effect/impact?	4. Risk Statement (Description)
Poor quality care provided to patients	High staff sickness rate Inability to recruit sufficient staff. Inability to release staff for statutory and mandatory training	Adverse harm to patients Loss of public confidence in services Breach of Staffing Levels Act	There is a risk that safe staffing levels are not maintained, compromising patient safety and care.
Staff could fall over storage boxes	Medical records stored in boxes unsafely in office accommodation	Staff absence due to injury Breach of Health & Safety at Work Legislation Litigation Claims for Injury	There is a risk that the unsafe storage of medical records could cause potential harm to staff and loss to the organisation.
Unable to update electronic patient records	System downtime Internet access IT failure	Adverse harm to patients Compliance with record-keeping standards Litigation claims Reputational damage	There is a risk that patient records will not be updated with critical information should access to web-based/electronic recording systems be compromised.

12 APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model)

X-Axis = Likelihood/Frequency of the risk occurring.

Y-Axis = the level of risk Consequence/Impact

Color-coding is crucial for a 5x5 risk assessment matrix to represent the combination level of probability and consequence of the identified risks.

Each risk box represents the rating of a risk that is calculated based on its levels of likelihood and impact using a numeric value.

Calculating Risks Using the 5x5 Risk Matrix

The first step is to assign a numeric value from 1 to 5, 1 being the lowest, for each of the categories under Likelihood and Consequence. Then, use the formula of multiplying the value of the Likelihood by the value of the Consequence to determine the Risk Level.

The likelihood of malicious risks should be assessed over a 2-year period. In contrast, the likelihood of non-malicious risks should be evaluated over a 5-year period.

Definition:

Non-Malicious - A risk arising from unintentional errors, system failures, or natural causes, where there is no deliberate intent to harm.

Malicious - A risk arising from intentional harmful actions aimed at causing damage, disruption, or financial/reputational harm.

Likelihood x Consequence = Risk Level

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely	4 (Low)	8 (Moderate)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely	2 (Low)	4 (Low)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare	1 (Low)	2 (Low)	3 (Low)	4 (Low)	5 (Moderate)

The 5 risk rating levels under Likelihood/Frequency are as follows:

	Likelihood/frequency score (severity levels) and examples of descriptors				
Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often Might it/does it happen.	This will probably never happen / recur. May occur once in 5 years or more	Do not expect it to happen / recur but it is possible it may do so. Could occur once every 2 to 5 years	Might happen or recur occasionally. Might occur once every 1 to 2 years	Will probably happen / recur but it is not a persisting issue. Expected to occur annually or more	Will undoubtedly happen / recur, frequently. Expected to occur frequently (e.g., several times a year)

The 5 risk rating levels under Consequence/Impact are as follows:

	Severity/Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical /psychological harm)	Minimal injury or illness requiring no intervention or treatment.	Minor injury or illness, requiring. minor intervention e.g., First Aid treatment.	Moderate injury or illness requiring professional intervention e.g., Hospital Treatment, Counselling.	Major injury or illness leading to long-term incapacity/disability e.g., Amputation, loss of sight or hearing.	Incident leading to death.
	No time off work	Requiring time off work up to 7 days or restricted / modified duties. No permanent effects Increase in length of hospital stay by 1-3 days	Specified injury e.g., Bone Fracture, Loss of consciousness, Burn / scalding. Requiring time off work for greater than 7 days. Potential for long term effects Increase in length of hospital stay by 4-15 days. An event which impacts on a small number of persons	Chronic and or acute short term high risk ill health effects. Requiring time off work for greater than 28 days Life changing illness or injury Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects RIDDOR/agency reportable incident or Dangerous Occurrence	Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/inquiry	Formal complaint (Stage 1)	Formal complaint (stage 2) complaint	Multiple complaints/independent review	Gross failure of patient safety if findings not acted on.
		Local resolution	Local resolution (with potential to go to independent review)	Low performance rating	Inquest/ombudsman inquiry
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report	Gross failure to meet national standards
		Minor implications for patient safety if unresolved	Major patient safety implications if findings are not acted on		
		Reduced performance rating if unresolved			

Human resources organisational development staffing competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training.	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis.
	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required. Zero performance rating Severely critical report

Adverse Publicity	Rumours	Local media coverage – short-term reduction in public confidence	Local media coverage	National media coverage with <3 days	National media coverage with >3 days service
	Potential for public concern	Elements of public expectation not being met	long-term reduction in public confidence	service well below reasonable public expectation	well below reasonable public expectation.
					MP concerned. (Questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget.	5–10 per cent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
		Schedule slippage	Schedule slippage	Schedule slippage	Schedule slippage
				Key objectives not met	Key objectives not met
Finance including claims	Small loss	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective	Non-delivery of key objective
	Risk of claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Loss of 0.5–1.0 per cent of budget	Loss of >1 per cent of budget
				Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage Loss of contract / payment by results

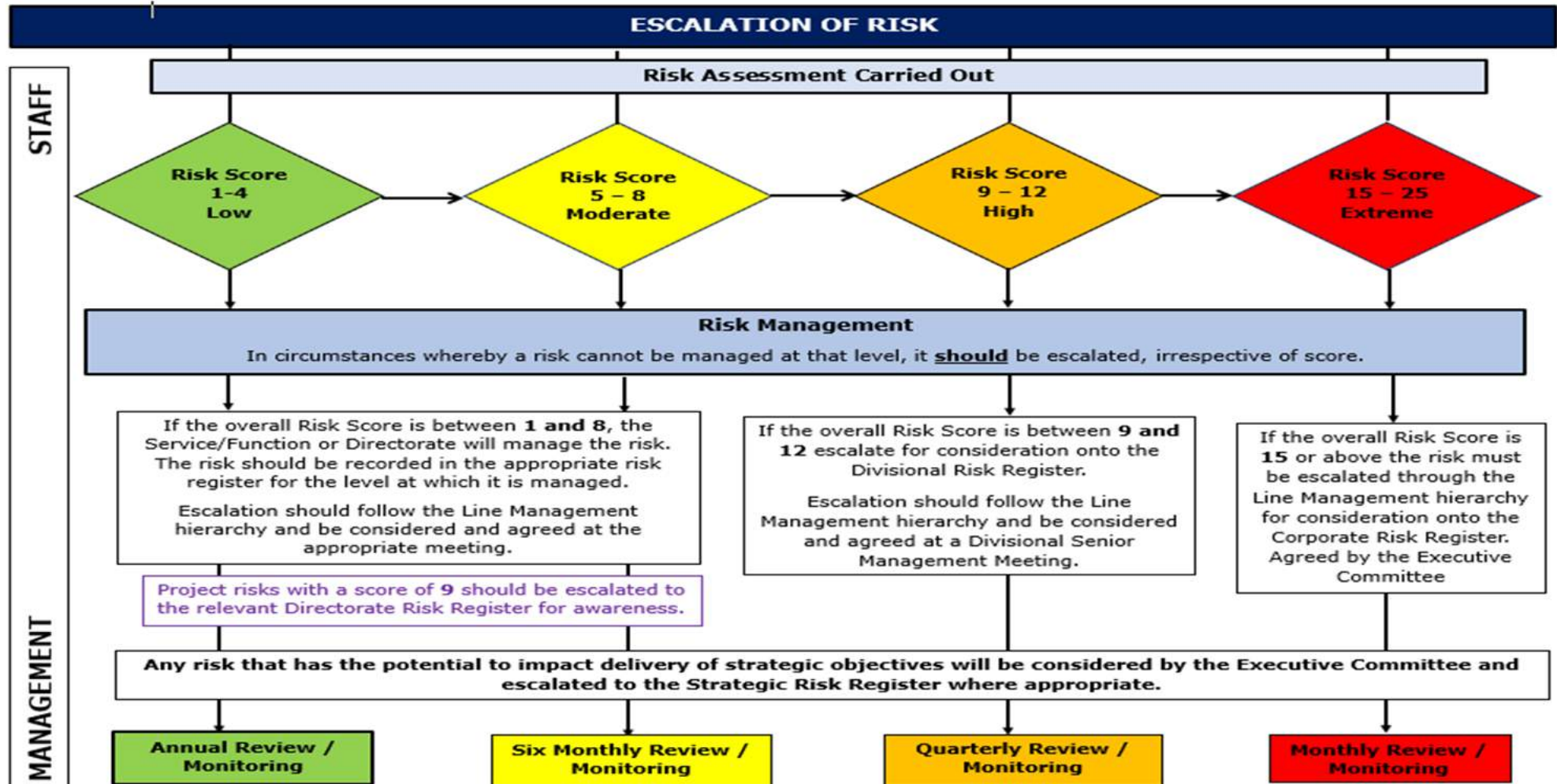
				Purchasers failing to pay on time	Claim(s) >£1 million
Fraud	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint	Could result in material loss or reputational damage. (Moderate risk to the organisation which may result in reduction of service. Material loss of up to £10000. Reputational damage across NHS with a high potential for complaint or a low risk of litigation	Could result in high material loss or reputational damage. (May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation	Could result in high material loss or reputational damage. (May result in temporary loss of service or material loss of up to £50000. Reputational damage widespread and outside of NHS with a likelihood of litigation
Digital Disruption	Minimal disruption. No impact on patient care or availability of operational systems. Clinical Critical / Admin Critical / Infrastructure Critical interface may load slower. Workarounds available and effective.	Noticeable delay or inconvenience Slight workflow inefficiencies. No patient harm expected. Temporary login issues with Clinical Critical / Admin Critical / Infrastructure Critical services.	Degraded functionality affects clinical decision-making or operations. Risk of care delays emerges.	Core system loss halts critical workflows. High risk of patient safety incidents or data loss. Clinical Critical / Admin Critical / Infrastructure Critical service offline for >1 hour.	Complete failure of vital clinical systems. Immediate and widespread threat to life and system integrity.

Service / business interruption Environmental impact	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility.
	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
	No damage to equipment or property	Slight / minor damage to equipment or property	Moderate damage to equipment or property	Major damage to equipment or property	Catastrophic damage to equipment or property

The table below outlines the time frame for implementation of actions based on risk score and level.

Risk Score	Overall Risk	Timeframe
1 - 4	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit.
5 - 8	Moderate	Actions implemented as soon as possible but no later than a year.
9 - 12	High	Actions implemented as soon as possible but no later than six months.
15 - 25	Extreme	Requires urgent action. The Health Board is made aware, and it implements immediate corrective action. However, where likelihood is rare or unlikely then potential decision needed on tolerance and action timescales.

13 APPENDIX 3: Escalation Process



14 APPENDIX 4: Risk Assessment Template Strategic/Corporate Risk *(this will be updated of new template approved)*

RISK THEME		USE RISK APPETITE DOCUMENT TO DETERMINE			
LINK TO IMTP / ANNUAL PLAN		USE IMTP 2025 - 26			
Strategic/ Corporate Risk SRR XXX / CRR XXX	There is a risk			Publication Status	Public
Threat (As a result of)				Risk Appetite Level – Use Risk Appetite Document	
Impact (Consequences of the threat)	Patient	Staff	Organisation	Risk Appetite Threshold –	
Lead Director		Risk Exposure	Current Level	Target Level	SUMMARY
Monitoring Committee / Group		Likelihood			
Initial Date of Assessment		Impact			
Last Reviewed		Risk rating			
Next Review (xx based on risk score)					
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)			Plans to Improve Control (What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included))		
EXAMPLES • Policies /procedures/protocols etc • Systems • Meetings					
Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)		Gaps in Assurance (Insufficient evidence as to the effectiveness of the controls or negative assurance)		Actions to Address Gaps (What further evidence is required to provide the effectiveness of controls)	
Level 1 Operational (Implemented by the department that performs daily operation activities)					
EXAMPLES • Adherence to clinical guidelines, protocols, and standard operating procedures (SOPs). • Dashboards measuring compliance • Performance dashboards KPI's		• Performance – workforce – finance reporting • Incident reporting • Thematic reviews		What information would give you assurance. e.g., dashboards, report data, What do you need to implement in to provide you with the assurance e.g., develop a dashboard, pull report data from ESR, local audit of process	
Level 2 Organisational (Executed by risk management and compliance functions)					
EXAMPLES • Reports to assurance and oversight committees (performance data against KPIs, objectives) • Findings and reports from inspections, annual reporting		• Training and competence data • HB level Accreditation		• Governance processes • risk management input (register, risk assessment) What do you need to implement in to provide you with the assurance e.g., develop a dashboard, pull report data from ESR, local audit of process	
Level 3 Independent (Implemented by both auditors internal and external independent bodies)					
EXAMPLES • Internal Audit Plan • External Audits • HIW inspections		• External Visits and accreditations • Independent Reviews • Patient/staff/public surveys and feedback		• Independent assurance that the controls are mitigating the risk What do you need to implement in to provide you with the assurance e.g., commission an independent review, develop feedback surveys	
Assurance Rating (Overall Assessment of controls and assurances) Guidance					
Negative – insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.		Positive - robust evidence that the controls in place are working effectively.	
OVERALL ASSURANCE RATING					

Status: **Issue 3- DRAFT**

Issue date: **MM 2026**

Approved by: Audit Committee on behalf of the Aneurin Bevan University Health Board

15 Appendix 5: Risk Assessment Template Divisional/Directorate Risk

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Aneurin Bevan University Health Board

Risk Appetite Statement

January 2024

Status: Issue 1 (No changes)
Approved by: Aneurin Bevan UHB Board
Owner: Corporate Governance Directorate

Issue date: January 2024
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Review by date: XX XXX
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INTRODUCTION

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's (the Health Board's) ability to achieve its objectives.

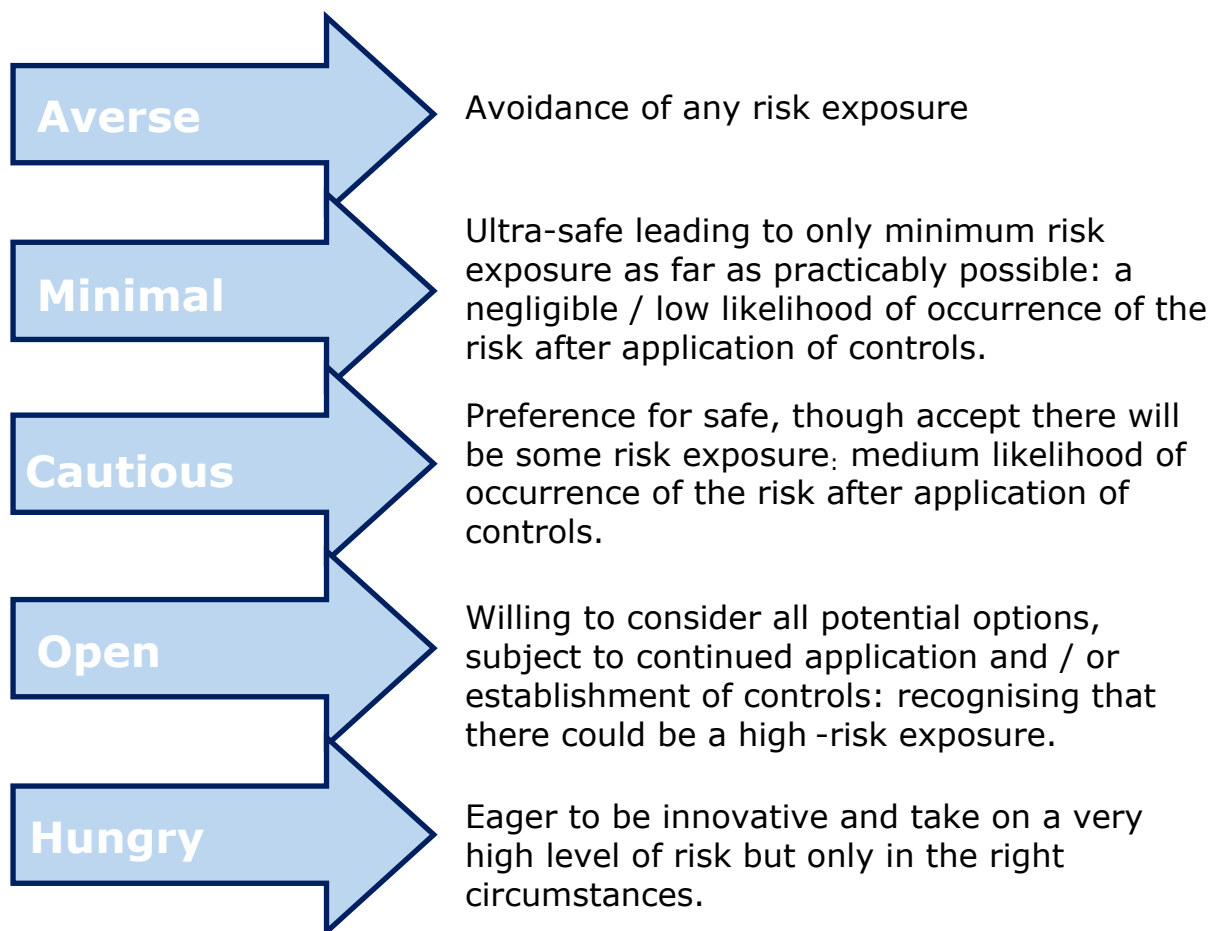
Risk itself is neither positive nor negative, but the outcome of taking risks can be to realise an opportunity or a threat. Only in extreme circumstances is the risk unforeseen. Therefore, through careful consideration and based on information available, the Health Board should be able to determine when it can take more risk and when it should not.

Risk appetite is a way of expressing the Health Board's attitude to different types of risk and the nature of the risks the Health Board is prepared to take. The Health Board's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

The Health Board's Risk Appetite Statement is not prescriptive but instead provides several underlying component parts that encourage structured thinking. The aim of the risk appetite is to enable the Health Board to reach an informed conclusion as to whether a risk can be accepted and to what extent.

RISK APPETITE DESCRIPTION

The Board has agreed the following levels of risk appetite,



RISK APPETITE BOUNDARIES

To enable translation of the risk appetite into Aneurin Bevan University Health Board's risk scoring methodology, the tolerance for each risk appetite has been plotted on the matrix below i.e., at what point a risk is acceptable (within tolerance) and when it is not (outside tolerance).

There may at times be risks which exceed appetite thresholds and the Health Board will therefore need to actively consider and agree to any risks managed outside tolerance in line with escalation levels.

Risk Appetite Level	Risk Appetite Threshold
Averse	Score 5 and below
Minimal	Score 8 and below
Cautious	Score 13 and below
Open	Score 17 and below
Hungry	Score 21 and below

RISK APPETITE THEMES

All risks should be considered in the context of the Health Board's risk appetite. To assist this a number of risk appetite themes have been developed, against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, the Health Board will be more easily able to determine how to respond and so make best use of mitigation resources.

Safety, quality and the Health Board's staff are key considerations in any risk-based decisions and so with that in mind, the following risk appetite themes and descriptions below have been determined by the Board after considering key negative and positive events that might affect the achievement of the Health Board's objectives.

People

Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of the Health Board's People Strategy which would include culture & wellbeing.

The Health Board will continue to provide and review creative opportunities to develop and grow its workforce, building the operational capability and skills needed to deliver its strategic priorities. To do this the Health Board recognises that its risk appetite will need to be **open**, exploring new innovative workforce models, innovative ways of working and recruitment while always being aligned to positive culture and promoting wellbeing.

Aneurin Bevan University Health Board Activities (Compliance & Safety)

Risks relating to all aspects of patient safety but also including safeguarding, staff & public security, in addition risks relating to compliance and/or legal implications.

Compliance, safety & security is of the utmost importance. To reflect this the Health Board has a **minimal** risk appetite when making decisions about any matter or risk that may influence compliance, legality, patient harm & safety including safeguarding.

Aneurin Bevan University Health Board Activities (Service Delivery)

Risks relating to all aspects of the Health Board's ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of the organisation's infrastructure such as IM&T and Estates, including the Health Board's ability to deliver its associated strategy.

The Health Board will have an **open** risk appetite to service delivery. This openness will be reflected in decisions that increase the likelihood of creative, innovative, and positive outcomes but also encompass wider improvements to service delivery models, including the use of IT and new technology, acknowledging that investment of resource needed to purchase equipment or deliver successful projects can be significant and must be managed appropriately.

Financial Sustainability

Risks relating to all aspects of the Health Board's financial performance and its ability to manage cost and efficiencies.

The Health Board's risk appetite for effective financial management is **cautious** as making sure there is sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While the Health Board is more receptive in its approach to risk, it shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.

Transformation & Partnership Working

All risks relating to the Health Board's ability to engage effectively with other organisations, including development of collaborations and partnerships, along with all risks associated with innovation, transformation, and strategic change.

The Health Board will be **open** in its risk appetite to transformation and when working with local authorities, healthcare partners and other agencies to improve the health of the population. It is acknowledged that risk exposure may exist in decisions to transform and work with others, so the Health Board shall be conscious of those risks that could have quality, reputational and safety implications for patients and/or the organisation.

Confidence & Trust

All risks relating to confidence and trust in the Health Board, including risks relating to key stakeholders, communities and adapting to external challenges.

The Health Board's natural position is to not tolerate risks that breakdown or impact confidence & trust. Building on and maintaining the confidence and trust of all stakeholders, including staff is vital, so to highlight both the complexity and importance of transparency, the Health Board shall be **cautious** to any risk or opportunity that may influence that confidence and/or trust.

RISK APPETITE REVIEW

The Health Board will review its risk appetite on an annual basis, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks the Health Board is prepared to take.

The Health Board's Risk Appetite Statement will remain an integral part of its Risk Management Framework and will be embedded into the organisation's risk management system.

MONITORING AND REPORTING

The Health Board will align existing risks with risk appetite themes. In addition, the Health Board will report the volume (including an approximation of cumulative exposure/risk clusters) of risks by risk theme vs risk appetite and develop a set of Key Risk Indicators, as appropriate, to help measure/inform risk appetite.

In order that the Health Board can understand its risk exposure in connection with the risk appetite themes and ensure an effective response, reporting will be undertaken in-line with the **Risk Management Procedure**. Risk register entries will be categorised by the risk appetite theme to enable the Health Board to understand the type, nature, and volume of risk attributable to each risk appetite theme.

APPENDIX A – Risk Appetite Summary Table

RISK APPETITE	Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
	Aneurin Bevan University Health Board Activities (Compliance & Safety)	Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls	Score 8 and below
	Aneurin Bevan University Health Board Activities (Service Delivery)	Open	Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure	Score 17 and below
	People	Open		
	Transformation and Partnership working	Open		
	Financial Sustainability	Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls	Score 13 and below
	Confidence and Trust	Cautious		

SRR Ref: TBC	Risk Theme : Use the Risk Appetite Statement Please identify the relevant risk appetite theme to determine the applicable appetite level and risk score threshold						Publication Status	Open / Closed
Link to IMTP / Annual Plan	USE IMTP 2025 - 28 Please identify the specific IMTP objective(s), priority(ies) or deliverables that may be adversely impacted by this risk.							
EVENT <i>(There is a risk)</i>	There is a risk							
CAUSE <i>(Due to / caused by)</i>	Due to					Risk Appetite Level – when you have determined the ‘Theme’ from the ink in the top row, this information can be populated		
IMPACT <i>(Consequences of the Cause)</i>	<u>Patient/Public</u>	<u>Staff</u>	<u>Organisation</u>	Risk Appetite Threshold –				
				SUMMARY				
Executive Director		Risk Exposure	Inherent Risk Score (First identified)	Current Risk Score (With current controls)	Target Risk Score (Enhanced controls)	Trajectory of the risk Increasing Decreasing Stable	CG Team to add a Run Chart to show risk movement over time	
Monitoring Forum		Likelihood						
Last Reviewed		Impact						
Next Review <i>(determined by risk score)</i>		Risk rating						

Strategic Objective <i>(Which strategic objective could be adversely affected should this risk materialise?)</i>	Control <i>(What key controls are currently in place to manage the risk?)</i>	Control Effectiveness <i>(How effective is the control?)</i>	Assurance Evidence <i>(What evidence demonstrates the control is operating effectively? [3 Lines Model])</i>	Assurance Opinion <i>(How confident are we that the control is effective?)</i>	Gap In Assurance <i>(What information or evidence is missing that limits confidence in the control?)</i>	Further Action to Address Gaps in Assurance <i>(What action is required to strengthen assurance or address identified gaps?)</i>
EXAMPLE Improve Workforce Retention	Retention Programme	Partially Effective	- Turnover rates - Staff establishment figures - Exit interviews - Retention stories - Staff survey - Oversight Executive Committee and People & Culture Committee - Internal Audit Outcome Reports - Audit Wales Independent assessment of workforce arrangements	Reasonable	Limited evidence demonstrating the impact of retention initiatives on workforce stability, turnover reduction and retention of staff in priority workforce groups.	Develop and implement a retention effectiveness framework linking retention initiatives to measurable workforce outcomes, including turnover, vacancy levels, staff experience and retention of key workforce groups, with quarterly reporting through existing governance arrangements.
Overall Assurance Rating: Limited – Reasonable – Positive – Substantial <i>(Delete as appropriate. Amend the row colour to the text)</i>						

Control	Actions to Improve Control Effectiveness <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i>	Timeframe <i>(Indicate whether it is Short, Medium, or Long-Term)</i>
Example Retention Programme	- Career pathway development - Succession planning - HCSW retention plan - New starter feedback mechanisms	

Control Rating	Description
Effective	The control is operating as intended and there is evidence that it is reducing the likelihood and/or impact of the risk.
Partially Effective	The control is operating but does not fully address the risk, is not consistently applied, or evidence of effectiveness is mixed.
Ineffective	The control is not operating as intended, is not consistently applied, or there is little evidence that it is reducing the risk.

Assurance Rating	Criteria
Positive	Multiple sources of evidence demonstrate the control is consistently effective. Independent assurance supports the conclusion.
Reasonable	Evidence demonstrates the control is generally effective, although some gaps or weaknesses exist.
Limited	Some evidence exists, but it is incomplete, inconsistent or does not fully demonstrate effectiveness.
No Assurance	Little or no evidence exists that the control is effective.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Post Payment Verification (PPV) End of Year Report 2025-2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe – Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Legge Post Payment Verification (PPV) Manager

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specifications and relevant legislation.

The report details specific risks but provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits.

Cefndir / Background

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): We progressed well this year with our GMS routine visits and all are either closed or in progress by the end of this financial year.

Beginning 2026/2027 we will be concentrating the first quarter on GMS visits only and incorporating both revisits and the practice routine visit. This is part of our ongoing recovery plan. Some vaccination claims are now being claimed on the Welsh Immunisation System (WIS) and due to PPV highlighting the issues we found whilst conducting our verification checks, new internal process changes have been implemented to stop the duplicate vaccination payments prior to payment and not post payment, which is beneficial to everyone.

General Ophthalmic Services (GOS): The visit plans for GOS 2025-2026 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We have had to still carry out elements of physical visits too, as not all contractors are electronic.

In 2025/2026, we verified claims for an additional 2 services, which were the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5). These checks have been going well with learning shared with our contractors and our teams.

General Pharmacy Services (GPS): In 2025-2026, the PPV team undertook checks on the Collaborative Working Scheme along with the Quality and Safety Scheme which we conduct remotely by verifying the data we hold against the evidence that we request from the contractors. This again has been positive for all HB, PPV team and contractor learning.

Additional Service: The quarterly dispensing data checks were completed, and we introduced a robust service moving forward into the new financial year, which resulted in financial recoveries. The results for the dispensing practices in Aneurin Bevan University Health Board have been added to PPV reports.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our WGOS contractors into our clinical waste process in the next financial year.

Meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks. The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services. The team also arrange quarterly National GMS, GOS Working Group meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training requirements continue to be delivered to Health Boards and contractors, whenever needed and we also facilitate one-on-one training requirements when requested, particularly for new practice staff within the Primary Care setting.

We currently have our data analysts looking at producing some PPV dashboards with information for submission to future committee meetings.

Argymhelliad / Recommendation

It is recommended that the Audit & Risk Assurance Committee Members note the contents of this report. There are no options included in this report. The report is for Assurance.

The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

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):	Not Applicable Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

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

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

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

Audit Report - 1st April 2025 to 31st March 2026 = Aneurin Bevan University Health Board

General Medical Services (GMS)	ABUHB							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress/completed	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress/completed	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2024 - 2025	Combined		31				£23,385.49		202			£257,073.67
GMS 2025-2026	Routine	26	26	577	£18,589.28	£20,388.13	£38,977.41	103	102	£80,912.90	£72,691.84	£153,604.74
	Revisit	14	9	259	£9,185.10	£733.17	£9,918.27	148	54	£37,048.01	£5,736.38	£42,784.39
	TOTAL	40	35	836	£27,774.38	£21,121.30	£48,895.68	251	156	£117,960.91	£78,428.22	£196,389.13

General Ophthalmic Services (GOS)	ABUHB					ALL WALES		
	Visit Type	Annual Visits Planned	No. In progress/Completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	All Wales Value of Recoveries
GOS 2024-2025	Combined		18		£1,976.15		100	£16,316.67
GOS 2025-2026	Routine	20	20	86	£3,400.86	168	127	£12,939.39
	Revisit	3	3	38	£1,491.39	11	9	£583.84
	TOTAL	23	23	124	£4,892.25	179	136	£13,523.23

General Pharmacy Services (GPS)	ABUHB					ALL WALES			
	Visit Type	Annual Visits Planned	No. In progress/completed	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress/completed	No. Recoveries	All Wales Value of Recoveries
GPS 2024 - 2025	Combined	37	37		£10,745.90		238		£48,153.27
GPS 2025 - 2026	Routine	34	34	4 pending	£5,143.24	232	200	Pending	Pending
	TOTAL	34							

New Recovery process					
	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
DISPENSING 2025-2026	Quarter 4 2024/25 (Jan to Mar 2025)	12	£2,872.30	64	£24,444.29
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy					

GMS Summary								
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Routine	161	2	1.24%	£127.30	£0.00	£127.30	2x DOAC/DOAR
Practice 2	Revisit	379	3	0.79%	£202.50	£0.00	£202.50	3x Care Homes
Practice 3	Routine	189	15	7.94%	£459.00	£0.00	£459.00	5x Care Homes, 4x Flu, 5x Immunisations, 1x Pertussis
Practice 4	Revisit	126	36	28.57%	£911.05	£33.82	£944.87	36x Denosumab (2x Denosumab duplicates)
Practice 5	Routine	368	18	4.89%	£576.85	£238.60	£815.45	2x Contraceptives, 3x Lithium, 1x Minor Surgery, 5x Near Patient Testing, 5x DOAC/DOAR, 2x Administration of Gonadorelins (22x Flu, 1x Lithium, 1x Pertussis duplicates)
Practice 6	Routine	366	3	0.82%	£80.12	£787.36	£867.48	1x Near Patient Testing, 2x Administration of Gonadorelins (1x Flu, 27x Administration of Gonadorelins duplicates)
Practice 7	Routine	292	80	27.40%	£1,922.16	£130.39	£2,052.55	13x Asylum Seekers, 7x Care Homes, 1x Contraceptives, 9x Denosumab, 20x Immunisations, 27x Near Patient Testing, 3x Administration of Gonadorelins (11x Immunisations, 2x Flu duplicates)
Practice 8	Routine	471	22	4.67%	£985.01	£915.23	£1,900.24	5x Asylum Seekers, 8x Care Homes, 1x Flu, 2x Immunisations, 1x Learning Disabilities, 1x Near Patient Testing, 4x DOAC/DOAR (21x Administration of Gonadorelins, 2x Flu, 10x Near Patient Testing, 1x DOAC/DOAR, 1x Pneumococcal, 1x Unscheduled Vaccinations duplicates)
Practice 9	Routine	386	7	1.81%	£526.98	£40.12	£567.10	2x Learning Disabilities, 3x Minor Surgery, 1x DOAC/DOAR, 1x Transgender (1x Flu, 3x Non-routine Immunisations duplicates)
Practice 10	Revisit	27	0	0.00%	£0.00	£0.00	£0.00	All claims verified. No recoveries.
Practice 11	Routine	257	14	5.45%	£438.09	£275.42	£713.51	3x Care Homes, 4x Flu, 1x Immunisations, 2x Near Patient Testing, 4x DOAC/DOAR (2x Care Homes, 10x Flu, 3x Immunisations duplicates)
Practice 12	Routine	377	14	3.71%	£740.17	£289.16	£1,029.33	2x Near Patient Testing, 12x DOAC/DOAR (1x Care Homes, 1x Administration of Gonadorelins, 7x Near Pateint Testing, 1x DOAC/DOAR duplicates)
Practice 13	Revisit	924	59	6.39%	£2,177.96	£70.17	£2,248.13	1x INR - Warfarin, 58x DOAC/DOAR (1x DOAC/DOAR duplicate)
Practice 14	Routine	320	6	1.88%	£85.20	£127.80	£213.00	4x Immunisations, 2x Near Patient Testing (10x Flu, 1x Transgender duplicates)
Practice 15	Routine	332	56	16.87%	£1,393.38	#####	#####	1x Contraceptives, 2x Denosumab, 7x Flu, 11x Immunisations, 1x Learning Disabilities, 1x Lithium, 6x Near Patient Testing, 14x DOAC/DOAR, 6x Pertussis, 1x Substance Misuse, 6x Administration of Gonadorelins (2x Diabetes, 4x Administration of Gonadorelins, 499x Flu, 179x DOAC/DOAR, 4x Substance Misuse, 1x INR - Warfarin duplicates)
Practice 16	Routine	370	45	12.16%	£1,165.56	£700.49	£1,866.05	1x Contraceptives, 4x Denosumab, 7x Immunisations, 1x Minor Surgery, 2x DOAC/DOAR, 28x Ukrainian Refugees Ongoing Care 2x Administration of Gonadorelins (49x Flu, 1x Care Home, 3x Administration of Gonadorelins, 5x RSV duplicates)
Practice 17	Routine	212	27	12.74%	£1,183.07	£147.85	£1,330.92	2x Flu, 3x Immunisations, 1x INR-Warfarin, 2x Near Patient Testing, 2x DOAC/DOAR, 13x Transgender, 4x Administration of Gonadorelins (8x Flu, 1x Rotavirus, 2x Gonadorelins duplicates)
Practice 18	Routine	416	17	4.09%	£706.94	£80.20	£787.14	2x Care Homes, 2x Immunisations, 5x INR- Warfarin, 2x Near Patient Testing, 5x DOAC/DOAR, 1x Administration of Gonadorelins (1x Flu, 1x DOAC/DOAR duplicates)

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

Practice 19	Routine	330	20	6.06%	£293.71	£87.65	£381.36	10x Asylum Seekers , 2x Flu, 5x Immunisations , 3x Near Patient Testing (5x Flu, 1x Warfarin duplicates)
Practice 20	Routine	237	3	1.27%	£45.56	£0.00	£45.56	1x Asylum Seekers, 1x Flu, 1x Near Patient Testing
Practice 21	Revisit	2554	85	3.33%	£881.30	£561.68	£1,442.98	3x Asylum Seekers , 1x Denosumab, 14x Flu, 67x Immunisations (56x Flu duplicates)
Practice 22	Routine	395	53	13.42%	£1,631.75	£22.22	£1,653.97	4x Asylum Seekers , 4x Care Homes , 2x Contraceptives, 1x Flu, 10x Immunisations , 2x Extended Minor Surgery, 3x Minor Surgery , 2x Near Patient Testing, 4x DOAC/DOAR , 2x Pertussis, 17x Ukrainian Refugees , 2x Administration of Gonadorelins (1x Contraceptive duplicate)
Practice 23	Revisit	314	9	2.87%	£147.74	£67.50	£215.24	1x Care Home, 8x Immunisations (1x Care Home duplicate)
Practice 24	Revisit	508	56	11.02%	£4,394.34	£0.00	£4,394.34	3x Minor Surgery, 16x DOAC/DOAR, 37x Ukrainian Refugees
Practice 25	Revisit	635	7	1.10%	£70.21	£0.00	£70.21	7x Flu
Practice 26	Routine	296	15	5.07%	£483.42	£1,301.67	£1,785.09	2x Contraceptives, 4x Denosumab , 4x Immunisations, 1x Learning Disabilities, 1x Minor Surgery, 1x DOAC/DOAR, 1x Pertussis, 1x Administration of Gonadorelins (25x Contraceptives, 1x Immunisations, 2x Administration of Gonadorelins duplicates)
Practice 27	AD HOC	4	4	100.00%	£400.00	£0.00	£400.00	4x Ukrainian refuggess Initial Assessments
Practice 28	Routine	376	18	4.79%	£573.66	£621.86	£1,195.52	1x Care Homes, 3x Denosumab , 5x Immunisations , 1x Learning Diasbilities, 1x RSV, 6x DOAC/DOAR , 1x Transgender (6x Flu duplicates)
Practice 29	Routine	329	44	13.37%	£2,437.51	£1,614.23	£4,051.74	9x Care Homes , 4x Flu , 1x INR-Warfarin, 20x Minor Surgery , 1x DOAC/DOAR, 9x Pertussis (1x Pneumococcal, 20x Flu, 40x DOAC/DOAR duplicates)
Practice 30	Routine	310	48	15.48%	£1,289.34	£137.82	£1,427.16	3x Care Homes, 9x Denosumab ,17x Immunisations, 3x INR-Warfarin , 1x Minor Surgery, 1x Near Patient Testing, 9x DOAC/DOAR , 1x Pertussis, 4x Administration of Gonadorelins (2x Administration f Gonadorelins, 1x Flu, 7x Rotavirus duplicates)
Practice 31	Routine	290	23	7.93%	£450.66	£0.00	£450.66	1x Flu, 8x Immunisations , 7x Lithium , 5x Minor Surgery , 2x Near Patient Testing
Practice 32	Routine	486	27	5.56%	£993.84	£869.68	£1,863.52	9x Asylum Seekers , 2x Contraceptives, 1x Covid, 2x Denosumab , 2x Homeless, 2x Immunisations, 3x INR - Warfarin , 5x Learning Diasbilities , 2x DOAC/DOAR (5x Extended Minor Surgery, 1x Administration of Gonadorelins, 1x Learning Disabilities, 29x Immunisations duplicates)
Practice 33	Routine	In progress						
Practice 34	Routine	In progress						
Practice 35	Routine	In progress						



GOS Summary									
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery		Breakdown of Recoveries and individual services with 10% or more error rate		Advisory Notes
Practice 1	Routine	103	7	6.80%	£95.13		GOS 4W claims.		• The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to change due to ad
Practice 2	Routine	103	5	4.85%	£111.25		GOS 4W claims.		

Practice 3	Routine	103	0	0.00%	£0.00
Practice 4	Routine	103	4	3.88%	£176.00
Practice 5	Routine	103	5	4.85%	£198.00
Practice 6	Routine	103	5	4.85%	£492.23
Practice 7	Routine	103	0	0.00%	£0.00
Practice 8	Revisit	300	21	7.00%	£707.72
Practice 9	Routine	103	2	1.94%	£172.14
Practice 10	Routine	103	0	0.00%	£0.00
Practice 11	Routine	103	0	0.00%	£0.00
Practice 12	Routine	103	13	12.62%	£962.46
Practice 13	Routine	103	0	0.00%	£0.00
Practice 14	Routine	103	0	0.00%	£0.00
Practice 15	Revisit	300	17	5.67%	£783.67
Practice 16	Routine	103	9	8.74%	£252.53
Practice 17	Routine	103	2	1.94%	£22.37
Practice 18	Routine	103	3	2.91%	£149.53
Practice 19	Routine	103	24	23.30%	£583.25
Practice 20	Routine	103	4	3.88%	£65.36
Practice 21	Routine	103	2	1.94%	£94.00
Practice 22	Routine	103	1	0.97%	£26.61
Practice 23	Revisit	96	0	0.00%	£0.00

All claims verified.
WGOS 2 claims. Claim recovery under 10% per service.
GOS 4W and WGOS 2 claims.
WGOS 2 and WGOS 5 claims.
All claims verified.
WGOS 2 claim. Claim recovery under 10% per service.
GOS 3W and WGOS 2 claims. Claim recovery under 10% per service.
All claims verified.
All claims verified.
GOS 3W, GOS 4W , WGOS 2, WGOS 4 and WGOS 5 claims.
All claims verified.
All claims verified.
WGOS 2 claims. Claim recovery under 10% per service.
GOS 3W, GOS 4W and WGOS 4 claims.
GOS 4W claims. Claim recovery under 10% per service.
GOS 4W and WGOS 5 claims. Claim recovery under 10% per service.
GOS 4W and WGOS 2 claims.
GOS 4W and WGOS 2 claims. Claim recovery under 10% per service.
GOS 4W and WGOS 2 claims. Claim recovery under 10% per service.
WGOS 2 claim. Claim recovery under 10% per service.
All claims verified.

hoc visits or closures/mergers.

• As contractors are transitioning to electronic records, remote access and physical visits are progressing well

GPS Summary				Advisory Notes	
PRACTICE	In progress	Closed	Value of recovery	Awaiting further evidence for 6 practices. Out of 45 planned visits 11 have been postponed due to change of ownership. All Wales recoveries are pending due to finalising reports. We do not begin GPS work until the second quarter of the financial year.	
Practice 1		Y	£0.00		
Practice 2		Y	£0.00		
Practice 3	Y				
Practice 4		Y	£0.00		
Practice 5		Y	£0.00		
Practice 6		Y	£0.00		
Practice 7		Y	£1,519.52		
Practice 8		Y	£0.00		
Practice 9		Y	£0.00		
Practice 10		Y	£0.00		
Practice 11		Y	£1,519.52		
Practice 12		Y	£0.00		
Practice 13		Y	£0.00		
Practice 14		Y	£934.84		
Practice 15		Y	£0.00		
Practice 16		Y	£0.00		
Practice 17	Y				
Practice 18	Y				
Practice 19		Y	£0.00		
Practice 20		Y	£0.00		
Practice 21		Y	£0.00		
Practice 22		Y	£0.00		
Practice 23		Y	£0.00		
Practice 24	Y				
Practice 25		Y	£1,169.36		
Practice 26		Y	£0.00		
Practice 27		Y	£0.00		
Practice 28		Y	£0.00		
Practice 29	Y				
Practice 30	Y				
Practice 31		Y	£0.00		
Practice 32		Y	£0.00		
Practice 33		Y	£0.00		
Practice 34		Y	£0.00		



GIG
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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Plan 2026/27 Annual Clinical Audit Activity Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Stimpson – National Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Clinical audit is one tool available for assessing whether clinical services are safe and effective. It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care. The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes.

This paper presents a refreshed and strengthened Clinical Audit Activity Report and Forward Plan for 2026–27, building on delivery during 2025–26 and responding to feedback from QMG, PQSOC and Board discussions. The intention is to move the audit programme further from a description of activity towards a clearer narrative of assurance, learning and improvement.

Aligned to the established governance structure for clinical audit, which provides oversight and reporting through the Quality Management Group (QMG), the Patient Quality, Safety and Outcomes Committee (PQSOC), and ultimately the Audit and Risk Assurance Committee (ARAC), these papers have progressed through each level of scrutiny. They were endorsed by QMG, formally discussed and subsequently ratified at PQSOC on 3rd June. Collectively, they now provide robust and triangulated assurance to ARAC on the delivery of the 2026/27 clinical audit plan, while also demonstrating measurable progress from the 2025/26 audit plan through the production of a comprehensive annual report.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP), published annually by Welsh Government, remains a key mechanism for driving improvement in the quality, safety, and effectiveness of healthcare across Wales. It sets out the national expectations for participation in clinical audit and outcome review programmes, enabling organisations to systematically assess compliance with evidence-based standards and demonstrate year-on-year improvement in patient outcomes.

The Health Board's Clinical Audit Plan for 2026–27 is aligned to NCAORP and supports delivery of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). As a core component of Pillar Three – Clinical Effectiveness within the Quality Strategy, clinical audit provides structured assurance that care is delivered in line with national standards and best practice.

The programme continues to strengthen its contribution to organisational assurance through a more standardised, transparent, and risk-based approach to audit delivery, reporting, and governance.

Key developments this year have included:

- Further standardisation of audit reporting, through the introduction of consistent templates, enabling improved scrutiny of findings, clearer articulation of risk, and strengthened oversight of action plans
- Further development and optimisation of the Audit Management and Tracking system (AMaT), enabling end-to-end management of the audit cycle, including audit registration, data collection, reporting, action planning, and re-audit within a single system, improving visibility, accountability, and assurance
- Improved divisional engagement and governance, supported by structured reporting cycles, forward planning of audit submissions, and strengthened visibility of audit activity at Directorate and Divisional level
- Strengthened governance and escalation arrangements, ensuring clinical audit is embedded within established committee structures, including the Clinical Standards and Effectiveness Group (CSEG), Quality Management

Group (QMG), Patient Quality and Safety Outcomes Committee (PQSOC), and Audit, Risk and Assurance Committee (ARAC), enabling robust scrutiny and Board-level assurance

All clinical audit activity is required to be recorded on AMaT, providing a single source of truth for audit data across the Health Board. The system supports the development of standardised audit tools, capture of audit findings, and production of SMART improvement plans, ensuring a consistent and auditable approach to quality improvement.

Asesiad / Assessment

Clinical Audit – Strengthening Assurance and Driving Improvement

For 2026–27, the Clinical Audit Programme, led by the Medical Director’s Clinical Audit Team, will be positioned as a core component of the Health Board’s Quality Management System (QMS), providing strengthened and systematic assurance to the Board and its Committees on the quality, safety and effectiveness of care.

Aligned to Pillar Three – Clinical Effectiveness, the programme will ensure that audit activity consistently tests compliance against evidence-based standards and best practice, providing robust assurance that care is safe, effective and continuously improving.

This will be delivered through a more mature, risk-based and governance-driven approach, including:

- Risk-based prioritisation of audit activity, ensuring focus on areas of highest patient safety concern, unwarranted variation and known organisational risks, strengthening the Board’s line of sight on key quality issues
- Robust accountability and governance arrangements, with clear ownership of audit findings, strengthened oversight of improvement plans, and formal escalation where standards are not met
- A strengthened focus on demonstrable impact, ensuring the audit cycle is completed through re-audit, providing explicit evidence of improvement, sustainability of change, and impact on patient outcomes

There is now a well-defined and embedded process for the scrutiny of National Clinical Audit reports, supported by standardised reporting through AMaT. This enables consistent identification of good practice, areas requiring improvement, and the development of clear, SMART action plans, improving both transparency and the quality of assurance provided.

The Clinical Audit Team continues to enhance the use of AMaT as a single source of truth for audit activity across the organisation, including the development of

organisational and governance structures within the system to support full participation, monitoring of progress, and visibility of improvement actions. This includes the ability to identify where there are gaps in participation, delivery of improvement, or emerging risks, with clear escalation routes to ensure appropriate Executive oversight.

Strengthening Governance, SOPs and Escalation

To further enhance assurance, the Medical Director's Clinical Audit Team is strengthening Standard Operating Procedures (SOPs) and formal escalation processes, ensuring a consistent, transparent and systematised approach to managing audit findings across all Directorates and Divisions.

Key developments include:

- Standardised end-to-end SOPs, defining the audit lifecycle from identification of non-compliance through to action planning, delivery, re-audit and closure
- Defined escalation thresholds and triggers, ensuring that high-risk findings, failure to meet standards, delays in delivery, or lack of re-audit are escalated in a timely and proportionate manner
- Clear accountability and ownership, with named leads responsible for delivery of improvement actions at Directorate, Divisional and corporate level
- Formalised governance and escalation pathways, aligned to Divisional Quality and Safety Groups, the Clinical Standards and Effectiveness Group (CSEG), and the Patient Quality and Safety Outcomes Committee (PQSOC), ensuring appropriate scrutiny and oversight
- Integration with the organisational risk management framework, ensuring that significant audit findings inform risk registers and wider assurance processes
- Enhanced tracking and visibility through AMaT, enabling real-time monitoring of action delivery, identification of overdue actions, and a clear audit trail
- A strengthened focus on re-audit, ensuring that improvement is not assumed but evidenced, with escalation where sustained change is not demonstrated

Collectively, these developments significantly strengthen the organisation's ability to identify, manage and mitigate quality risks, whilst ensuring consistent and reliable assurance to the Board.

Delivering Participation, Compliance and Continuous Improvement

The Health Board remains mandated to participate in all National Clinical Audits. Where non-participation is identified, the Medical Director provides formal oversight and escalation to the relevant specialty, reinforcing accountability and ensuring that corrective action plans are developed and implemented. This

approach ensures compliance with national expectations and minimises gaps in assurance.

The Clinical Audit Team continues to work collaboratively with Divisions, clinicians, service managers and governance teams to ensure that audit programmes are aligned to clinical priorities, statutory and regulatory requirements, and Health Board objectives, while supporting frontline teams to use audit as a tool for improvement.

Looking Ahead – Strengthening the Role of Audit within the QMS

Over the next 12 months, alongside the refresh of the Quality Plan with an increased focus on Clinical Effectiveness, clinical audit will play an increasingly central role in providing integrated assurance on patient outcomes within the QMS.

This will include:

- Triangulation of audit findings with other data sources, including Value-Based Healthcare and Patient Experience data, to provide a more comprehensive and holistic view of service quality
- Systematic sharing of learning, through established forums such as the Learning and Improvement Forum, ensuring that insights from audit are disseminated and embedded across clinical services
- A continued focus on closing the audit loop, ensuring that audit not only identifies issues but demonstrably drives sustained improvement

Through these developments, the Medical Director's Clinical Audit Team is strengthening the role of clinical audit as both an assurance mechanism and a driver for continuous improvement, providing the Board with increased confidence that:

- Care is being delivered in line with evidence-based standards
- Risks are identified, escalated and managed in a timely and systematic way
- Improvement actions are delivered and sustained
- The impact of audit activity on patient outcomes is clearly evidenced

Attached appendices include:

- 1) Clinical Audit Plan 2026/27
- 2) Annual Clinical Audit Activity Report 2025/26

Argymhelliad / Recommendation

The Committee is asked to:

- Approve the Clinical Audit Plan for 2026–2027, noting its alignment to the Health Board’s Quality Management System and its role in providing assurance on clinical effectiveness
- Receive assurance from the 2025–2026 Clinical Audit Activity Report that robust arrangements are in place to deliver the clinical audit programme, including compliance with national requirements, effective participation in mandated audits, and the systematic identification, escalation, and management of risks arising from audit findings
- Take assurance that clinical audit activity is driving measurable improvement, through strengthened governance, delivery of action plans, and evidence of sustained change through re-audit, supporting the Health Board in meeting its statutory and regulatory obligations

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):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:
Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

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	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/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.



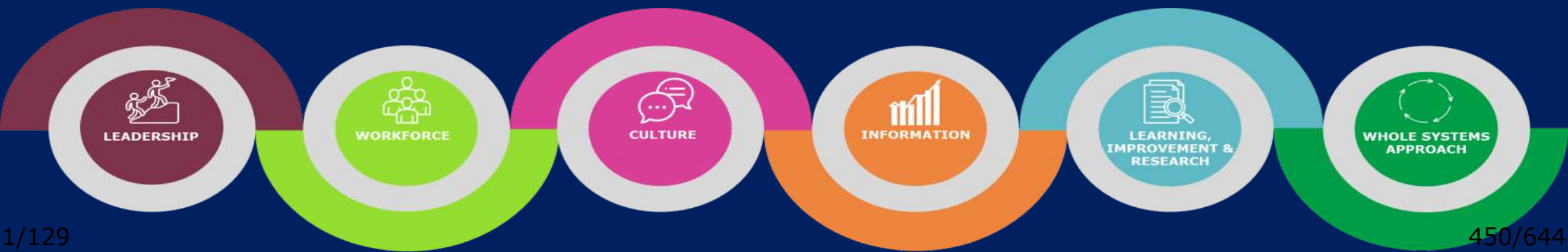
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National Clinical Audit Activity Report 2025/2026

Medical Director's Quality & Patient Safety Team

June 2026



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Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report for 2025/2026

- This report provides a comprehensive and transparent account of Aneurin Bevan University Health Board's clinical audit activity during 2025/2026 and demonstrates the continued importance of mandatory participation in the National Clinical Audit Programme. Through sustained engagement over the past 12 months, the Health Board has been able to assess clinical performance against recognised national standards, benchmark outcomes, and provide robust assurance on the quality, safety, and effectiveness of care.
- Clinical audit remains a cornerstone of improving health and care services across Aneurin Bevan University Health Board and Wales. By systematically reviewing clinical practice against evidence-based standards, clinical audit supports the delivery of safe, effective, and reliable care—ensuring that people receive the right care, in the right way, at the right time. The continuous cycle of audit, action planning, and re-audit provides assurance on current performance while also acting as a key driver of meaningful and sustained improvement across medical, surgical, and mental health services.
- Within Aneurin Bevan University Health Board, clinical audit is embedded as a core component of clinical effectiveness and aligned with the Duty of Quality, ensuring that healthcare delivery is underpinned by the best available evidence. Participation in the National Clinical Audit Programme enables objective scrutiny of services and strengthens transparency, accountability, and consistency in how care is reviewed and improved. Robust audit activity supports the identification of variation and risk, enables evidence-based change, and ensures that improvement efforts are focused where they can have the greatest impact.



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Progress – Compliance with the National Clinical Audit Programme

- Audit priorities are informed by both national and local drivers, including Quality Statements, National Service Frameworks, incident reporting, and the implementation of best-practice guidance. Through structured participation in national clinical audits, services are supported to translate findings into meaningful, measurable actions that align with Health Board priorities and national expectations. The engagement and commitment of clinical teams are central to this process, ensuring that audit findings are clinically owned and that learning is embedded within Directorates and Divisions.
- This report sets out the Health Board's achievements, challenges, and ongoing priorities in advancing high-quality, safe, and effective care for the population of Gwent, as detailed in the [GWENT 35 – Our Ten Year Strategy](#). It demonstrates how delivery of the Clinical Audit Plan and participation in the National Clinical Audit Programme support learning at both service and organisational level, strengthen governance and assurance arrangements, and enable quality improvement at scale. Through clinical audit, the Health Board is able to:
 - Improve the delivery of high-quality, safe, and effective care for patients
 - Support cost-effective and sustainable clinical services through evidence-based decision-making
 - Strengthen engagement and clinical ownership of national audit participation
 - Demonstrate compliance with NHS Wales, Health and Social Services, and Public Health Wales requirements
 - Provide assurance through robust, consistent, and transparent quality reporting
 - Drive improvement initiatives aligned to Health Board priorities
 - Evidence NICE compliance and support the consistent adoption of best practice



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Clinical Audit: Improving Quality, Safety and Patient Care

- For Aneurin Bevan University Health Board, delivery of the clinical audit programme has strengthened Health Board learning and assurance. The standardisation of reporting processes, consistent documentation, and systematic recording of audit activity have improved visibility and comparability of audit findings across services.
- The use of AMaT to coordinate audit activity and to log and monitor SMART action plans has enhanced the Health Board's ability to track progress over time, follow through on audit recommendations, and understand where improvements have been delivered and where residual risks remain.
- Crucially, the programme's success has been underpinned by strong partnership working between the Clinical Audit Team and clinical leads. This ensures audit findings are clinically owned and that learning flows back into Directorates to inform local improvement and decision-making.



- This creates a clear line of sight between national audit participation, local action, and organisational risk and assurance, supporting informed oversight through established governance forums.



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- Learning from clinical audit is embedded within the Quality Management System, supporting both improvement and assurance.
- Positioning clinical effectiveness as pillar three of the Six Pillars of Quality has further raised the profile of clinical audit and the National Clinical Audit Programme, strengthening expectations around participation, consistency, and robust reporting. As a result, national clinical audit performance and outcomes are now reported in a more structured and visible way, providing stronger assurance to the Health Board.
- The next phase of focus is on maximising the learning gained from audit activity by ensuring insights and improvement actions are consistently embedded within Directorates and Divisions. This will strengthen local ownership of improvement, enable shared learning, and ensure that participation in the National Clinical Audit Programme continues to translate into sustained changes in practice and improved outcomes for patients.



- Being a long-standing partner of the NHS, the Healthcare Quality Improvement Partnership (HQIP) has a strong understanding of the complex challenges faced by healthcare providers and commissioners. HQIP recognises that sustainable healthcare improvement requires an evidence-informed approach, supported by continuous learning and robust use of data, to transform services and improve patient outcomes.
- HQIP is responsible for managing and commissioning several national healthcare quality improvement programmes, including the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England and the Welsh Government. Participation in NCAPOP is a mandatory requirement under the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) 2025–2026. This enables benchmarking against national standards through transparent data submission in line with HQIP guidance. This supports the Health Board in demonstrating performance that meets or exceeds national outcomes.
- Aneurin Bevan University Health Board is continually strengthening its clinical audit capability to:
 - Empower clinical teams to use audit data to inform and drive improvement, including improving data literacy
 - Apply robust clinical audit methodologies to support benchmarking and the consistent embedding of evidence-based standards of care
 - Use clinical audit data to inform population-based commissioning decisions and integrated care strategies
 - Build organisational capability to embed the patient voice within quality improvement and service redesign



National Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) Team coordinates delivery of the Clinical Audit Plan with Clinical Leads, ensuring compliance with NCAPOP and the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP).
- Divisions are supported to deliver audits, with participation, findings, and actions consistently documented and tracked.
- The Clinical Standards and Effectiveness Group (CSEG) provides multidisciplinary operational oversight of clinical audit findings, including the identification of risks and opportunities for improvement.
- Key themes and risks are escalated to the Quality Management Group (QMG), ensuring learning from audit informs the wider Quality Management System.
- Board-level assurance is provided through the Patient Quality, Safety, and Outcomes Committee (PQSOC).
- The Audit, Risk, and Assurance Committee (ARAC) oversees the robustness of audit governance arrangements.
- Together, these routes ensure a clear line of sight from front-line audit activity to corporate risk and Board assurance.



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Overview of National Clinical Audits: 2025/26



Reporting of National Clinical Audits aligned to the Annual Audit Plan and dates presented to CSEG in 2025/2026:

HQIPO Ref.		Name of publication	Publication date	Proposed Date	Actual date
NICOR	National Audit of Cardiac Rhythm Management (NACRM)	2023/2024 & 2024/2025	11/12/2025	CSEG Sep 2025	CSEG Mar 2026
NICOR	Myocardial Ischaemia National Audit Project (MINAP)	2023/2024	01/04/2025	CSEG Sep 2025	CSEG Nov 2025
NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)	2023/2025	01/04/2025	CSEG Sep 2025	CSEG Nov 2025
NICOR	National Heart Failure Audit (NHFA)	2023/2026	01/04/2025	CSEG Sep 2025	CSEG Sep 2025
641	Fracture Liaison Service Database (FLSD)	State of the Nation report	08/01/2026	CSEG Mar 2026	CSEG Feb 2026
639	National Bowel Cancer Audit (NBOCA)	State of the Nation report (England & Wales)	09/10/2025	CSEG Nov 2025	CSEG Feb 2026
635	National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Mar 2026
632	National Metastatic Breast Cancer Audit (NAoMe)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Feb 2026
631	National Primary Breast Cancer Audit (NAoPri)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Feb 2026

HQIPO Ref.		Name of publication	Publication date	Proposed Date	Actual date
616	National Respiratory Audit Programme (NRAP)	State of the Nation report - Children and young people's asthma : Elements of care received by children admitted with near-fatal asthma	12/06/2025	No planned date	CSEG Feb 2026
605	National Emergency Laparotomy Audit (NELA)	State of the Nation report - Year 10	09/10/2025	No planned date	CSEG Jan 2026
583	National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation report 2026	09/10/2025	No planned date	CSEG Jan 2026
581	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal Mortality Surveillance 2025 State of the Nation report	12/06/2025	CSEG Nov 2025	CSEG Nov 2025
580	National Neonatal Audit Programme (NNAP)	State of the nation report 2026	09/10/2025	CSEG Nov 2025	CSEG Nov 2025
578	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	CSEG Nov 2025	CSEG Nov 2025
577	National Hip Fracture Database (NHFD)	State of the Nation report 2025	11/09/2025	CSEG Nov 2025	CSEG Nov 2025
576	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Annual report 2024	11/07/2025	CSEG Sep 2025	CSEG Sep 2025
574	National Vascular Registry (NVR)	State of the Nation 2025 report	13/11/2025	CSEG Jan 2026	CSEG Mar 2026
567	National Clinical Audit of Psychosis (NCAP)	State of the Nation report (Bespoke data)	13/02/2025	Previous year activity	CSEG May 2025

HQIPO Ref.		Name of publication	Publication date	Proposed Date	Actual date
545	National Maternity and Perinatal Audit (NMPA)	State of the Nation report (containing 5 years of data)	14/08/2025	No planned date	CSEG Nov 2025
535	National Paediatric Diabetes Audit (NPDA)	Annual Core State of the Nation Report (Year 3)	13/03/2025	Previous year activity	CSEG May 2025
519	National Lung Cancer Audit (NLCA)	State of the Nation report (England & Wales)	10/04/2025	No planned date	CSEG May 2025
501	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal confidential enquiry	12/12/2024	CSEG Nov 2025	CSEG Nov 2025
500	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	CSEG Nov 2025	CSEG Nov 2025
466	Sentinel Stroke National Audit Programme (SSNAP)	State of the Nation 2024	14/11/2024	Previous year activity	CSEG Sep 2025
464	National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (01/01/2022-31/12/2022 Eng, 01/01/2023-31/12/2023 Wales)	12/09/2024	Previous year activity	CSEG May 2025



National Clinical Audit – Actions within Aneurin Bevan University Health Board

National clinical audit reports provide evidence-based recommendations to support the delivery of best practice and greater standardisation of services across the United Kingdom. However, differences in service models and commissioning arrangements mean that recommendations must be considered in context to ensure they are appropriate and deliver meaningful improvement within NHS Wales.

Actions arising from national and locally agreed recommendations are recorded and monitored through AMaT by the Quality and Patient Safety Team. The pace of delivery varies depending on complexity, service pressures, and resource requirements, and it is common for actions to extend across audit cycles or for multiple reports to be reviewed concurrently. During 2025/2026, 27 national clinical audit reports were presented to CSEG. Of these, three reports had actions remaining open from the previous reporting period. These relate to: National Audit of Cardiac Rhythm Management (NACRM), the National Emergency Laparotomy Audit (NELA), and the National Hip Fracture Database (NHFD), where actions remain subject to ongoing resource, funding, or service model considerations. Continued oversight through governance forums ensures these actions remain visible and are progressed appropriately, providing assurance that learning from audit continues to inform improvement and risk management.

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Audit of Cardiac Rhythm Management (NACRM)	2023/24 & 2024/25 (two reports)	11/12/2025	CSEG Mar 2026	1				4	*1		6	31/03/2027	Open
Myocardial Ischaemia National Audit Project (MINAP)	2023/2024	01/04/2025	CSEG Nov 2025					2			2	01/06/2026	Open
National Audit of Percutaneous Coronary Interventions (NAPCI)	2023/2024	01/04/2025	CSEG Nov 2025	2				1	*1		4	30/06/2026	Open

*NACRM - Specialist services are commissioned outside of the Health Board therefore not within ABUHB control
*NAPCI - Lead interventional cardiology services are outside of ABUHB (C&VUHB)

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Heart Failure Audit (NHFA)	2023/2024	01/04/2025	CSEG Sep 2025	1	*1			14			16	30/11/2026	Open
Fracture Liaison Service Database (FLSD)	State of the Nation report	08/01/2026	CSEG Feb 2026	2				3			5	21/12/2026	Open
National Bowel Cancer Audit (NBOCA)	State of the Nation report (England & Wales)	09/10/2025	CSEG Feb 2026	4				1			5	31/07/2027	Open
National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (England & Wales)	11/09/2025	CSEG Mar 2026	1				1			2	01/07/2026	Open
National Metastatic Breast Cancer Audit (NAoMe)	State of the Nation report (England & Wales)	11/09/2025	CSEG Feb 2026	1				6			7	24/08/2026	Open
National Primary Breast Cancer Audit (NAoPri)	State of the Nation report (England & Wales)	11/09/2025	CSEG Feb 2026	2				5			7	24/08/2026	Open
National Respiratory Audit Programme (NRAP)	State of the Nation report - Children and young people's asthma : Elements of care received by children admitted with near-fatal asthma	12/06/2025	CSEG Feb 2026	3							3	N/A	Closed
National Emergency Laparotomy Audit (NELA)	State of the Nation report - Year 10	09/10/2025	CSEG Jan 2026					3			3	31/08/2026	Open

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation report 2026	09/10/2025	CSEG Jan 2026	1							1	N/A	Closed
National Neonatal Audit Programme (NNAP)	State of the nation report 2026	09/10/2025	CSEG Nov 2025					2			2	01/09/2026	Open
National Hip Fracture Database (NHFD)	State of the Nation report 2025	11/09/2025	CSEG Nov 2025	1				4			5	01/06/2026	Open
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Annual report 2024	11/07/2025	CSEG Sep 2025	1					*1		2	N/A	Closed
National Vascular Registry (NVR)	State of the Nation 2025 report	13/11/2025	CSEG Mar 2026	1							1	N/A	Closed
National Clinical Audit of Psychosis (NCAP)	State of the Nation report (Bespoke data)	13/02/2025	CSEG May 2025	6							6	N/A	Closed
National Maternity and Perinatal Audit (NMPA)	State of the Nation report (containing 5 years of data)	14/08/2025	CSEG Nov 2025	5	*1			3			6	31/05/2026	Open
National Paediatric Diabetes Audit (NPDA)	Annual Core State of the Nation Report (Year 3)	13/03/2025	CSEG May 2025						*1		1	27/11/2025	Open

*EP12 – This action relates to the EEG waiting times, which has been raised across two specialties, Paediatrics and Neurophysiology
*NPDA – The business case was for additional staffing, but did not consider the staffing required from increased workloads
*NMPA – Part of the action remains in the control of HEIW and NHS Wales

Project name		Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Lung Cancer Audit (NLCA)		State of the Nation report (England & Wales)	10/04/2025	CSEG May 2025	4					*3		7	N/A	Closed
Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal Mortality Surveillance 2025 State of the Nation report		12/06/2025	CSEG Nov 2025	3				3			6	31/05/2026	Closed
	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report		09/10/2025											Closed
	Perinatal confidential enquiry		12/12/2024											Closed
	Saving lives, improving mothers care report (2021-2023, UK wide)		10/10/2024											Closed
Sentinel Stroke National Audit Programme (SSNAP)		State of the Nation 2024	14/11/2024	CSEG Sep 2025	1					*3		4	N/A	Closed
National Non-Hodgkin Lymphoma Audit (NNHLA)		State of the Nation report 01/01/2023-31/12/2023 Wales)	12/09/2024	CSEG May 2025	N/A as first round of audit (also presented in Mar 2026 – See above)									

*NLCA - 1 - National roll out inhibiting this action. ABUHB Clinical Lead joined National Steering Committee for implementation of new enterprise.
2 - This is a combine action between C&VUHB, WG, Velindre and AWMGS and affected by national resource shortages
3 – This measure is dictated by All Wales Medical Genomics Service at national level

*SSNAP - Key Changes in Stroke metrics anticipated to impact negatively on all stroke centres

Fully complete	40	42%
Partially complete (open)	2	2%
Partially complete (overdue)	0	0%
Overdue	0	0%

New/Ongoing	49	52%
Unable to complete	10	11%
Action no longer relevant	0	0%
	95	

New/ongoing actions are chased by the QPS team on a regular basis. One processes does not fit all actions, so they are managed individually and AMaT is updated to reflect accurate results.

National Clinical Audit – Assurance and Risk

Clinical Leads are responsible for determining the appropriate level of service assurance and assigning the associated risk rating for each audit. They also decide whether the audit should be recorded on the relevant divisional or directorate risk register. CSEG subsequently reviews these assessments and agrees whether escalation to the corporate risk register is required. For the 27 audits presented to CSEG during 2025/2026, the agreed assurance and risk ratings were as follows:



Project name	Assurance Level	Risk Level	Risk Register
Sentinel Stroke National Audit Programme (SSNAP)	Limited	Major	Yes
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Limited	Major	Yes
National Respiratory Audit Programme (NRAP)	Significant	Moderate	No
National Hip Fracture Database (NHFD)	Limited	Moderate	No
Myocardial Ischaemia National Audit Project (MINAP)	Significant	Minor	No
National Metastatic Breast Cancer Audit (NAoMe)	Limited	Minor	No
National Primary Breast Cancer Audit (NAoPri)	Significant	Minor	No
National Heart Failure Audit (NHFA)	Significant	Minor	No
Fracture Liaison Service Database (FLSD)	Significant	Minor	No
National Emergency Laparotomy Audit (NELA)	Significant	Minor	No
National Clinical Audit of Psychosis (NCAP)	Significant	Minor	No
National Paediatric Diabetes Audit (NPDA)	Significant	Minor	No
National Audit of Cardiac Rhythm Management (NACRM) 2023/2024 & 2024/2025	Significant	Minor	No

Project name	Assurance Level	Risk Level	Risk Register
National Bowel Cancer Audit (NBOCA)	Significant	None	N/A
National Non-Hodgkin Lymphoma Audit (NNHLA)	Significant	None	N/A
National Early Inflammatory Arthritis Audit (NEIAA)	Full	None	N/A
National Neonatal Audit Programme (NNAP)	Significant	None	N/A
National Vascular Registry (NVR)	Full	None	N/A
National Audit of Percutaneous Coronary Interventions (NAPCI)	Full	None	N/A
National Maternity and Perinatal Audit (NMPA)	Full	None	N/A
National Lung Cancer Audit (NLCA)	Significant	None	N/A
Perinatal Mortality Surveillance 2025 State of the Nation report	Full	None	N/A
Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	Full	None	
Perinatal confidential enquiry	Full	None	
Saving lives, improving mothers care report (2021-2023, UK wide)	Full	None	
National Non-Hodgkin Lymphoma Audit (NNHLA)	Significant	None	N/A

89% Full/Significant Assurance

85% None or

Minor Risk

The audits with Limited Assurance:
Metastatic Breast Cancer, Hip fracture
Database, Epilepsy 12, SSNAP

Full & Significant Assurance equate to 89%
& no or minor risk 85% in relation National
Clinical Audits.

Assurance		
Full	8	31%
Significant	15	58%
Limited	3	12%
Very Limited	0	0%
	26	

Risk		
None	13	50%
Minor	9	35%
Moderate	3	12%
Major	1	4%
Catastrophic	0	0%
	26	

Limited Assurance - Issues are being progressed via the Clinical Lead and are captured on the Directorate risk register. For 2026–27, the QPS Team will support the Directorate to ensure robust action plans are in place, with clear escalation, governance oversight and evidence of progress and delivery

National Metastatic Breast Cancer Audit (NAoMe) – Limited Assurance

(Relatively new processes around Metastatic Breast CA)

Dataset extremely limited across Wales and England.

Major challenge to identifying all metastatic patients, especially:

- Those presenting via emergency admissions
- Those managed only in oncology without re-referral to breast surgery
- Those with recurrence not coded as such

New Metastatic Breast Clinical Nurse Specialist (Sept 2025), acts as keyworker across acute and oncology services enables consistent patient tracking which is expected to significantly improve:

- MDT capture
- Treatment documentation
- Patient experience

National Hip Fracture Database (NHFD) – Limited Assurance

- Admission delays remain a major challenge, patients spend >15 hours in A&E before transfer to orthopaedic ward.
- Delay in surgery beyond 36 hours in 40% of patients
- Mobilisation POD1 is persistently low (68.7% vs 82% national), largely due to weekend and holiday physiotherapy gaps.
- Lack of ring-fenced beds for trauma patients
- Theatre space constraints
- Trauma review meeting overdue for >1 year; spinal priorities have delayed hip fracture pathway review.

Risk register: escalated to directorate risk register.

- Ring-fencing at least two beds for hip fracture patients, similar to UHW model (empty beds created when patients arrive).
- Monthly governance meetings already review run charts; QI projects underway to engage nursing staff in mobilisation.

Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12) – Limited Assurance/Major Risk

Significant improvement in most KPIs however:

- Major concern (KPI 1): Only 14% of children seen by epilepsy specialist within 2 weeks (down from 80% (Uncertainty over definition of “first paediatric assessment”).
- MRI within 6 weeks (KPI 5) also underperforming due to clinical appropriateness issues.
- Consultant unavailability extending waiting lists and data entry to audit (anticipated cohort 8 better for ABUHB)
- Need to improve waiting time for EEG’s which will hopefully improve MRI waiting times

Sentinel Stroke National Audit Programme (SSNAP) – Limited Assurance/Major Risk

- New stroke metrics (Oct 2024) anticipated to impact negatively on all stroke centres, and is a challenge for ABUHB to meet KPI’s
- Ring-fencing stroke beds breached by General Medicine patients also impacting Stroke Ward capacity for Stroke patients
- Thrombectomy rates best in Wales, Wales national rate 2.7%, ABUHB rate 4.6%, highest performing sites across the UK are 8-10%, SSNAP recommends 10-12% (based on Jan – Dec 2025)
- Consultant review <14hrs is the KPI and Jan – Dec 2025 ABUHB 58.6% compared to Wales national average 45.1%
- Need for organisational support for ring-fencing beds and therapy staffing rates
- ABUHB would benefit form CT perfusion to extend treatment window from 4.5 hrs to 9 hrs which provide an opportunity to increase Thrombectomy rates.

National Clinical Audit highlights for 2025/2026

Introduction of a new Haematology MDT proforma has improved staging documentation for Non-Hodgkin Lymphoma patients.
Embedding NICOR datasets into AMaT to enable real-time tracking for heart failure care. This will allow the HF specialist nurses to access results and act promptly to any areas of concern
National Paediatric Diabetes Audit – No longer an outlier for HbA1c, improvements due to better use of available technologies
National Lung Cancer Audit – High surgical resection rates, improved early-stage diagnosis, and participation in national research
National Heart Failure Audit – Nurse-led service across all sites, high medication optimisation performance
Myocardial Infarction National Audit Programme & National Audit Percutaneous Coronary Intervention –excellent echo completion rates, NSTEMI angiography before discharge at 94%
National Maternity Perinatal Audit – Strong performance in core maternity indicators with lower-than-expected adverse outcome rates
Epilepsy 12 audit - Significant improvements in care planning
Cardiology and Cardiac Intervention Improvements in Intracoronary imaging use at 96%
Stroke - Improvements in ring-fenced stroke beds and thrombectomy access, with the highest thrombectomy rate in Wales – however improvements can still be achieved
Neonatal Retinopathy of Prematurity - GUH no longer an alert-level outlier & Lowest mortality rates compared with UK average with excellent follow-up (97% at two years)
National Early Inflammatory Arthritis Audit – No longer negative outlier, now a positive outlier status for patients seen within 3 weeks
Fracture Liaison Service-Database - Second award in a consecutive two-year period



National Clinical Audit – Summary of Successes and Concerns May 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Lung Cancer Audit - State of the Nation Report (England & Wales)	- Improved early-stage diagnosis and curative treatment rates - Participation in national research on circulating tumour DNA	- Delays in diagnosis and treatment - Need for lung cancer screening in Wales
National Paediatric Diabetes Audit - Annual Core State of the Nation Report (Year 3)	- No longer an outlier - Reduction in median HbA1c - Improved completion of care processes - Increased numbers of CYP on Hybrid closed loop pumps	- Difficulty achieving 4 MDT appointments/year. - Retinopathy screening outside local control.
National Clinical Audit of Psychosis - State of the Nation Report (Bespoke data)	- Physical health monitoring and interventions (74%) - Carer focussed education and support (89%) - High uptake of family interventions and supported employment - Real-time data collection now in place	- Access and Waiting Time (23%) - Administrative errors in data submission - Need for better awareness and referral pathways
National Non-Hodgkin Lymphoma Audit - State of the Nation	- New MDT proforma implemented to improve staging documentation. - New patients with NHL always see a CNS - One-year overall survival for both low- and high-grade NHL comparable with rest of UK	- Data suggests less than 50% of patients receive chemotherapy within 62 days of referral for high grade NHL-data not in keeping with clinical experience - Data not analysable due to format incompatibility with NATCAN - Staging documentation needs improvement - Significant data gaps (not unique to ABUHB, due to way data is captured in Wales)



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National Clinical Audit – Summary of Successes and Concerns September 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People - Annual Report 2024	• Significant improvement in KPI2 – Children and YP seen by an ESN within the first year of care • Improvement in KPI4 – Children and YP with convulsive seizures had an ECG within the first year of care (94% vs 55% in cohort 5) • Significant improvement in assessing/asking for mental health KPI 6 (87% vs 15% in cohort 5) • Significant improvement in documented evidence of care planning KP1 9B (93% vs 76% in cohort 5)	• Not able to see children and young people within 2 weeks (KP1) by consultants with expertise in epilepsy (14%) • Failing to achieve MRI within 6 weeks of request (33%) • Continue struggling with backlog and significant delays in getting an EEG. However, this has improved since previously year.
National Heart Failure Audit (NHFA)	• Nurse-led service expanded across all sites • Improved discharge planning and cardiac rehab referrals • Medication prescribing above national average	• No dedicated acute heart failure service • No provision for preserved ejection fraction patients • Lack of live tracking for inpatient service
SSNAP - Sentinel Stroke National Audit Programme - State of the Nation 2024	• Successes/Concerns – Due to the new metrics performance has reduced however this was expected • Significant changes to measurements • Old measures not comparable to new measures • Raised the expectation on delivery of stroke services • Expected that most hospitals will revert to D/E grading • Most recent quarter (Jan-Mar 2025) not released to the public	



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National Clinical Audit – Summary of Successes and Concerns November 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Neonatal Audit Programme - State of the Nation Report 2026	• Mortality lower than national average (Wales: 5.8 vs UK: 6.4). • Low rates of brain injury (PHVD, cystic PVL). • High parental involvement (consultation and ward rounds). • 2-year neurodevelopmental follow-up at 97% (commended nationally). • Nurse staffing above national average.	• Non-invasive ventilation (NIV) rates: Alarm-level outlier (30% vs national 51%). • ROP screening: Improving but still below national average (68% vs 80%). • Breastfeeding rates: Below national average at discharge (~50–60%). • Antenatal magnesium sulphate and steroid administration: Slightly below benchmarks.
National Hip Fracture Database - State of the Nation 2025 Report	• Prompt ortho-geriatric assessment (top quartile) (KPI 1) • Low delirium post-op (KPI 5) • Strong bone health prescribing (KPI 7) • High return to original residence • Mortality at 1-month significantly better than national with recent commendation.	• Admission to Orthopaedic ward (KPI 0) • Adequate physiotherapy cover for prompt out of bed (KPI 4)
National Maternity and Perinatal Audit - State of the Nation Report (containing 5 years of data)	• Rates as expected: readmissions, vaginal tears, PPH, preterm birth • Rates lower than expected: induction of labour, term baby apgar scores < 7 , episiotomy rates • Benchmarking	• Data completeness • Rates higher than expected: SGA, late booking after 10 weeks gestation • Lower rates of VBAC



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National Clinical Audit – Summary of Successes and Concerns November 2025

Clinical Standards and Effectiveness Group	Successes		Concerns
Perinatal confidential enquiry Saving lives, improving mothers care report (2021-2023, UK wide) Perinatal Mortality Surveillance 2025 State of the Nation Report Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	- Maternal deaths: Thrombosis remains leading cause; disparities by ethnicity and deprivation persist. - Perinatal deaths: Stillbirth and neonatal mortality improving overall; worse for <31 weeks gestation.		
Myocardial Ischaemia National Audit Project (MINAP)	- Almost all patents are seen by a cardiologist and admitted to a cardiac ward - Angiography rates are high in NSTEMI and above the national average - Echocardiography and cardiac rehabilitation offer rates are high and exceed the national average	- Poor door to needle times in STEMI reflect skewed case mix and lack dedicated service ** (BUSINESS CASE IN) - Delays to IP angiography reflect staffing and lab time - Slight concern re secondary prevention meds – requires further ix but may reflect less clear evidence base some medications in lower risk cases	
National Audit of Percutaneous Coronary Interventions (NAPCI)	- The use of intracoronary imaging in unprotected left main coronary stenting is now mandatory in the standard practice. Both intracoronary imaging modalities namely intra vascular ultrasound (IVUS) and optical coherence tomography (OCT) are available. Trainees in Percutaneous coronary intervention are also encouraged to use these devices when performing left main coronary stenting - The treatment of left main coronary stenting with ICI in our centre is associated with favourable long-term outcomes when compared with the national benchmark figures - Trend of drug eluting balloon use is similar to national trend		Data capture for the use of P2Y12 remains a challenge

National Clinical Audit – Summary of Successes and Concerns January 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Emergency Laparotomy Audit (NELA) – 10th Patient report. April 2023 – April 2024	• Mortality improved from 9.6% to 5.1%, the lowest in Wales and 23rd lowest of 169 UK hospitals • High pre-operative risk assessment compliance (94%), ensuring appropriate tripartite decision-making • Consultant presence for high-risk cases remains strong • Geriatrician review at 77%, well above national average • NELA M&M meetings continue to generate high-quality learning • Very low unplanned ICU readmission rate (0.7%), compared to national 3.5%	• Only 11.4% of immediate cases reach theatre within 6 hours (national 8.4%) • Antibiotic Timing - Significant data capture issues due to retrospective documentation & Risk of under-reporting true compliance • CT Reporting Communication - Only 6.2% cases had direct surgeon–radiologist communication documented (recent improvement to 11.7%) & radiology teams lack admin support to consistently complete documentation • Only 72% of high-risk patients admitted to ICU postoperatively (below national average 77%). • ICU occupancy regularly exceeds 85%, with unmet need frequently observed. • Limited ICU bed base relative to population demand • Frailty assessment and accuracy needs improving with more COTE involvement for frail older patients & requirement of NELA nurse practitioner to help pre-op pathway and COTE consultant • NELA dataset largely completed by clinicians, leading to incomplete or inaccurate entries.
National Early Inflammatory Arthritis Audit (NEIAA) - Data Collection Period: 1 April 2024 – 31 March 2025	Outstanding Performance – Now a Positive Outlier • 80% of patients start DMARD treatment within 6 weeks (national 60%) • 66% seen within 3 weeks of referral (national 43%) • 21-day average GP referral → clinic wait (national 32 days) • Second best performing Health Board in Wales • Remission rate at 71%, significantly improved • Increased recruitment for connective tissue diseases and Giant Cell Arteritis (GCA) • Effective use of new NEIAA dashboards at Directorate and Clinical Implementation Network (CIN) levels • Significant reversal from previous outlier status (clinic booking issues now resolved)	• Psychological Support - Only 14% of patients across the UK have psychology access; not available in ABUHB rheumatology.



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National Clinical Audit – Summary of Successes and Concerns February 2025

Clinical Standards and Effectiveness Group	Successes		Concerns
NRAP - National Respiratory Audit Programme - State of the Nation Report - Children and young people's asthma: Elements of care received by children admitted with near-fatal asthma	- Primary care education days - New pathway adopted with recent audit interactions - Better, earlier diagnosis of asthma - Data capture		- Prednisolone within 1 hr - Primary care follow up with 2 days - Hospital FU with 4 weeks - Documentation of smoking and interventions
National Bowel Cancer Audit - State of the Nation Report (NBCA)	- Data completion and submission is high quality. Good administrative support for Cancer coordinator - Perioperative Surgical quality of care and outcomes meet and, in some criteria, exceed national standards - Good input into the MDT from Oncologists, gastroenterology and Liver surgical team to help with complex cases - Established Early rectal cancer assessment and surgery within ABUHB through SPECC MDT and dedicated surgeons undertaking TAMIS procedure. Introduction of Robotic surgery for CRC		- Delay in Diagnostic pathway, mainly endoscopy. This is being addressed through vetting - Delay in Ileostomy closure- now being addressed with renewed process in place
National Audit of Primary Breast Cancer (NAoPri) - State of the Nation Report 2025	- Patients now have one stop triple assessment service this data will improve once we get to 2024 data point - Excellent 3-year breast cancer specific survival	- Data inputting to the audit remains an issue. It is too much work for one person and does not reflect the service - Data for performance status difficult to capture - Low rates of immediate breast reconstruction being offered – but unlikely to be captured correctly and also likely lower due to the COVID pandemic	
National Audit of Metastatic Breast Cancer NAoMe) - State of the Nation Report – 2025	- There is now a metastatic breast cancer clinical nurse specialist in post this has made a significant difference to patients and indeed the identification of patients who present acutely to other specialities - Good documentation of contact with a clinical nurse specialist, this will only improve with our new metastatic breast cancer nurse in post - Good access for patients receiving chemotherapy de novo		- Good access for patients receiving chemotherapy de novo - Still awaiting in house testing of Her 2 - Need to improve documentation of WHO performance criteria
Fracture Liaison Service Database (FLS-DB) Annual report	NHS Performance and Improvement winners 2025 -2nd award in consecutive years	- DXA within 90 days – needs attention - Demand will rise - other speciality – Breast, Coeliac - Primary Care engagement and FU	

National Clinical Audit – Summary of Successes and Concerns March 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
Non-Hodgkin Lymphoma State of the Nation Report 2025	- Performing above average in terms of CNS review for patients being diagnosed with both low grade and high-grade lymphoma - Outcomes at 1 year comparable/in keeping with national average for low grade and high-grade lymphoma	- Data completeness for performance status and staging - Improving data for timely SACT to ensure more people getting chemotherapy within 62 days (it should be noted that there is no single pathway for investigation of possible lymphoma due to the nature of the disease)
National Audit of Cardiac Rhythm Management State of the Nation Report 2025	- Complete data entry - Meeting minimum numbers - Increase in implant numbers since the opening of Grange University Hospital	- Discrepancies in numbers - Poor access to EP for ABUHB patients - Poor data entry from tertiary centre making it difficult to benchmark
National Vascular Registry State of the Nation Report 2025	- Good quality service from the ABUHB IR department. - Good and timely carotid service - Good and timely lower limb revascularisation service	- SEWVN Major Lower Limb Amputation mortality – a) post op care b) consider palliation - SEWVN delay for AAA repair – continue to monitor



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476/644

New procedure(s)/ Artificial Intelligence



Clinical specialties in the NHS are required to seek approval before introducing new clinical procedures or deploying AI-based tools to ensure **safety, legality, ethical compliance, and organisational readiness**. The key reasons include:

- Ensure Patient Safety and Minimise Clinical Risk
- To Meet Legal, Regulatory, and Data Protection Requirements
- Maintain Clinical Quality and Professional Standards
- To Ensure Appropriate Evaluation and Evidence of Effectiveness
- To Support Consistent, Scalable, and Safe Deployment Across the NHS
- Protect Patients' Rights and Maintain Trust

RefluxStop procedure

Purpose: Alternative to fundoplication for patients with poor oesophageal motility.

Benefits: 97% off PPIs, low dysphagia rate, high patient satisfaction. NICE guidance supports procedure.

Training: Structured programme with proctoring for 20 cases.

Outcome: Approved

Capsule Colon

Purpose: Non-invasive alternative to colonoscopy. Minimally invasive, outpatient based. Potential to reduce waiting times.

Plan: Start with 1 procedure/week, review in January.

Outcome: Approved

Cytosponge

Purpose: Minimally invasive Barrett's surveillance alternative to Endoscopy.

Trial Phase: Assess feasibility and patient uptake.

Lab: External UK lab handles analysis.

Outcome: Approved

Impella Assist Device

Purpose: Mechanical circulatory support for high-risk cardiac procedures.

Discussion:

- Concerns raised about NICE guidance being outdated (2016).
- Need for medical device group scrutiny.

Outcome: Approved

Conduction System Pacing

Purpose: More physiological pacing method for bradycardia patients

Discussion:

- Minimal additional risk; training and proctoring planned.
- NICE IPG reference to be verified.

Outcome: Approved

Biodegradable Embolisation for Greater Trochanteric Pain Syndrome (GTPS)

Purpose: Image-guided embolisation of abnormal neovascularisation using biodegradable particles.

Discussion: Successful ABUHB innovation in knee osteoarthritis embolisation. Demonstrated improvements in pain, function, PREMs and healthcare utilisation. Device is CE-marked & already used elsewhere in the UK. The proposal is a controlled pilot, not full-service rollout.

Strong governance, consent, audit and stop-review points in place.

Outcome: Approved for pilot of 30 cases

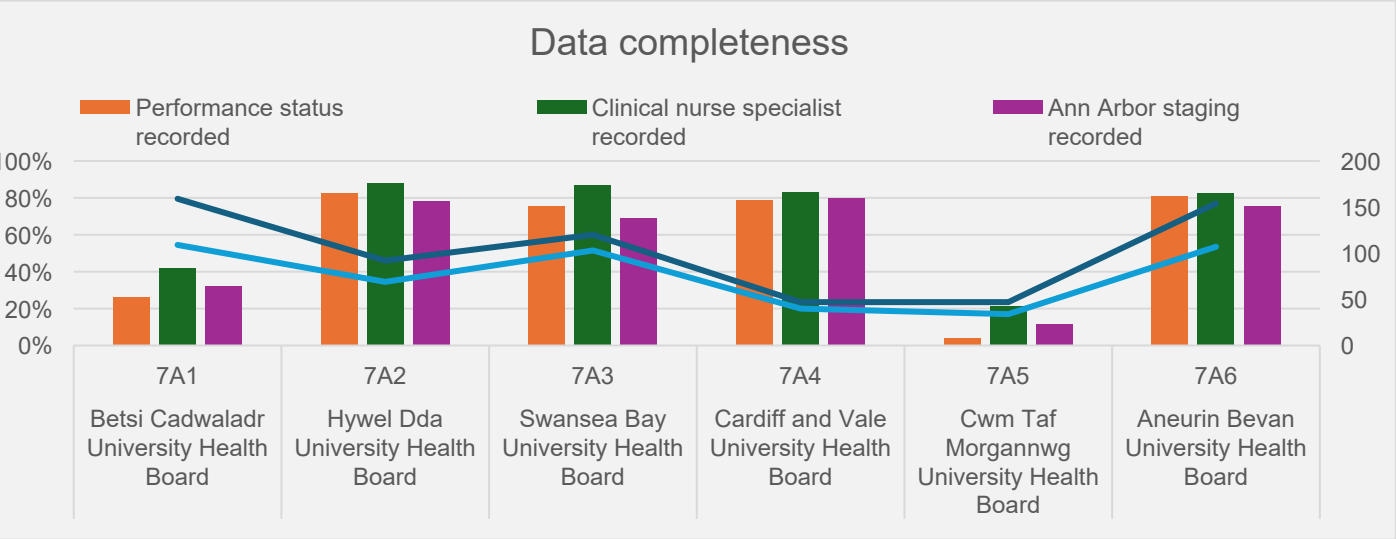
For Information

National Clinical Audits for 2025/26

The following pages present an overview of national clinical audit activity undertaken across Aneurin Bevan University Health Board aligned to the Annual Audit Plan for 2025/2026, demonstrating our continued commitment to excellence in patient care and continuous improvement.

National Non-Hodgkin Lymphoma Audit- State of the Nation Report 2024 - An audit of care received by people diagnosed with non-Hodgkin lymphoma in England (2020-2021) and Wales (2022)					
Clinical Lead: Dr Rachel Trickey – Consultant Haematologist					
Rationale:	The purpose of the National non-Hodgkin lymphoma Audit (NNHLA) is to evaluate the patterns of care and outcomes for patients with non-Hodgkin lymphoma in England and Wales, and to support services to improve the quality of care for these patients. The NNHLA is part of the National Cancer Audit Collaborating Centre (NATCAN), the home of the ten national cancer audits in England and Wales. This national centre of excellence was established to strengthen cancer services by evaluating the process of diagnosis and treatment, and patient outcomes in multiple cancer sites.				
Objectives:	• Performance Indicator: Aim: to provide a national picture and highlight regional variation in the patterns of non-Hodgkin lymphoma care across England and Wales. • Tumour Characteristics: Aim: to provide context for interpretation of performance indicators • Data Quality: Aim: to shine a spotlight on areas where improvements in data completeness are needed.				
Report Successes:		Assurance level	Description		
1	New patients with NHL always see a CNS	Significant	The project has mostly achieved the standards or criteria being audited against		
2	One-year overall survival for both low and high grade NHL comparable with rest of UK	Risk level	Description		
Report Concerns:		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved		
1	Data suggests less than 50% of patients receive chemotherapy within 62 days of referral for high grade NHL-data not in keeping with clinical experience	Has this audit been placed on a Risk Register (N/A if above risk is None)			NO
2	Significant data gaps (not unique to ABUHB, due to way data is captured in Wales)	If not on a risk register, why not: This is a new audit with incomplete data, the current data is not likely to be representative but will continue to be collected and improved on in the future			
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:
1	Commenced a new MDT proforma for all haematology MDT discussions, to try and improve recording of staging	This has already been initiated within Haematology for all patients and our aim is for 100% of patients with NHL have staging and PS accurately recorded at the time of MDT		Victoria Williams (Haem MDT lead) Sarah Hine (Cancer services)	Already implemented
30/129				479/644	

Data Completeness:



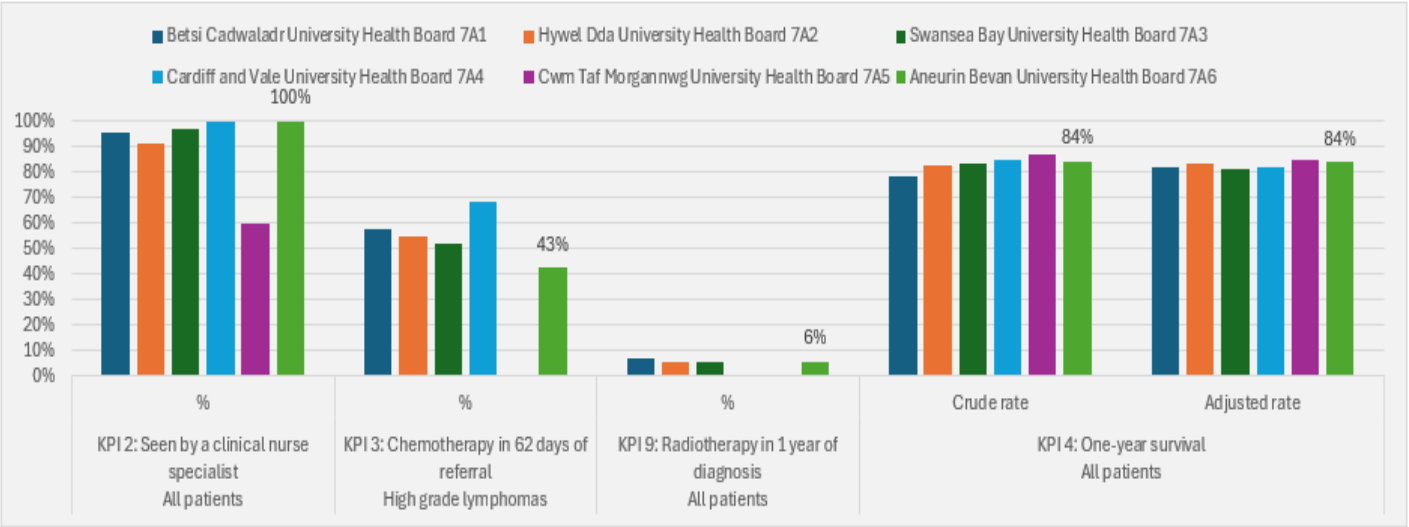
Key Message:
NHS trusts and MDTs should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Particular attention should be given to documentation of staging/prognostic indices, MDT records and CNS involvement in both England and Wales

Key Message:
Less than 67% of people with high-grade NHL in England and 50% of people with high-grade NHL in Wales receive chemotherapy within 62 days of referral.

Key message:
High 1 year survival of around 90% for people with low-grade lymphoma, and around 70% for people with high-grade lymphoma, with similar results reported for England and Wales.

RGH is performing better than the Wales and England for Performance Status and Clinical Nurse Specialist and better than Wales, however slightly reduced on the England result for Staging (Ann Arbor), whilst NNH is performing better than Wales and England in all 3 areas – *Binet staging is only recorded in one HB in Wales.*

Key Message: Less than 44% of people with high-grade lymphoma start their radiotherapy within 8 weeks of the end of first line chemotherapy and there is wide variation between trusts. Radiotherapy not often given unless specific indications



Due to current difficulties in radiotherapy capture with existing databases in Wales, only limited conclusions can be drawn from the current data provided for Wales; this may explain lower proportions of radiotherapy delivery in Wales compared to England.

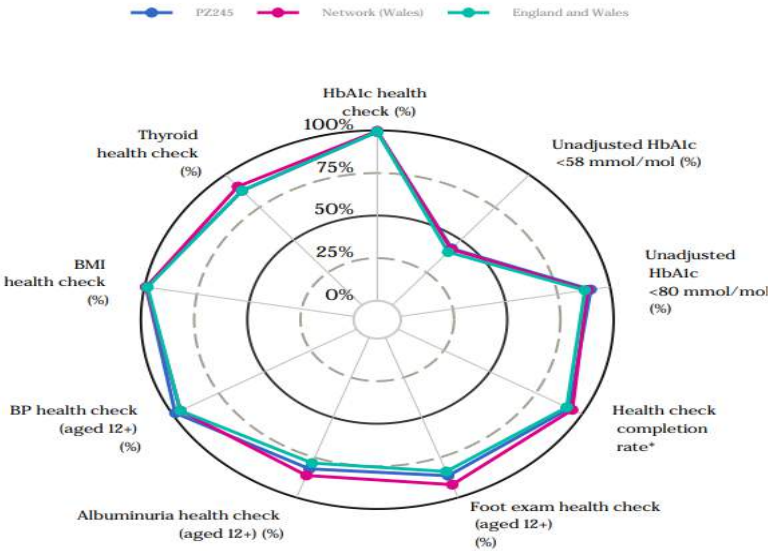
Report Recommendations:		S.M.A.R.T Actions:Responsible:Due Date:Progress:
1	Identify and address factors delaying people with NHL being discussed at a haematology or lymphoma MDT including referral pathways, staging investigations and record keeping.	Wales 2022: Not available
2	Identify pathway factors contributing to delays in people with high-grade NHL starting chemotherapy within 62 days of referral to develop strategies for process improvement <i>Wales 2022: 51.2%, ABUHB 43%</i>	Unlikely the data that has been collected is representative
3	Identify patient and hospital factors contributing to delays in radiotherapy delivery since last administered dose of Chemotherapy	Wales 2022: Not available
4	Ensure adequate resource allocation for data provision. They should support hospitals/trusts/health boards in England and Wales with coding, data entry, and quality assurance to improve quality and completeness of data submitted. Data items of focus include: • Cancer staging (Ann Arbor and Binet) • Prognostic indices for NHL <i>Ann Arbor Wales 60.0%, ABUHB 76%</i>	Binet Staging only relates to two Health Boards in Wales, SBUHB – Singleton Hospital and CTMUHB – Royal Glamorgan Hospital.
5	Deliver more comprehensive cancer data in Wales, with particular focus on: • Chemotherapy regimens and delivery • Radiotherapy regimes and delivery This is in the process of being developed with introduction of National Data Resource (NDR) as part of the newly established Digital Health and Care Wales (DHCW) as part of the “Digital Strategy for Wales”	Detailed chemotherapy and radiotherapy information is not currently available for Wales
• <i>It should be noted that provider-specific results are subject to variation in data completeness, data quality, and the influence of random variation (i.e. the role of chance).</i> • <i>At this stage, a formal Healthcare Quality Improvement Partnership (HQIP) outlier process has not been applied. This reflects that, whilst there is sufficient confidence to report findings publicly, this represents the first iteration of provider-level reporting, with data completeness and quality still being tested and risk adjustment methodologies continuing to be developed. In the absence of a formal outlier process, where results indicate a potential area of clinical concern, providers will be contacted within one month of publication of the State of the Nation Report.</i> • <i>This will enable a structured dialogue to explore the underlying factors contributing to the findings, in line with HQIP guidance, and to agree any necessary actions. This approach is intended to support learning, validation and improvement, with a view to implementing a formalised outlier process once data maturity, completeness and risk adjustment methodologies are sufficiently robust.</i>		

National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24
Clinical Lead: Dr Davida Hawkes – Consultant Paediatrician

NICE: NG18 & NICE 2015
TA943 (Technology Appraisal)
No quality statements, recommendations only

Rationale: The NPDA has been reporting for 20 years. Data is submitted by healthcare professionals in Paediatric Diabetes Units (PDUs) in England and Wales about the care received by the children and young people with diabetes using their service.

Objectives: The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes-related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and wellbeing of children and young people with diabetes.



Above shows GUH Health Checks compared to national rates, below right, shows 2023/24 versus 2022/23 ABUHB and below left ABUHB additional Health Checks

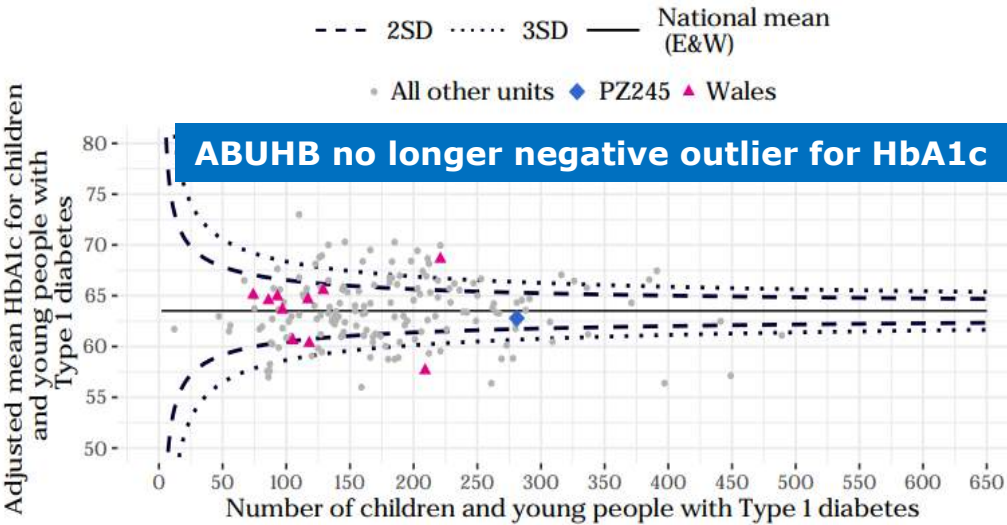
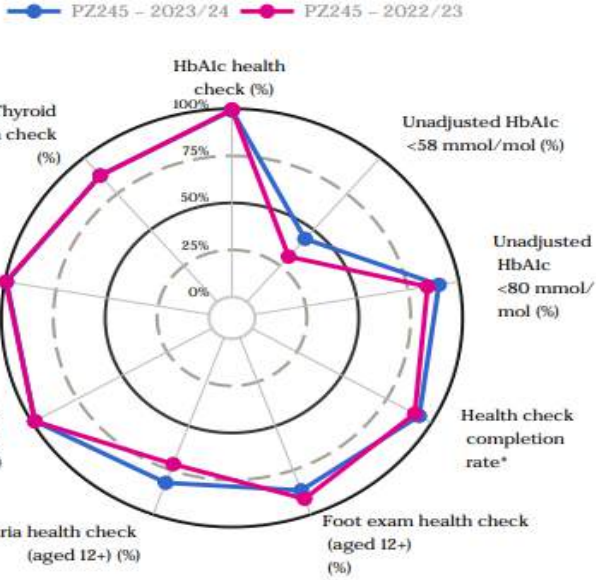
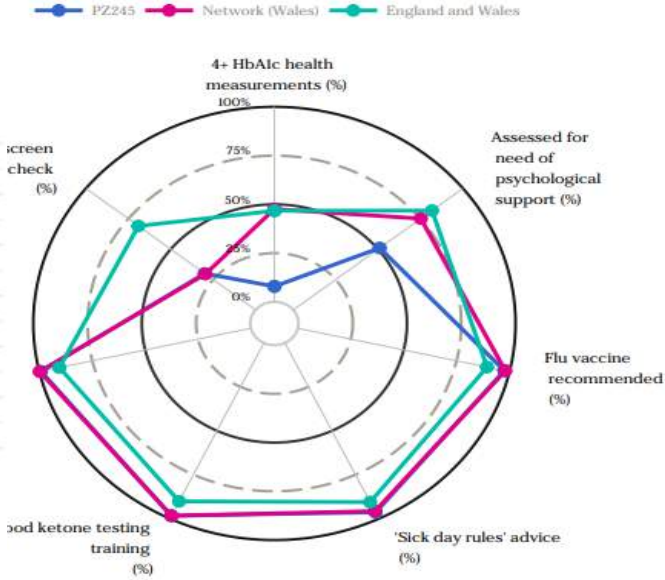
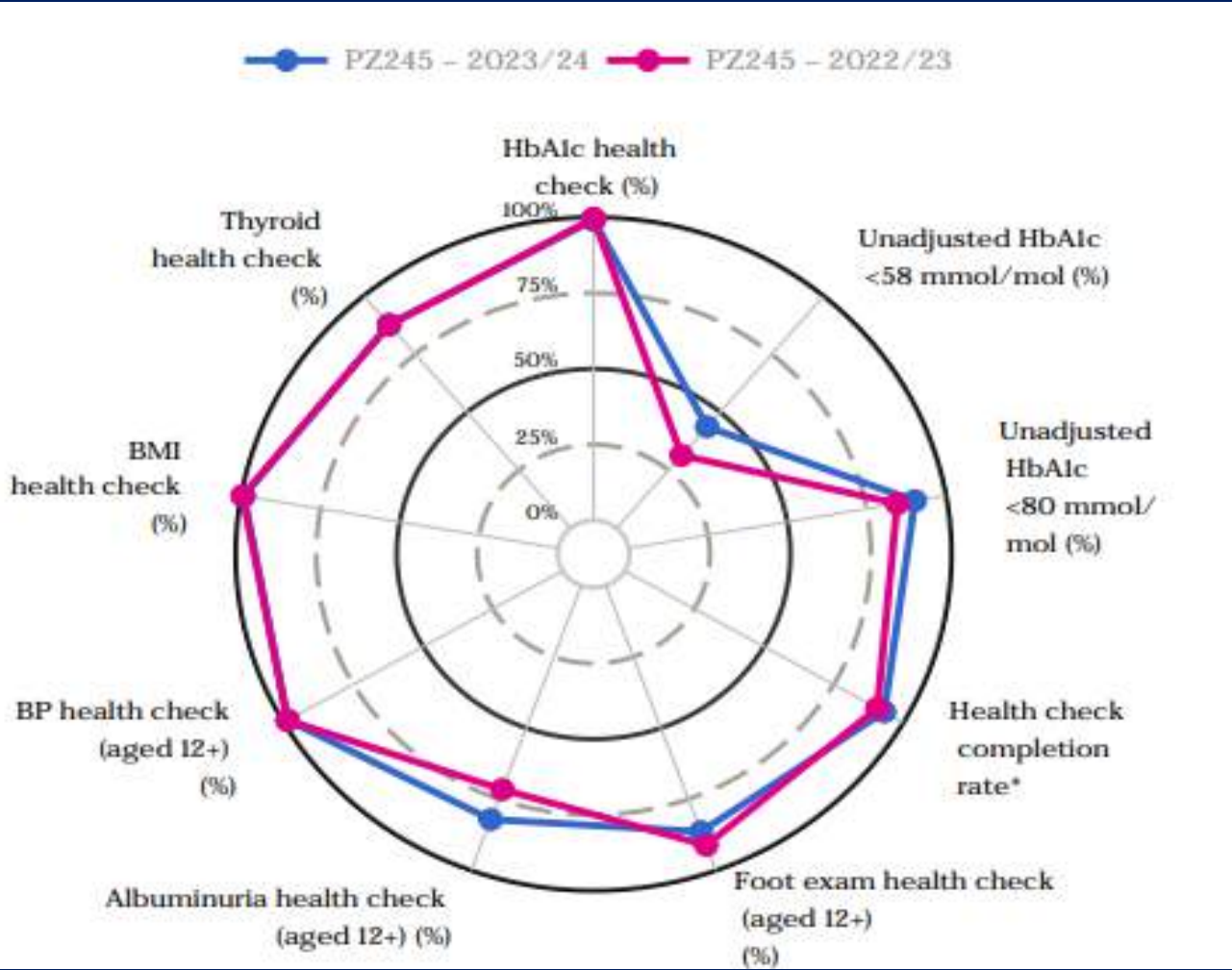
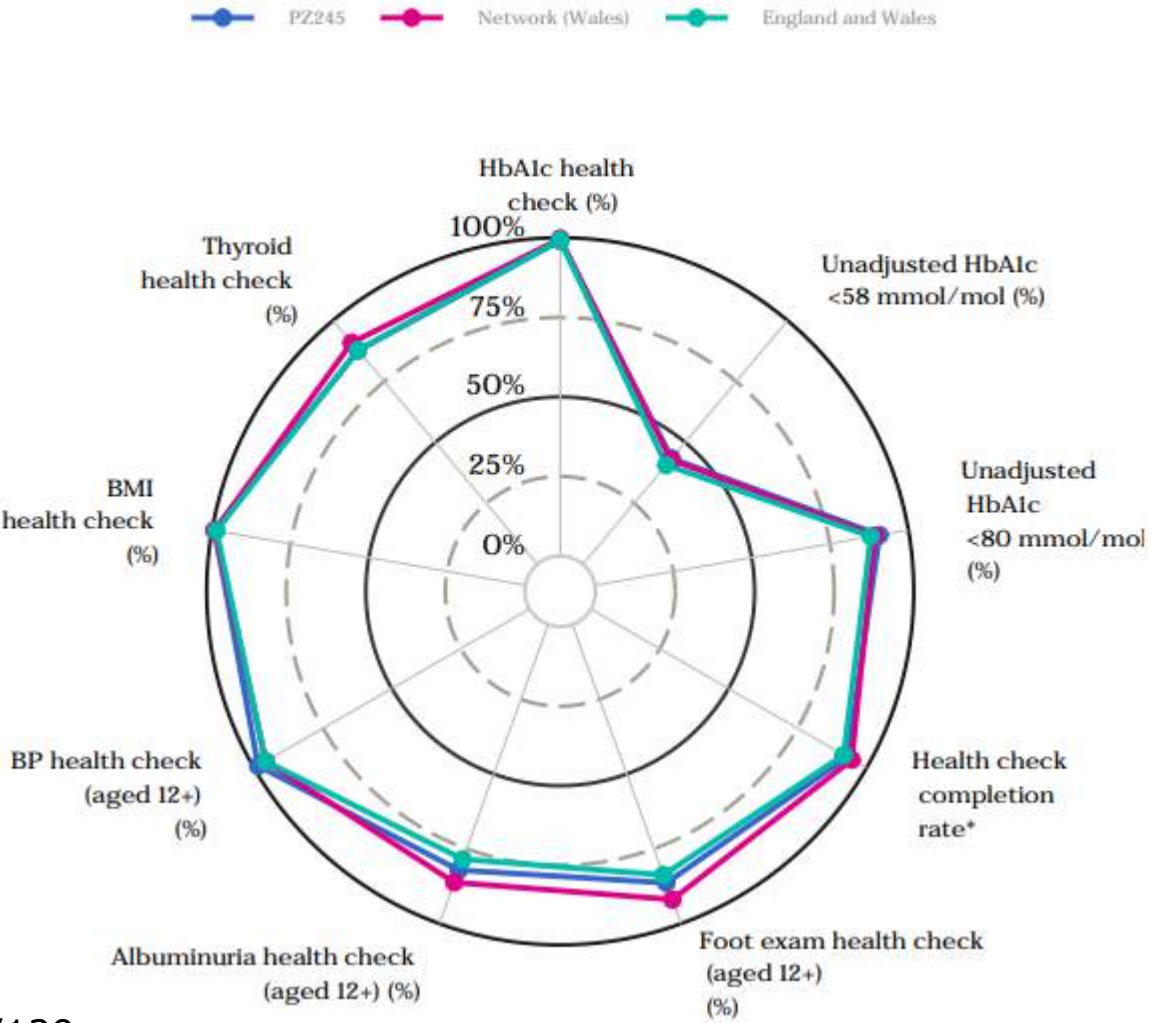


Figure 21: Adjusted mean HbA1c



DIABETES HEALTH CHECKS COMPLETION RATES

The chart below demonstrates that the Health Board is performing similarly to the rest of the Welsh Health Boards and compared to the overall national rates.



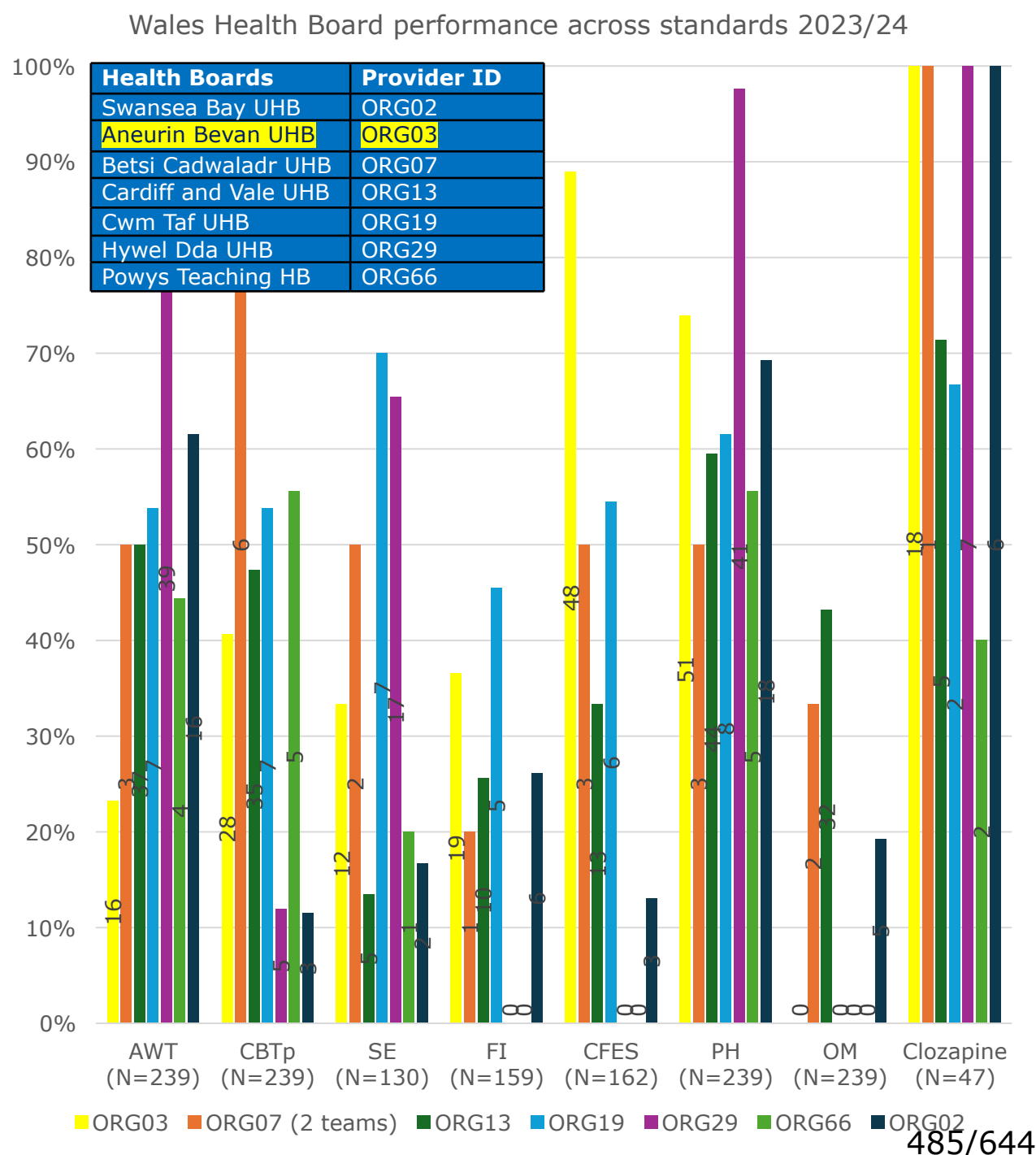
The Health Board has improved in relation to Unadjusted HbA1c <58mmol/mol & <80mmol/mol in 2023/24 compared to 2022/23 and has Albuminuria (aged 12+) with a slight reduction in foot examination

Assurance level		Description		Risk level	Description		
Significant		The project has mostly achieved the standards or criteria being audited against		Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		
Report Successes:					Report Concerns:		
1	Reduction I median HbA1c	3	Improvement in numbers completing health care checks				
2	No longer negative outlier for HbA1c	4	Increased numbers of CYP on Hybrid closed loop pumps				
Report Recommendations:				S.M.A.R.T Actions:		Responsible:	Due Date: Progress:
1	PDU workforce numbers should be mapped against the guidelines published by the National Children’s and Young People’s Diabetes Network in 2024 (NCYPDN), taking into account the 16% increase in children and young people with diabetes in their care.			Refer back to business case for pumps-request for increased staffing is being met – not yet requested additional staff for increased incidence		Diabetes leads	Mar 2027
2	The variation in outcomes by geography should be investigated and addressed to ensure that children and young people with diabetes have equitable access and care for diabetes. Commissioners should use NPDA data (three monthly and annual PDU level reports), alongside other trusted data sources and peer review programmes, to assess equity of care within and between their regions.			All CYP in ABUHB have access to same care by MDT and same access to Technology		MDT	
3	Studies should be funded to understand the progression from childhood signs of micro- and macro-vascular disease to the development of future diabetes complications, and to inform preventative interventions.			Action by: Research funding bodies and diabetes charities such as Diabetes UK and Breakthrough T1D.			
4	Diabetes services should offer holistic multidisciplinary support, including dietetic input, to children and young people with diabetes who are overweight or obese.			All CYP have access to specialist nurses specialise dietitians and specialist psychologists		MDT	Achieved
5	Children and young people with Type 1 diabetes, regardless of ethnicity and social deprivation, should have equitable access to diabetes-related technologies. This could include engagement with families that may experience inequalities (such as those within the Core20PLUS5 framework) and healthcare professionals to better understand the barriers to equitable access.			All cyp in ABUHB have access to diabetes tech regardless of ethnicity or deprivation		MDT	Achieved
6	Hybrid Closed Loop (HCL) systems should be offered to all eligible children in England and Wales in line with NICE Technology Appraisal guidance (TA943) and the implementation plans in England and Wales.			All CYP with type 1 DM in ABUHB are offered HCL pumps as per nice tech appraisal still a waiting list of over 6 months but much reduced		MDT	Achieved

35/129

484/644

State of the Nation Report 2024 - Audit of Early Intervention in Psychosis Provision in England and Wales in 2022/23 and 2023/24 Clinical Lead: Dr Gemma Williams, Consultant Psychiatrist, EIP.	
NICE QS 80 – See slide 9	
NICE QS 102 – see slide 9	
Rationale:	Early Intervention in Psychosis (EIP) services provide care to people with psychosis and at-risk mental states (ARMS) by providing treatments in accordance with NICE recommended guidance. The Royal College of Psychiatrists National Clinical Audit of Psychosis (NCAP) monitors the performance of EIP services across England and Wales against standards which cover waiting times, Cognitive Behavioural Therapy for psychosis (CBTp), education and employment support, family and carer interventions, Clozapine medication, outcome measures plus physical health screening and interventions. NCAP began auditing EIP services in 2018 and provides feedback to EIP services at a team, trust, regional and national level, helping shape local provision in response to data trends.
Objectives:	Tracking change over time, involves repeated data collection to monitor progress against expected standards of care. Exploring variation between different parts of the health system, e.g. making comparisons between teams, Trusts/ Health Boards and regions. Examination of variation by health inequalities, such as age, gender and ethnicity, and identifying where improvement efforts could reduce inequalities. Providing Quality Improvement (QI) guidance to support initiatives to improve aspects of care measured by the audit.
Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor 36/129	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

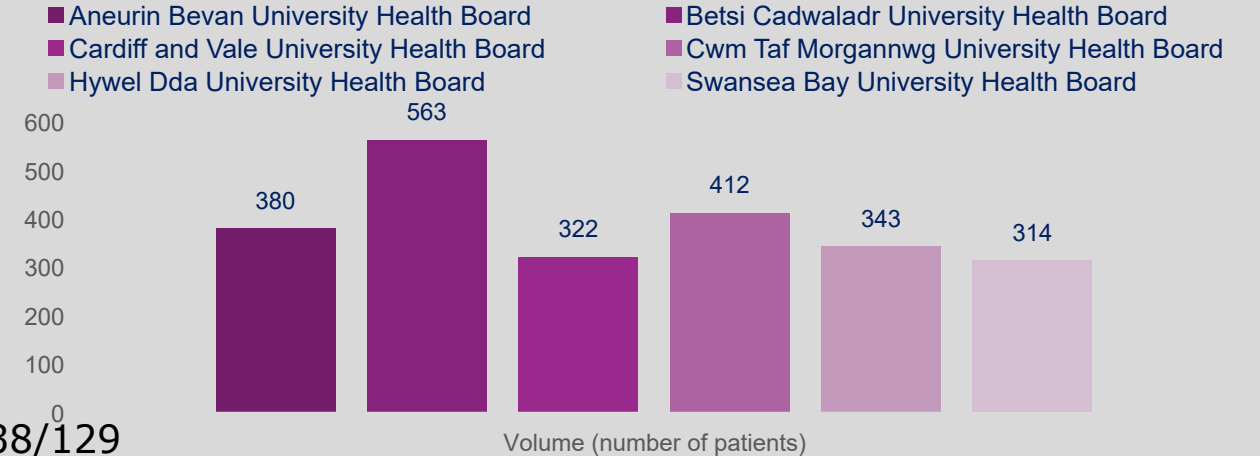


Report Successes:			Report Concerns:		
1	Physical health monitoring and interventions (74%)		1	Access and Waiting Time (23%)	
2	Carer focussed education and support (89%)		2	Outcome Measures (0%)	
3	Supported Education and Employment (33% taken up)		3	Provision for Children and Young People (BUT error with reporting)	
Report Recommendations:			S.M.A.R.T Actions:Responsible:DueDate:		Progress:
1	Focus on sustaining performance; notably around timely access and addressing factors affecting delivery of NICE concordant EIP and ARMS provision across all age groups, particularly Family Intervention (FI) in England, Cognitive Behavioural Therapy for psychosis (CBTp) in Wales and CBT for ARMS in England and Wales.		CBTp: new psychologists (trained or training in CBTp) in post should improve provision.		Ongoing
2	Improve lipid measurement screening in England and referral for blood pressure treatment by an appropriate clinician in response to elevated cardiovascular risk when completing physical health checks in both England and Wales.		Physical health monitoring and intervention workstream in Wales.		Ongoing
3	Routinely use standard nationally agreed outcome measures (DIALOG and ReQoL for Wales; DIALOG, ReQoL and GBO for England) and use of outcome measures data to evaluate EIP outcomes in England and Wales.		Routine collection following OPAs. NCAP routine data collection.		Ongoing
4	Continue to record and monitor which interventions get offered to whom. Actively seek to address health inequalities both in offer and take-up related to regional and health board variation, gender, ethnicity or age in both England and Wales.		Routine NCAP data collection is allowing us to be more proactive in addressing this. Ongoing discussions around how to improve awareness and referrals into the service.		Ongoing
5	Ensure the National Institute for Health and Care Excellence (NICE) recommended specialist EIP and ARMS interventions and care are available to Children and Young People (CYP) with First Episode Psychosis (FEP) and ARMS (England and Wales).		We offer joint working with CAMHS. No ARMS provision at present but we will continue to discuss how this can be offered within our current resource.		Partially complete
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:		Responsible:Due Date:Progress:	
1	Access and waiting time needs to be improved in line with target of 60% being seen within 14 days of referral.	QI project completed to improve awareness of target within the team and change process of screening and allocating referrals		Achieved. (Data from last 6 months show 64% allocated within 2 weeks and 85% within 4 weeks.)	
2	Completion of two outcome measures to be done as standard	Care coordinators are already more aware of the need to complete these. Discuss again within MDT and check outcomes via NCAP monthly audit data		Ongoing	

37/129

486/644

Rationale:	The aim of the National Lung Cancer Audit (NLCA) is to evaluate the patterns of care and outcomes for people with lung cancer in England and Wales, and to support NHS services to improve the quality of care for these individuals.
Objectives:	The management of people with lung cancer is informed by various national guidelines and the NLCA evaluates current patterns of care against the standards that these set. Specific standards were defined in: Quality Standard QS17 from the National Institute for Health and Care Excellence (NICE), the national commissioning guidance from the Lung Cancer Clinical Expert Group, and the National Optimal Lung Cancer Pathway. The NLCA has developed quality improvement goals and indicators using these standards and after consultations with its clinical reference group and Patient and Public Involvement (PPI) forum. The goals and indicators are described in the {NLCA Quality Improvement Plan}.



It is important to note that data is not comparable to the English data as data is derived from different dataset collection systems.

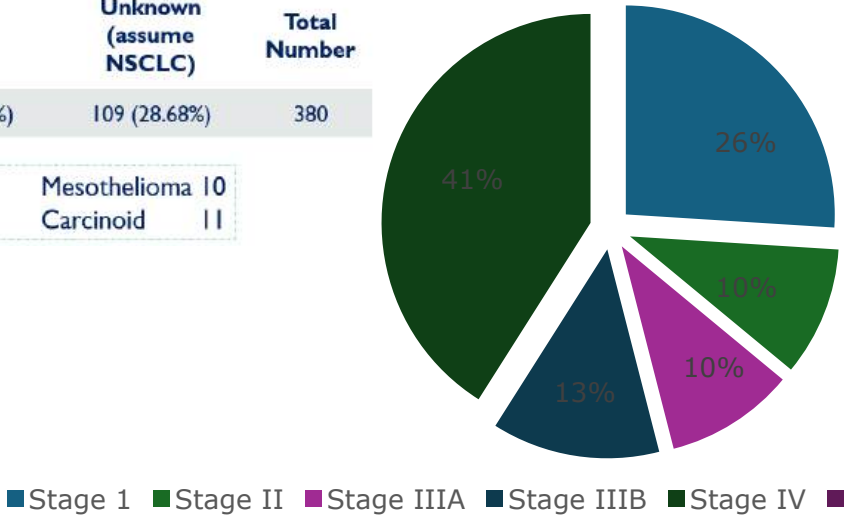
Data quality indicators

WALES	ABUHB
2,334 patients diagnosed with lung cancer in Wales in 2023. Completeness of key data items in the Welsh data was excellent. Completeness for the 2,334 patients analysed were: 100% for basis of diagnosis, 69% for tumour morphology (100% with tissue), 99% for disease stage, and 100% for performance status. 98% of records had data on whether a lung cancer nurse specialist was present at diagnosis. - Data was not provided for the ethnicity or smoking status data items.	380 patients diagnosed with lung cancer in Wales in 2022. The completeness of the key data items in the Welsh data was excellent. The levels of completeness for the 380 patients analysed were: 100% for basis of diagnosis, 71.3% for tumour morphology (100% with tissue), 99.74% for TNM stage, and 100% for performance status. 95.26% for IMD (deprivation) – 2nd in Wales 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis. - Data was not provided for the ethnicity or smoking status data items.

NLCA Audit 2023

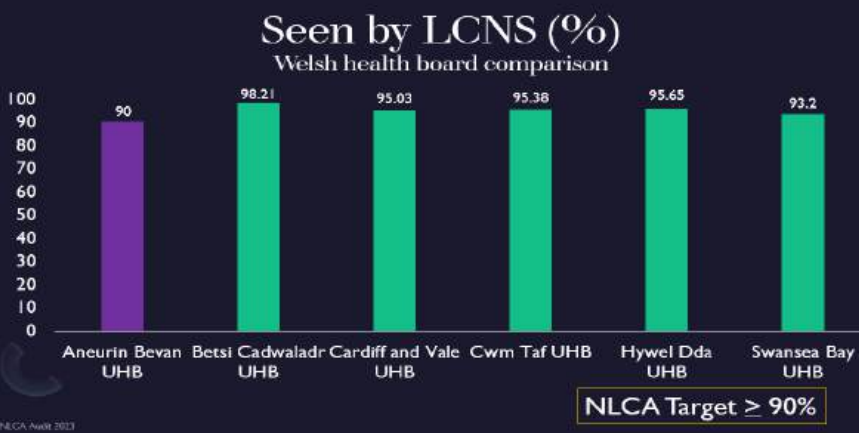
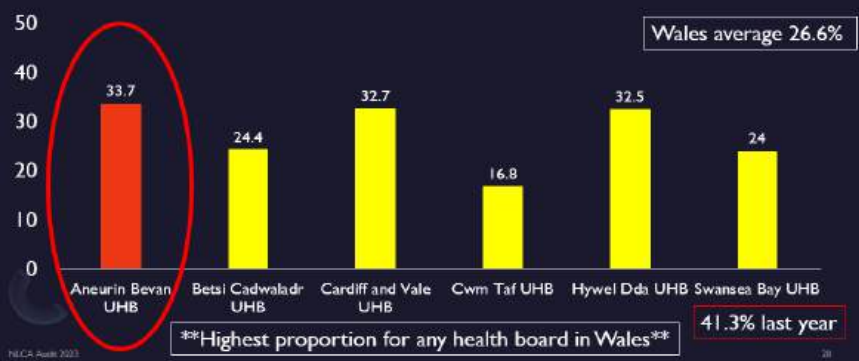
ABUHB Patient Cohort

Small Cell Cancer	NSCLC	Unknown (assume NSCLC)	Total Number
32 (8.42%)	239 (62.89%)	109 (28.68%)	380
●			
Others: Mesothelioma 10 Carcinoid 11			



Diagnosis after emergency presentation (%)

Welsh health board comparison



Waiting times in NSCLC (Wales)



One year and median survival (%)

Wales as a whole

Median survival	One year survival
301 days	46%
262 days in 2022	43% in 2022
222 days in 2021	39% in 2021
224 days in 2020	40% in 2020

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
Report Successes:	
1	NSCLC patients with stage I/II and good performance status (0-2) curative treatment rates 81.2% - higher than Wales mean
2	NSCLC patients with stage IIIA and good performance status (0-2) curative treatment rates 78.2% - higher than Wales mean
3	Surgical resection rate for patients with NSCLC 17.47% - higher than Wales mean
4	Use of systemic anti-cancer therapy for stage IIIB/IV NSCLC patients (PS 0-1) 72.2%- higher than Wales mean
5	Patients with Stage I/II with PS 0-1 confirmed pathological staging 95.1% - higher than Wales mean

Performance indicator values

- Velindre treatment data no longer input into Canisc as in previous years
- No national functioning radiotherapy or SACT dataset (Wales)
- Each cancer site database managed by different team and obtain information differently
- Manual systems to treatment data into audit spreadsheet for submission – not a robust solution
- This year – we were unable to review the data prior to submission
- We had gone through the data, highlighting treatments prior to submission – validation

Concerns concerns over this in November 2024 – no reply

Report Concerns:	
1	Proportion of SCLC patients having chemotherapy 56.2% - lower than Wales mean
2	Proportion of patients seen by a Lung Cancer Nurse Specialist – lower than Wales mean but above audit standard
3	Proportion of patients with lung cancer diagnosed after an emergency presentation 33.7% - highest in Wales cohort
4	Proportion of patients in Quintile 5 (most deprived) IMT 31.5% - highest in Wales (England 15.11%)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure services maximise the uptake of lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer. <i>The percentage of people with lung cancer diagnosed with stage 1/2 disease in Wales was 33.9% in 2023.</i> Goal 1: Improve early diagnosis of lung cancer	Lung Health Check Operational Pilot complete HB conducted scoping exercises – part of nationwide ongoing endeavours Evaluation 2 submitted and PHW report and recommendations awaited	PHW Welsh Government Individual Health Boards	Decision pending from WG on next steps	Initial response to recommendations from screening committee submitted. Ongoing engagement with central stakeholders
2	Ensure providers have sufficient thoracic surgery capacity to accommodate the larger number of people with Non-Small Cell Lung Cancer (NSCLC) who are candidates for curative surgery. <i>In Wales, 364 people had surgery in 2023, up from 276 in 2022.</i> Goal 2: Increase the proportion of patients who have treatment with curative intent	Surgical resection rate above NLCA target Ongoing increase in patients undergoing surgery Continued early diagnosis and prioritisation of patients requiring surgical intervention No issues with access – but waiting times >4 weeks	CAVUHB/WG MDT members	Ongoing Report recommendations complete	Complete – continued growth going forward
3	Identify opportunities for increasing the proportion of people with NSCLC stage 3B-4 (PS 0-1) to have Systemic Anti-Cancer Therapy (SACT) as per NICE guidance, such as help people maintain their fitness for SACT throughout the care pathway. <i>In Wales during 2023, the proportion was 55.2%, a fall from 2022 (=60.1%)</i> Goal 3: Increase the proportion of people receiving SACT and reduce variation in access	Improved pathological services – PD-L1 in-house, QuicDNA ctDNA project pioneers and imminently to be provided as part of the National Test Directory Oncology delays – recent resignation of oncologist – replacement pending and some delays related to external tissue processing	Velindre University NHS Trust ABUHB pathology service All Wales Medical Genomics Service	ctDNA with NGS panel to be added to the National Test Directory imminently Ongoing liaison with Velindre NHS trust – replacement appointment anticipated this year	Above audit standard achieved Ongoing refinement of pathways according to threats

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure NHS hospitals have the necessary resources and capacity to meet the timelines for patients to start primary treatment. <i>In England and Wales, among key subgroups, most people diagnosed in 2023 did not start treatment within the recommended timeframes</i> Goal 4: Improve the quality of the patient pathway	All facets of the pathway to be assessed on an ongoing basis to ensure efficiency – breach reports, tracker meetings, engagement from wider MDT. Ensure timely review and treatment from Oncology and Surgical services	CAVUHB/WG MDT members Velindre University NHS Trust AWMGS	This is an ongoing, prospective endeavour	Continued service development with ongoing improvement in active treatment rates and achievement of NLCA standards – however, ongoing vigilance, refinement and improvement is core to our MDT working
5	Ensure NHS hospitals have the necessary resources and capacity so that biomarker test results are delivered within 14 calendar days of the test being performed, as defined in the National Optimal Lung Cancer Pathway. <i>England: Between 2017 and 2021, approx. 25% of people with stage 4 (PS 0-1) had genomic testing.</i> Goal 4: Improve the quality of the patient pathway	This remains a challenge and is unachievable with current structures Turnaround time for AWMGS is 14 days from receipt of sample – therefore attainment impossible Ongoing review of timeliness ABUHB pathology service processing of samples	AWMGS ABUHB pathology services	This is a prospective endeavour – ongoing liaison with AWMGS no current plans to change service centrally	With the advent of ctDNA, this may speed up one aspect of the pathway and allow a T.A.T of 14 days No current opportunity to achieve T.A.T of 14 days for tissue samples
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Proportion of patients seen by a Lung Cancer Nurse Specialist Target $\geq$ 90%: ABUHB proportion = 90% Target achieved but below All Wales average	To review feasibility of inpatient review of patients given route of entry	Lung CNS team ABUHB	Prospective – feasibility to be assessed and planned	Discussed at MDT operational meeting 21/5/25 and planning ongoing
2	Proportion of patients with SCLC receiving chemotherapy Target $\geq$ 70% ABUHB proportion = 56.2%	Audit conducted Appropriate decisions made	MDT members Oncology services Velindre NHS Trust	Ongoing	Patient prioritisation for oncology review under ongoing review
41/129		490/644			

Epilepsy12 - 2025 combined organisational and clinical audits: Report for England and Wales

Clinical Cohort 6 – The first year of care for children and young people following a first paediatric assessment undertaken between 1 December 2022 and 30 November 2023

Clinical Lead(s):
Dr Nadeem Syed – Consultant Paediatrician

NICE guidance: [NG217 / QS211 Epilepsy12 Power BI tool](#)

Rationale: Epilepsy12, established in 2009, aims to support epilepsy services and health commissioners in assessing and improving the quality of care for children and young people with seizures and epilepsy. Epilepsy is the most common serious long-term neurological condition in childhood, affecting approximately 112,000 children and young people in the UK.

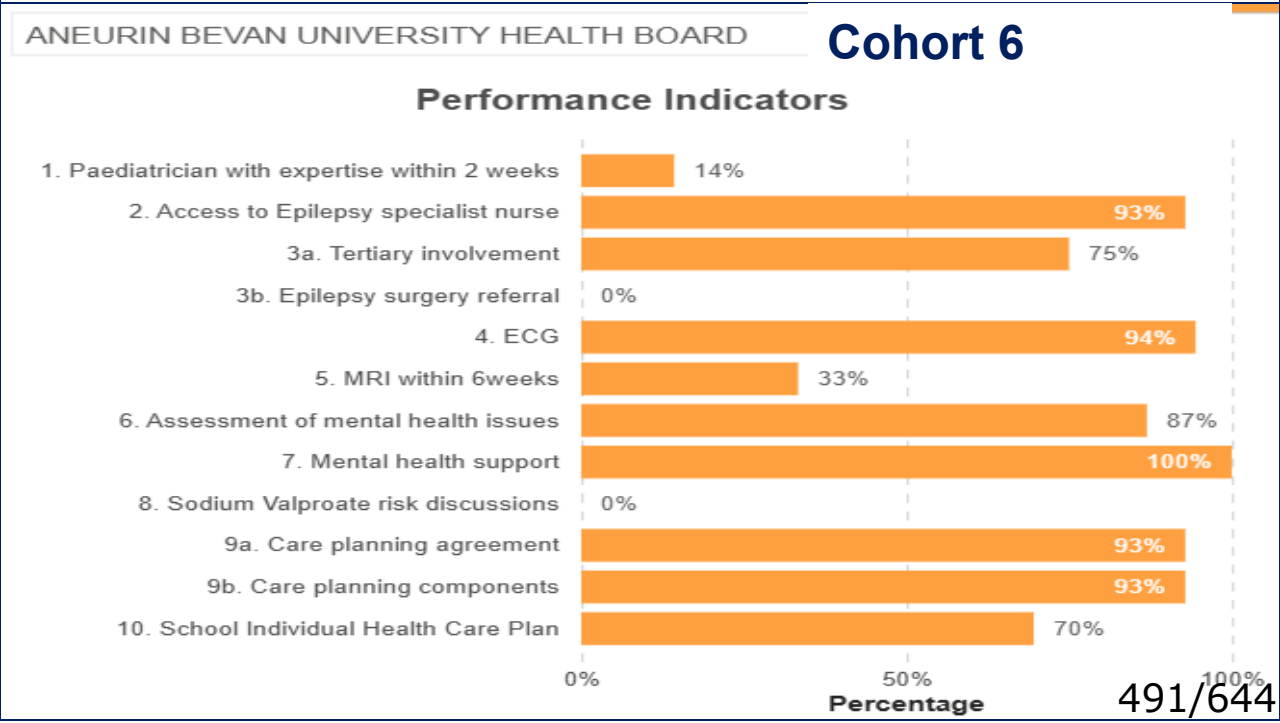
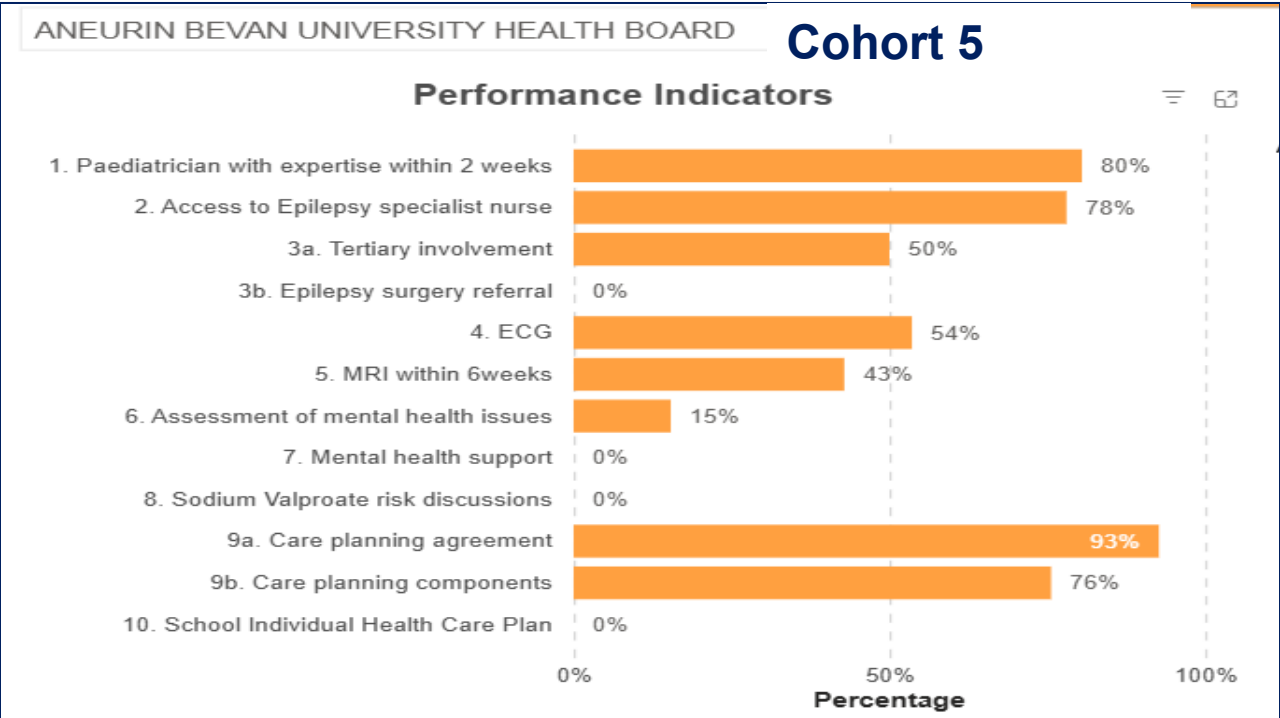
Objectives: **Epilepsy12** aims to raise the standard of care for children and young people with epilepsy by auditing clinical practice and service organisation. It collects and analyses data on patient care and service delivery to identify strengths and areas for improvement.

The programme has three core components:

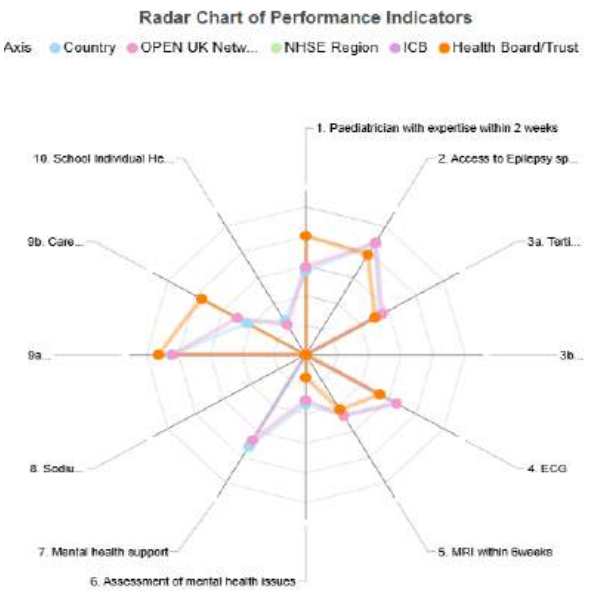
- Auditing of clinical care
- Quality improvement
- Epilepsy12 Youth Advocate

CSEG date: 25th September 2025

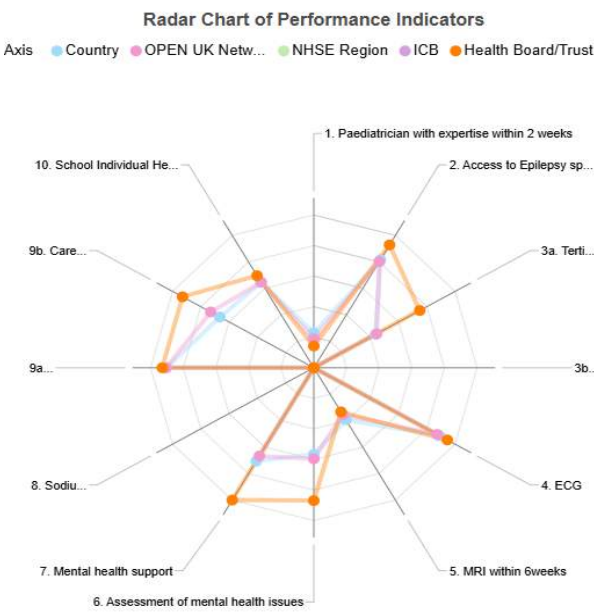
Epilepsy12 and Wales
Wales currently has representation on the UK Epilepsy Programme Board and OPEN UK. Epilepsy12 and NHS Wales are collaborating to formalise Welsh representation within the Epilepsy12 Project Board.



Cohort 5



Cohort 6



Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Low	Peripheral element of treatment or service suboptimal

Report Successes: (completed by the Clinical Lead)

1	Significant improvement in KPI2 – Children and YP seen by an ESN within the first year of care
2	Improvement in KPI4 – Children and YP with convulsive seizures had an ECG within the first year of care (94% vs 55% in cohort 5)
3	Significant improvement in assessing/asking for mental health KPI 6 (87% vs 15% in cohort 5)
4	Significant improvement in documented evidence of care planning KP1 9B (93% vs 76% in cohort 5)

Report Concerns: (completed by the Clinical Lead)

1	Not able to see children and young people within 2 weeks (KP1) by consultants with expertise in epilepsy (14%)
2	Failing to achieve MRI within 6 weeks of request (33%)
3	Continue struggling with backlog and significant delays in getting an EEG. However, this has improved since previously.

Report Recommendations: (national)	Progress:
Support Health Boards and Trusts identified as nonparticipation outliers. Identify specific barriers and enablers to facilitate and resource epilepsy team involvement. Work with young people and families, including the Epilepsy12 Youth Advocates and RCPCH Engagement Team, to help promote and support local participation. Action by: Integrated Care Boards across England and Local Health Boards across Wales.	Regular participation in RCPCH Epilepsy 12 audit achieved. There is some allocation of time in consultants job plan, this would be reviewed in forthcoming job planning.
Improve timely and equitable access to tertiary and epilepsy surgery services by: ❖ Reviewing and updating referral criteria and pathways for epilepsy surgical evaluation, ensuring ongoing consistency between the evidence base, national recommendations and regional and local practices. ❖ Reviewing the specification of tertiary neuroscience services to ensure commissioning towards a sustainable workforce and capacity to meet the needs of local populations. Action by: NHS England, the Children’s Epilepsy Surgery Service (CESS) in England and Integrated Care Boards across England. The Welsh Government and Local Health Boards across Wales.	Not applicable in secondary care services. Children requiring epilepsy surgical evaluation is referred timely to tertiary services at UHW who are the gate keepers of further referrals.
Support improvements in mental health provision, including screening, signposting, triaging, co-locating and clinical management, for children and young people with epilepsy in England and Wales. This could be achieved by: ❖ Completing the evaluation of mental health pilots in England including how they impact on Epilepsy12 performance metrics. ❖ Identifying opportunities for scaling and sustaining equitable mental health provision. Action by: NHS England Epilepsy Oversight Group and Integrated Care Boards across England. The Welsh Government and Local Health Boards across Wales.	Significant improvement in assessing/asking for mental health concerns. Sign posting to SPACE wellbeing and clinical psychologist (ACT therapy) available though needs increase in their capacity with recruiting more psychologists.

State of the Nation Report 2024

SSNAP - Sentinel Stroke National Audit Programme

Stroke care received between April 2023 to March 2024

Clinical Lead:

Dr Yaqoob Bhat

Clinical Director Stroke Medicine Presented by Rhys Monk - Directorate Manager for Stroke, CoTE, Neurology & Nephrology

- National Clinical Guideline for Stroke (2023) and NICE guidelines (Stroke and TIA, NG128; Stroke rehabilitation, NG236; and Quality standard for stroke)
- National policy documents including the NHS Long Term Plan, the National Stroke Service Model, the National service model for an integrated community stroke service and the Quality statement for stroke.

Rationale:	SSNAP measures the quality and organisation of stroke care across England, Wales and Northern Ireland.
Objectives:	The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered. Processes of care are measured against evidence-based quality standards referring to the interventions that any patient may be expected to receive.

Presented at Clinical Standards and Effectiveness Group – 25th September 2025

Sentinel Stroke National Audit - Key Changes:

- New metrics introduced in Oct 2024.



> Significant changes to measurements



> Raised the expectation on delivery of stroke services



> Old measures not comparable to new measures



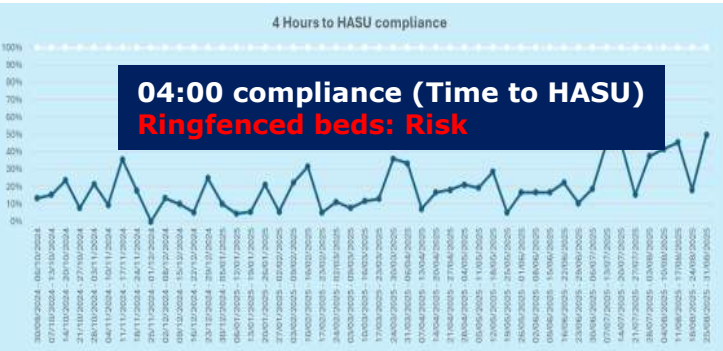
> Expected that most hospitals will revert to D/E grading



> Most recent quarter (Jan-Mar 2025) **not** released to the public

- Performance dropped due to higher standards

% Scanned within 20 Minutes (Aug-24 to Jul-25)



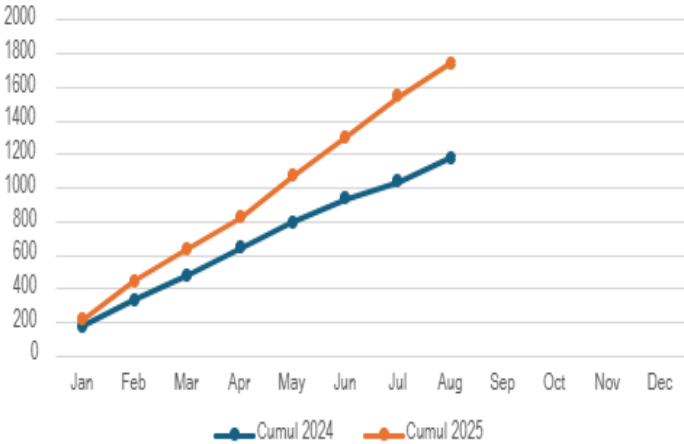
SSNAP Scoring Summary:
[See "Outline of report" for further information about this section of the report](#)

Team Type	Routinely admitting team
ISDN	Wales
Trust	Aneurin Bevan University Health Board
Team	Grange University Hospital
Time Period	Jan - Mar 2025
SSNAP level	
SSNAP score	21.4
Case ascertainment band	A
Audit compliance band	B
Combined Total Key Indicator level	C
Combined Total Key Indicator score	22.5
Patient-centred KI levels:	
Patient-centred Domain levels:	1) Hyperacute assessment: E, 2) Specialist pathway: E, 3) Reperfusion: D, 4) MDT assessment: E, 5) Therapy intensity: E, 6) Therapy frequency: E, 7) Standards by discharge: E
Patient - centred KI level	Patient-centred Total KI level: E, Patient-centred Total KI score: 22.5, Patient-centred SSNAP level: E, (after adjustments): E, Patient-centred SSNAP score: 21.4
Team-centred KI levels:	
Team-centred Domain levels:	1) Hyperacute assessment: E, 2) Specialist pathway: E, 3) Reperfusion: E, 4) MDT assessment: E, 5) Therapy intensity: E, 6) Therapy frequency: D, 7) Standards by discharge: E
Team - centred KI level	Team-centred Total KI level: E, Team-centred Total KI score: 22.5, Team-centred SSNAP level: E, (after adjustments): E, Team-centred SSNAP score: 493/644

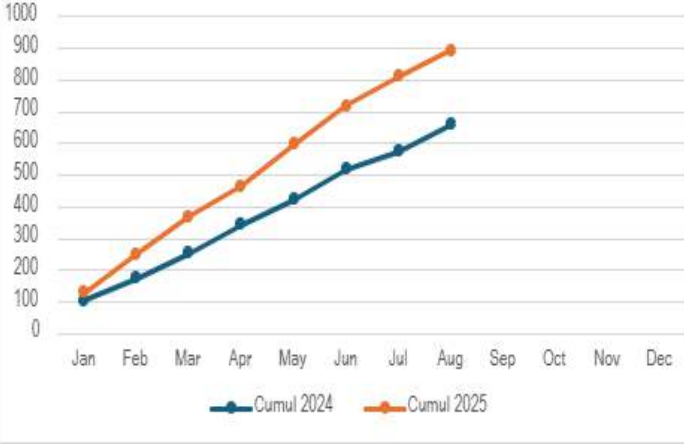
Thrombolysis & Thrombectomy

Stroke Consultant assessment <1 hour

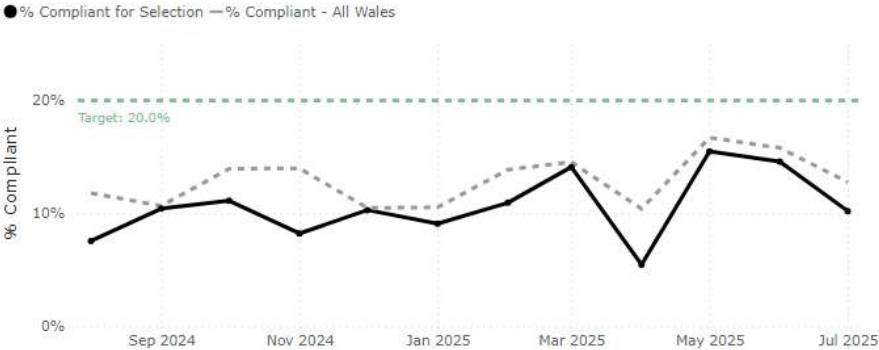
Stroke Front End Demand



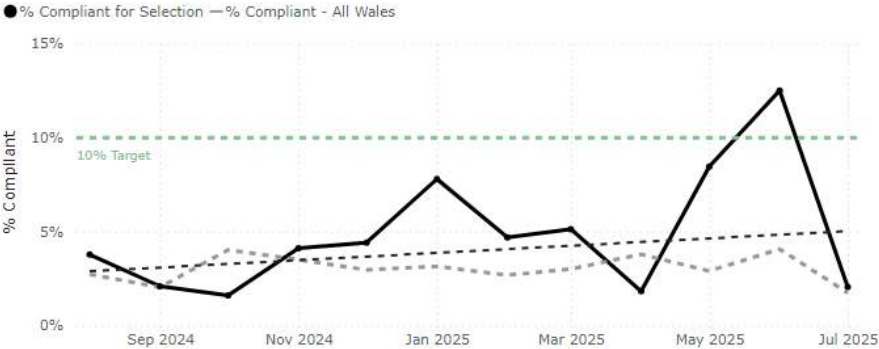
HASU Demand



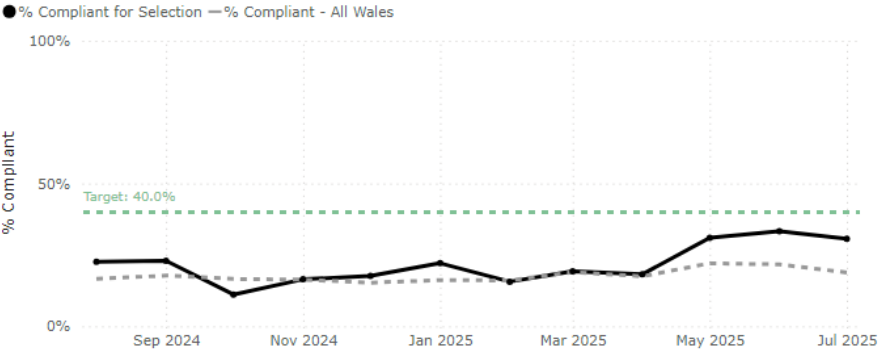
% Thrombolysed (Aug-24 to Jul-25)



% Received Thrombectomy (Aug-24 to Jul-25)



% Scanned within 20 Minutes (Aug-24 to Jul-25)



Scanning within 20 minutes & CTA



Stroke Consultant < 1 hour

Double up of CNS on front end
Demand has increased x% year on year



Time to HASU < 4 hours

Organisational priority needed
Ringfence of beds
Priority on patient flow through system (Scans, beds, transport)



Therapies

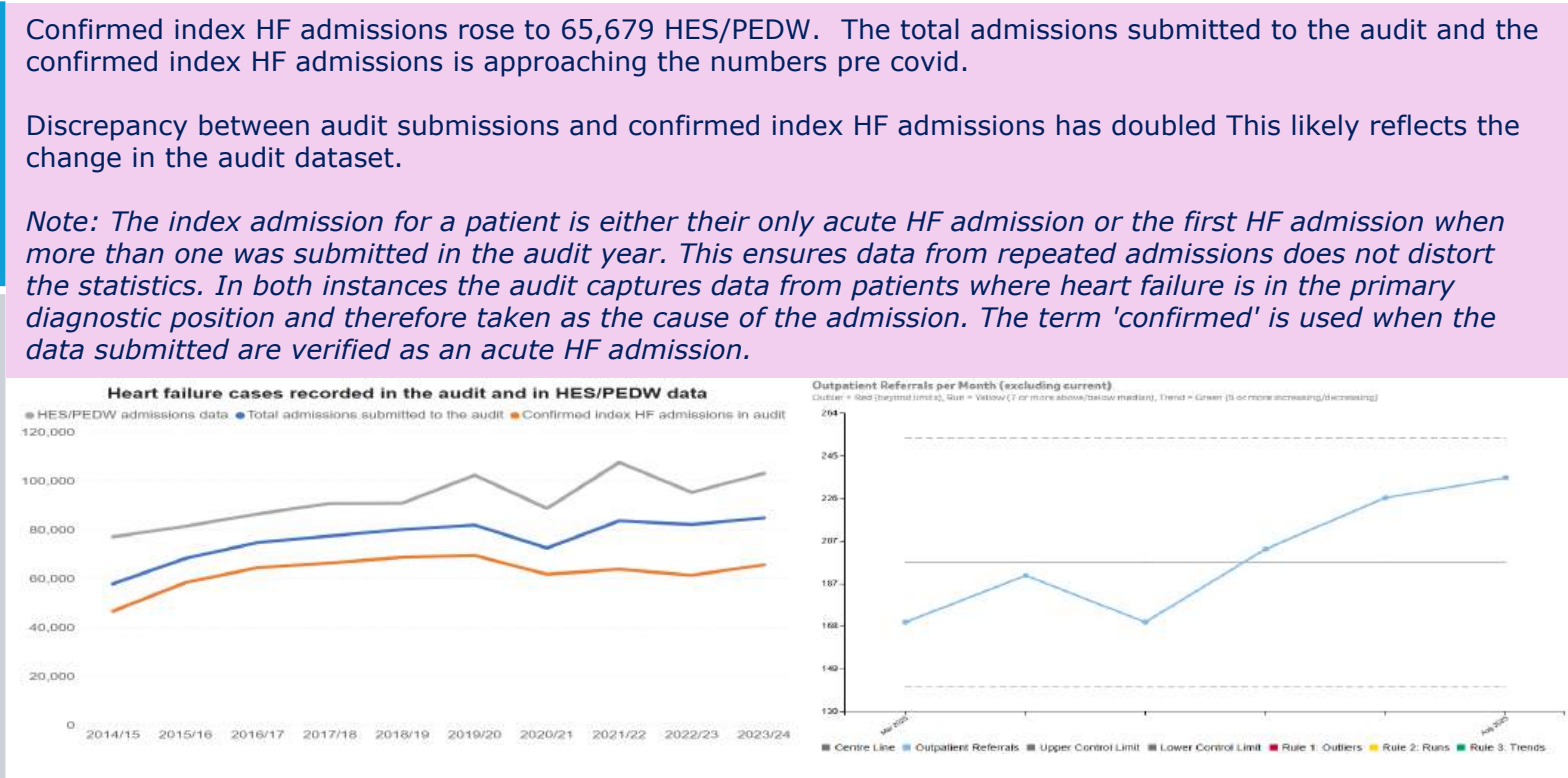
Business case to meet staffing guidelines

Actions: This is presented at Stoke Board

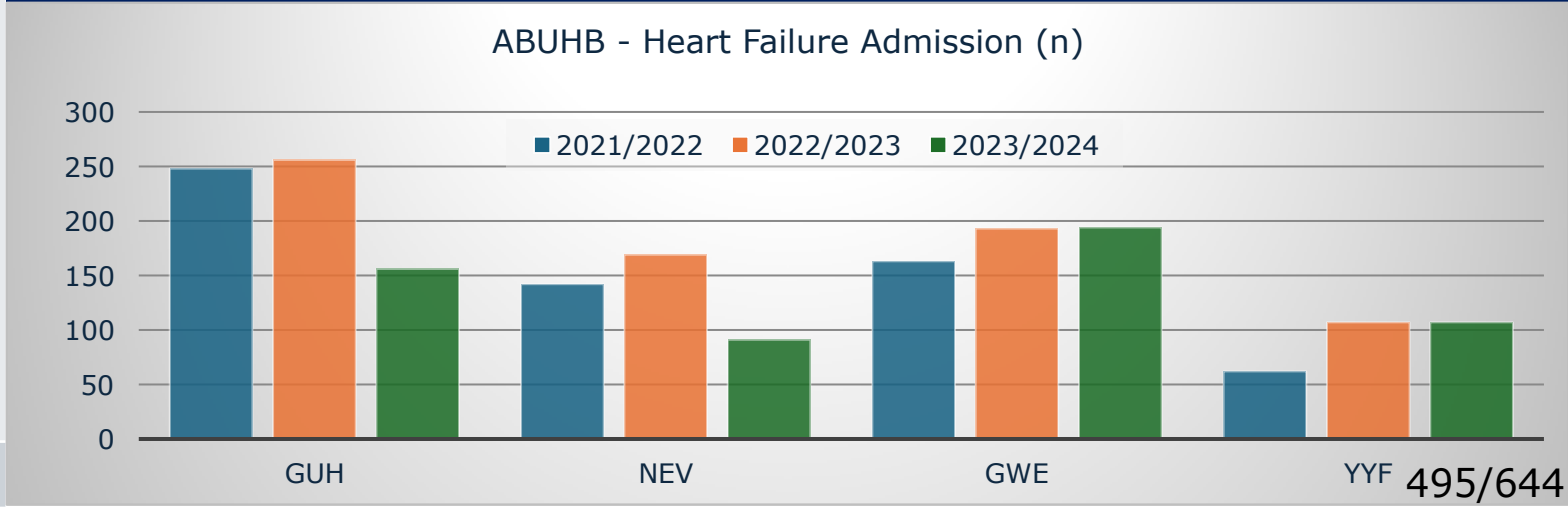
- Continue embedding flow coordinators.
- Expand thrombectomy access via Cardiff centre.
- Improve scanning and consultant review times.
- Support business case for therapy staffing.

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Rationale:	The National Heart Failure Audit (NHFA) monitors the care of patients admitted unexpectedly to hospitals in England and Wales who are discharged with a primary diagnosis of heart failure. The latest report covers the period April 2023 to March 2024 and provides a comprehensive review of care delivery for these patients. It examines patient characteristics, hospital investigations, treatments received, access to specialist care, discharge planning, and post-discharge follow-up.
Objectives:	The audit aims to enhance the quality of diagnosis, treatment, and management of heart failure. It is managed by NICOR and forms part of the National Cardiac Audit Programme within NHS England. The audit collects data on clinical indicators associated with better outcomes for heart failure patients and encourages the use of recommended diagnostics, treatments, and referral pathways. The dataset is regularly updated to ensure alignment with current clinical guidance.



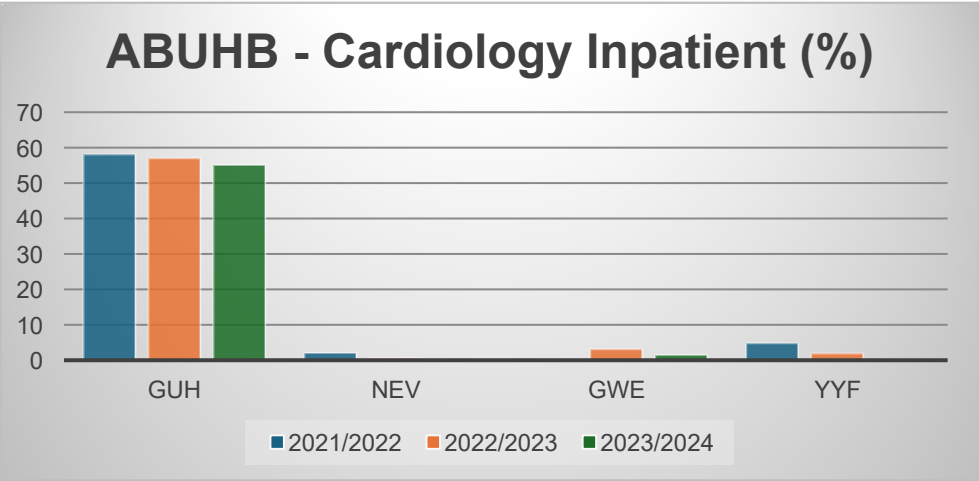
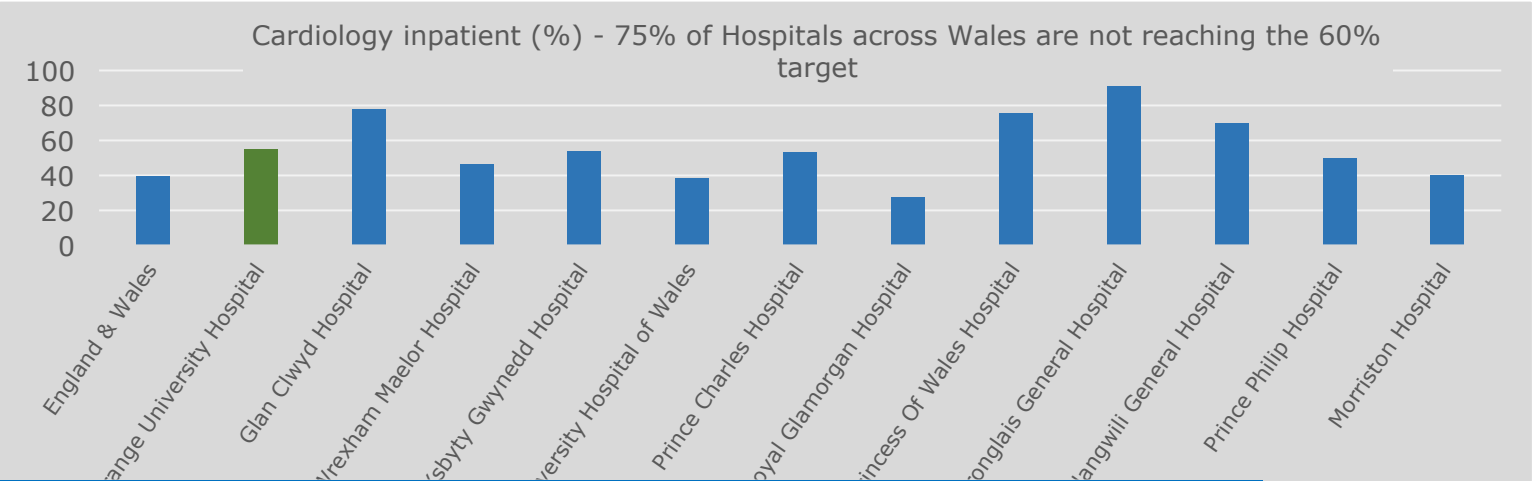
In the past 6 months, there have been a total of 1,105 Out Patient referrals to Cardiology Heart Failure recorded. This is around 181 referrals each month, ranging between a low of 146 in Feb 2025 and a high of 225 in July 2025.



Recommendations

Specialist care

- Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.



Nationally only 39% of HF patients care cared for on a cardiology ward – ABUHB patients in 2023/2024 main place of stay was 55.1% in cardiology ward

- Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.

Nationally 81% of HF patients were seen by a specialist heart failure team. ABUHB 62.8% of patients had input from Consultant Cardiologist & 64.7% received input from the HF specialist team.

- Specialist HF nurses should provide more support for 'non-HFrEF' patients – current service only funded for HFrEF.

Follow-up

- Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.

38% of ABUHB patients were referred for Cardiology F-Up

Best Practice Drugs

- A renewed focus on the importance of prescribing MRA's for HFrEF.

Nationally 68% are discharged on MRA - ABUHB 85.5% are discharged on MRA

- Use of anticoagulation for HF and AF should be improved.

Nationally 18% of HF & AF patients anticoagulated on discharge ABUHB of HF & AF patients anticoagulated on discharge – data not available

- The medication at discharge should be captured for all patients and accurately reported into the audit.

ABUHB - bespoke digital HF Nurse service documentation is in place on CWS. Forms are updated every six months to record disease modifying drugs and reasons for contraindications or delayed initiations.

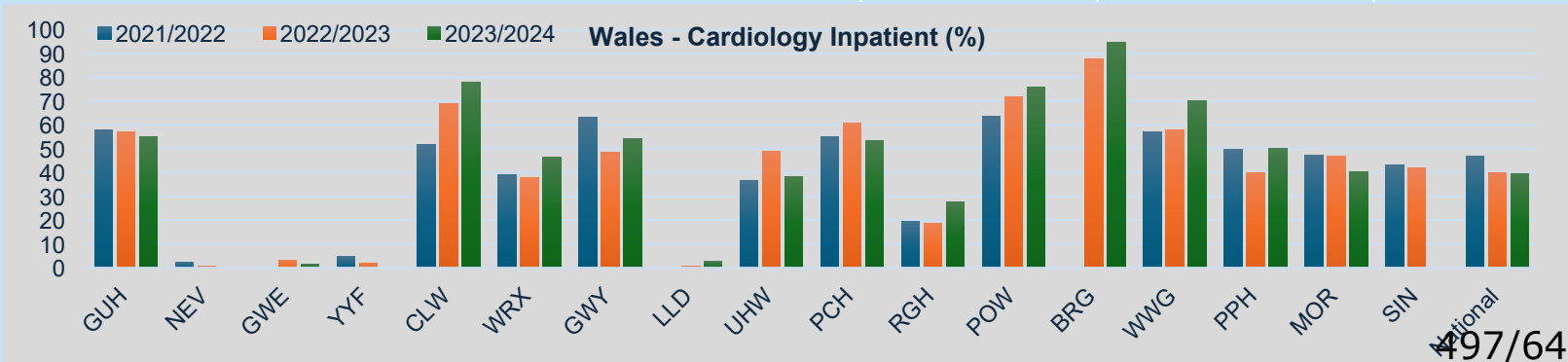
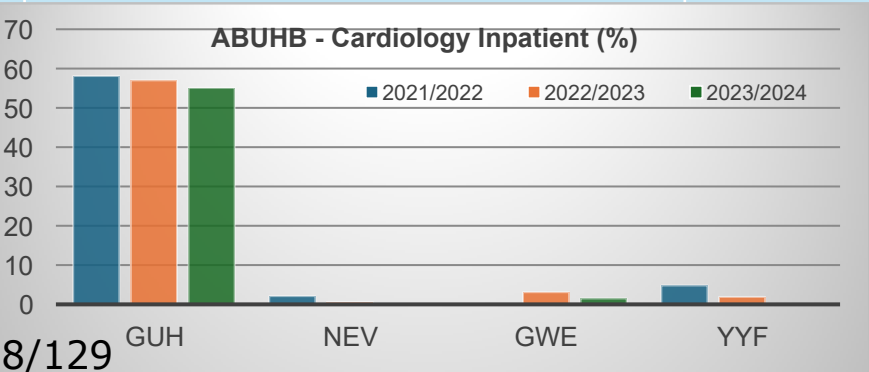
Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Low	Peripheral element of treatment or service suboptimal

Has this audit been placed on a Risk Register (N/A if above risk is None)	No

If not on a risk register, why not: To be discussed Cardiology Directorate

Report Successes:		Report Concerns:	
1	Increasing inpatient referrals year on year- AMaT development.	1	Increasing numbers of HFpEF – no current HF service provision.
2	Improved discharged planning and inpatient signposting.	2	Increasing inpatient and outpatients referrals to HF service year on year – demands vs capacity to maintain operational waiting targets.
3	All appropriate patients receive a 2 week follow up outpatient appointment following discharge.	3	No dedicated HF medical provision to establish bespoke HF management in the satellite hospitals.
4	In person medical support in all satellite hospitals from October 24 – June 25.	4	No live data to track timely in-patient service performance.
5	HF cardiac rehab now rolled out to all sites	5	No acute HF dedicated team

Report Recommendations: (national)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.	- Retrospective 3-month internal audit to ascertain the characteristics of patients that are not referred. - AMAT-live data. - Findings of the report presented in the Directorate/Clinical Governance Meeting. - Agree action plan, assign responsibilities, establish timeline for effective implementation and follow up.	Karen Hazel	Jan-March 2026 November 2025	



Report Recommendations: (national)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:																																																																																																								
2	Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.	Encompassed in the retrospective audit work, fulfilling the above actions.	Karen Hazel	Jan-March 2026																																																																																																									
		Develop, agree and sign off a clinical guidance within cardiology to confirm which patients should not be seen by Consultant Cardiologists.		April –May 2026																																																																																																									
3	Specialist HF nurses should provide more support for 'non-HFrEF' patients.	Additional resource required.	Karen Hazel	Jan-March 2026																																																																																																									
		Outcomes of the audit presented in: Clinical governance meeting, SMT meeting, Audit Team Consultant Cardiologists review pending the outcome a business case to be developed, if that is what is required.		April 2026																																																																																																									
4	All patients with HFrEF, irrespective of age or place of care, should receive best-practice disease-modifying drugs unless there is a contraindication.	Maintain inpatient quarterly education sessions.	Karen Hazel HF team	Ongoing Q1-4																																																																																																									
		Present findings at Grand round Agree action plan with COTE, GEN medicine		April 2026																																																																																																									
ABUHB - ACEI/ARB/ARNI on discharge (%) <table><thead><tr><th>Unit</th><th>2021/2022</th><th>2022/2023</th><th>2023/2024</th></tr></thead><tbody><tr><td>GUH</td><td>82</td><td>85</td><td>92</td></tr><tr><td>NEV</td><td>85</td><td>82</td><td>78</td></tr><tr><td>GWE</td><td>88</td><td>72</td><td>68</td></tr><tr><td>YYF</td><td>72</td><td>92</td><td>85</td></tr></tbody></table>		Unit	2021/2022	2022/2023	2023/2024	GUH	82	85	92	NEV	85	82	78	GWE	88	72	68	YYF	72	92	85	ABUHB - Beta Blocker on discharge (%) <table><thead><tr><th>Unit</th><th>2021/2022</th><th>2022/2023</th><th>2023/2024</th></tr></thead><tbody><tr><td>GUH</td><td>90</td><td>92</td><td>78</td></tr><tr><td>NEV</td><td>78</td><td>82</td><td>88</td></tr><tr><td>GWE</td><td>82</td><td>78</td><td>92</td></tr><tr><td>YYF</td><td>92</td><td>92</td><td>82</td></tr></tbody></table>		Unit	2021/2022	2022/2023	2023/2024	GUH	90	92	78	NEV	78	82	88	GWE	82	78	92	YYF	92	92	82	ABUHB - MRA on discharge (%) <table><thead><tr><th>Unit</th><th>2021/2022</th><th>2022/2023</th><th>2023/2024</th></tr></thead><tbody><tr><td>GUH</td><td>55</td><td>65</td><td>28</td></tr><tr><td>NEV</td><td>48</td><td>48</td><td>48</td></tr><tr><td>GWE</td><td>48</td><td>48</td><td>68</td></tr><tr><td>YYF</td><td>40</td><td>72</td><td>85</td></tr></tbody></table>		Unit	2021/2022	2022/2023	2023/2024	GUH	55	65	28	NEV	48	48	48	GWE	48	48	68	YYF	40	72	85	ABUHB - Triple therapy on discharge (%) <table><thead><tr><th>Unit</th><th>2021/2022</th><th>2022/2023</th><th>2023/2024</th></tr></thead><tbody><tr><td>GUH</td><td>45</td><td>65</td><td>15</td></tr><tr><td>NEV</td><td>22</td><td>40</td><td>38</td></tr><tr><td>GWE</td><td>32</td><td>40</td><td>52</td></tr><tr><td>YYF</td><td>25</td><td>72</td><td>60</td></tr></tbody></table>		Unit	2021/2022	2022/2023	2023/2024	GUH	45	65	15	NEV	22	40	38	GWE	32	40	52	YYF	25	72	60	ABUHB - SGLT2i on discharge (%) <table><thead><tr><th>Unit</th><th>2021/2022</th><th>2022/2023</th><th>2023/2024</th></tr></thead><tbody><tr><td>GUH</td><td>50</td><td>72</td><td>72</td></tr><tr><td>NEV</td><td>25</td><td>40</td><td>75</td></tr><tr><td>GWE</td><td>12</td><td>52</td><td>62</td></tr><tr><td>YYF</td><td>12</td><td>48</td><td>78</td></tr></tbody></table>		Unit	2021/2022	2022/2023	2023/2024	GUH	50	72	72	NEV	25	40	75	GWE	12	52	62	YYF	12	48	78
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		Grand round	HF team	February 2026	
6	Use of anticoagulation for patients with HF and AF should be improved.	Review internal audit data to gain deeper understanding Wider Consultant Discussion	Karen Hazel	Jan-March 2026	
7	The medication at discharge should be captured for all patients and accurately reported into the audit.	- Build the NICOR dataset into AMaT. - NICOR forms will be completed for all patients seen by the Inpatient HF service, irrespective of coding. Patients coded appropriately will be fed into NICOR. - Maintain inpatient quarterly education sessions to continue to raise the profile. Provide evidence from live data, with the premise to capture all medical teams to improve measure across all HF phenotypes.	Joanne Simpson Karen Hazel Karen Hazel	December2025 Dec 2025 Q1-4 ongoing	
8	Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.	Additional resource required Outcomes of the audit presented in: Clinical governance meeting SMT meeting Audit Team Consultant Cardiologists review pending the outcome a business case to be developed, if that is what is required.	Karen Hazel	April 2026 May 2026	

Recommendations



Specialist care

1. Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.
2. Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.
3. Specialist HF nurses should provide more support for 'non-HFrEF' patients.

Best-practice drugs

4. All patients with HFrEF, irrespective of age or place of care, should receive best-practice disease-modifying drugs unless there is a contra-indication.
5. There should be a renewed focus on the importance of prescribing MRAs for HFrEF.
6. Use of anticoagulation for patients with HF and AF should be improved.
7. The medication at discharge should be captured for all patients and accurately reported into the audit.

Follow-up

8. Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.

- Ref 500 - State of the Nation Report – Care of women with thrombosis and thromboembolism
- Ref. 501 - State of the Nation Report – Care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death
- Ref 578 - State of the Nation Report – Care of women with ectopic pregnancies
- Ref 581 - State of the Nation report – Perinatal deaths of babies born in 2023

Rationale:	MBRRACE-UK conducts national surveillance and perform confidential enquiries into the deaths of mothers and babies in the UK to identify lessons and improve care, thereby preventing future deaths and serious complications. It does this by collecting detailed data on maternal and perinatal deaths, auditing the care received, and using the findings to produce national recommendations for improving services. The goal is to reduce the number of avoidable deaths and improve outcomes for both mothers and babies.
Objectives:	The aim of MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is to improve maternal, newborn, and infant health outcomes by: • Conducting national surveillance of maternal deaths, late fetal losses, stillbirths, and neonatal deaths across the UK. • Undertaking confidential enquiries into selected cases of maternal and perinatal deaths and serious morbidity to identify lessons and make recommendations. • Supporting the delivery of safe, equitable, high-quality, and patient-centred care in maternity and neonatal services. • Reducing inequalities in outcomes by examining the impact of factors such as ethnicity, deprivation, and access to care.

Ref 500 - State of the Nation Report - Surveillance findings and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into **Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties.**

Recommendations (relevant to ABUHB):

1. Clearly define the rapid access pathways for prescribing thromboprophylaxis to ensure that women known to be at risk are able to access thromboprophylaxis when they need it, particularly in the first trimester. **Audience: Integrated Care Boards and Health Boards.**

Ref. 501 - State of the Nation Report - Care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death

Recommendations

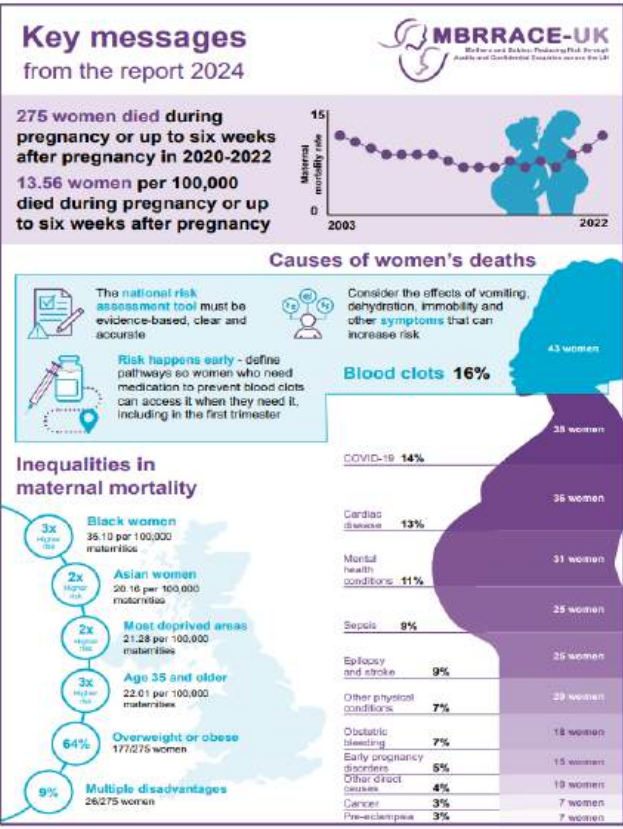
1. Ensure that the number of women who require language support, and the support provided at each visit, is recorded systematically. This includes documenting the use of professional interpreting services at clinical care interactions and when supporting women through the navigation of care pathways, as well as recording when these services are not available. The resulting data should be used to implement quality improvement measures and be assessed against existing NICE guidance. **Audience: Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.**
2. Ensure services provide advocacy for women who have been in the UK for less than a year, or do not speak or understand English, to support care navigation. This should incorporate midwifery and obstetric care when indicated. **Audience: Home Office, Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.**
3. Pilot the provision of an initial assessment appointment for migrant women of childbearing age when they first access health care services. The purpose would be to carry out a holistic assessment of their reproductive healthcare needs, provide information about reproductive health and availability of maternity services, and to understand any concerns they may have about accessing healthcare services. **Audience: NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency, research funders.**
4. Develop provision for multiple routes of access to maternity care. These routes should include the ability for a health or social care professional, in any setting, to make a direct referral to maternity services on behalf of a woman with her consent. **Audience: Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland)."**

Ref 578 - State of the Nation Report - Surveillance findings and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into **Maternal Deaths from hypertensive disorders, cardiac disease, mental health-related causes, homicide and accidents 2021-23, and morbidity findings for women living in the most deprived areas.**

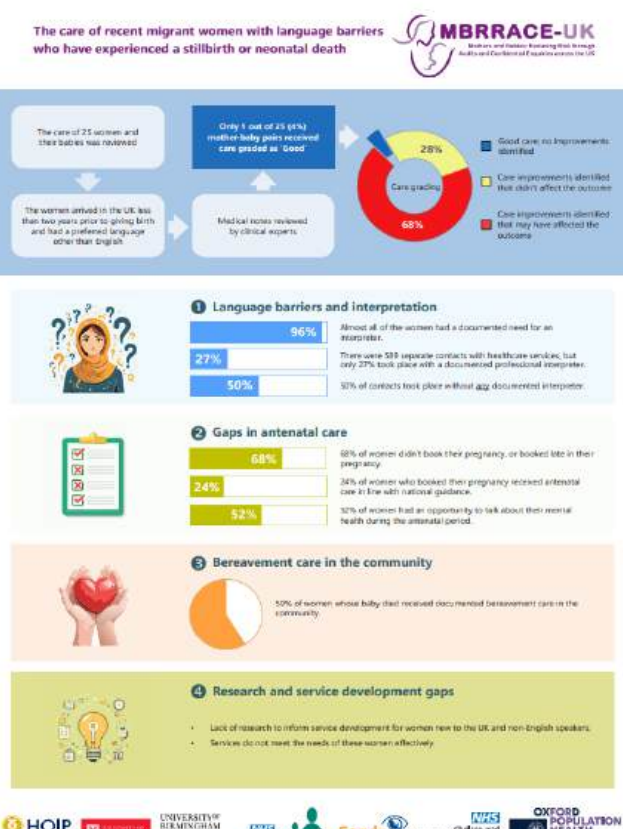
Recommendations

1. Set up an urgent referral pathway in early pregnancy for women with high-risk medical conditions or complex social circumstances to ensure they receive early triage for senior or specialist consultation **Audience: Maternal Medicine Networks in England and Health Boards in devolved nations**
2. Discharge summaries for primary care should clearly indicate in an initial summary box the key conditions that require ongoing support or management and a clear plan for postnatal care. Detailed information about medical, mental health and social complexities and ongoing medications, monitoring requirements or safeguarding concerns must be included to facilitate a clear plan for postnatal care **Audience: Integrated Care Boards and Health Boards**
3. Ensure specialist perinatal mental health teams undertake a leadership role for the care of pregnant or recently pregnant women with mental health conditions even if women are not accepted for care under their services. This should include a risk assessment, provision of advice and guidance, oversight for joint care planning and support to ensure rapid onward referral into other appropriate mental health **services Audience: Integrated Care Boards and Health Boards**

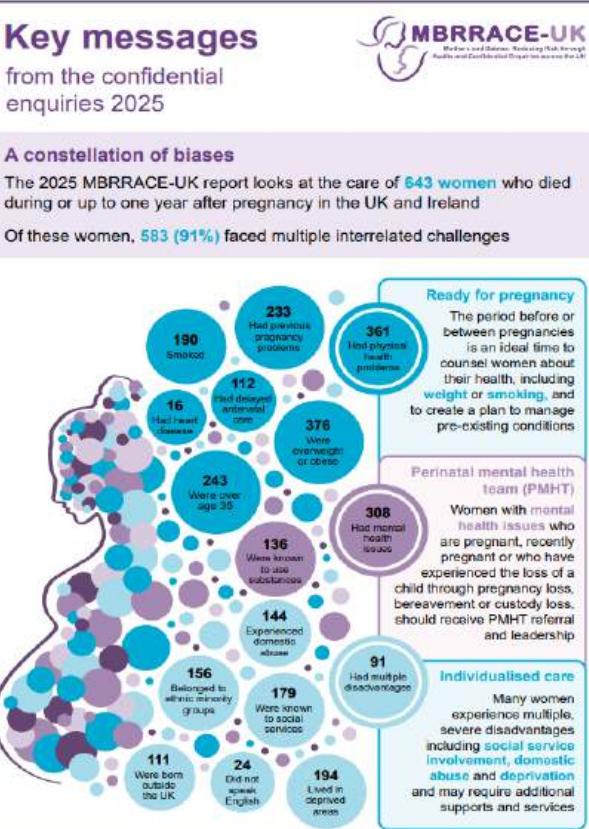
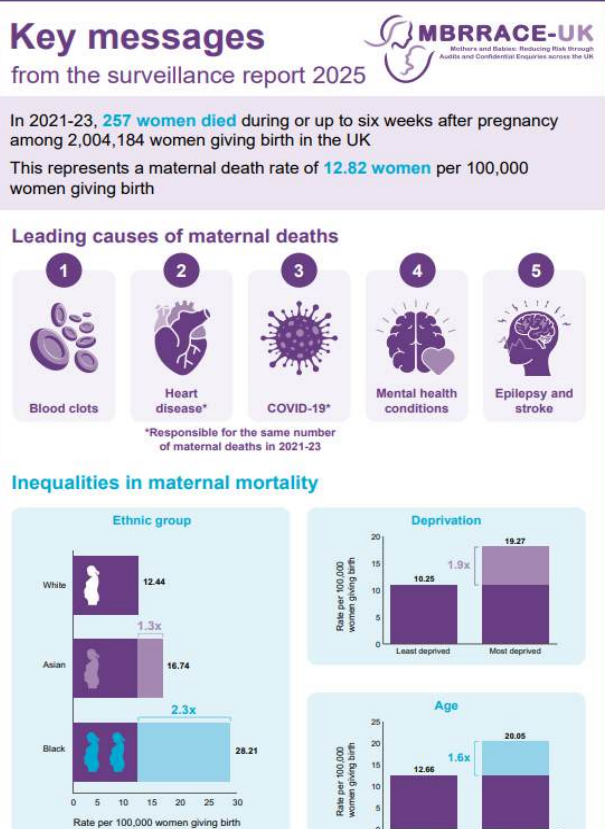
Infographics
Ref - 500



Ref - 501



Infographics
Ref - 578



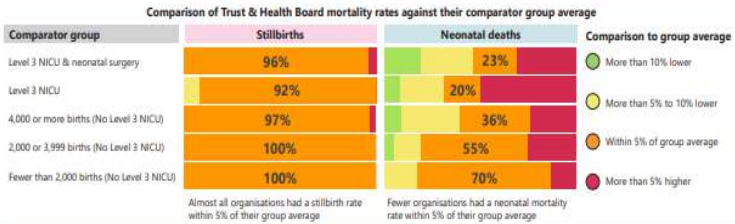
State of the nation report
UK perinatal deaths of babies born in 2023



1. Perinatal mortality rates continued to decrease in 2023, driven by a reduction in stillbirths.



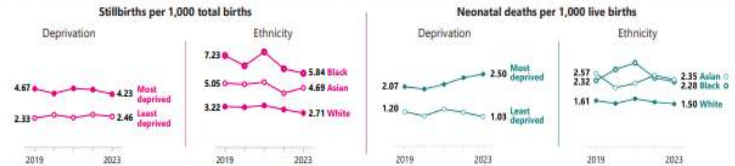
2. There was wide variation in neonatal mortality rates



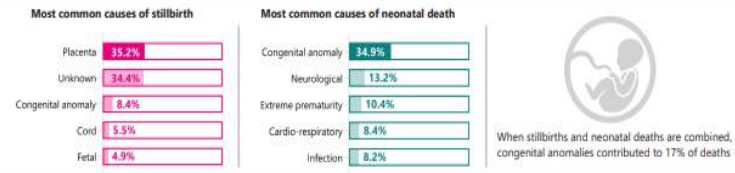
3. Neonatal mortality rates increased for the most preterm babies



4. Neonatal mortality rates for babies from the most deprived areas increased for the third year



5. The most common causes of stillbirth and neonatal death were unchanged



Ref 581 - State of the Nation report - perinatal deaths of babies born in 2023

Previous recommendations with continued relevance

1. Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care. (MBRRACE-UK 2024) **Audience: Commissioners**
2. Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation. (MBRRACE-UK 2023) **Audience: UK Governments, Royal Colleges, Commissioners**
3. Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes. (MBRRACE-UK 2023) **Audience: Royal Colleges, Commissioners**
4. Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities. (MBRRACE-UK 2023) **Audience: UK Governments, Royal Colleges, Commissioners**

	Trust/health board	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate (95% CI)
2023	Aneurin Bevan	5,272	3.22	3.61	(2.99 to 4.27)	1.90	2.01	(1.35 to 3.14)	5.12	5.61	(4.76 to 7.13)
2022	Aneurin Bevan	5,408	4.25	3.67	(3.11 to 4.38)	0.74	1.45	(0.88 to 2.37)	4.99	5.13	(4.47 to 6.56)
2021	Aneurin Bevan	5,398	4.45	4.17	(3.23 to 5.36)	0.93	1.66	(1.05 to 2.51)	5.37	5.81	(4.80 to 7.62)

Assurance level	Description	Risk level	Description
Full	The project has fully achieved the standards or criteria being audited against	None	Standards met and findings demonstrate no risk to patient safety

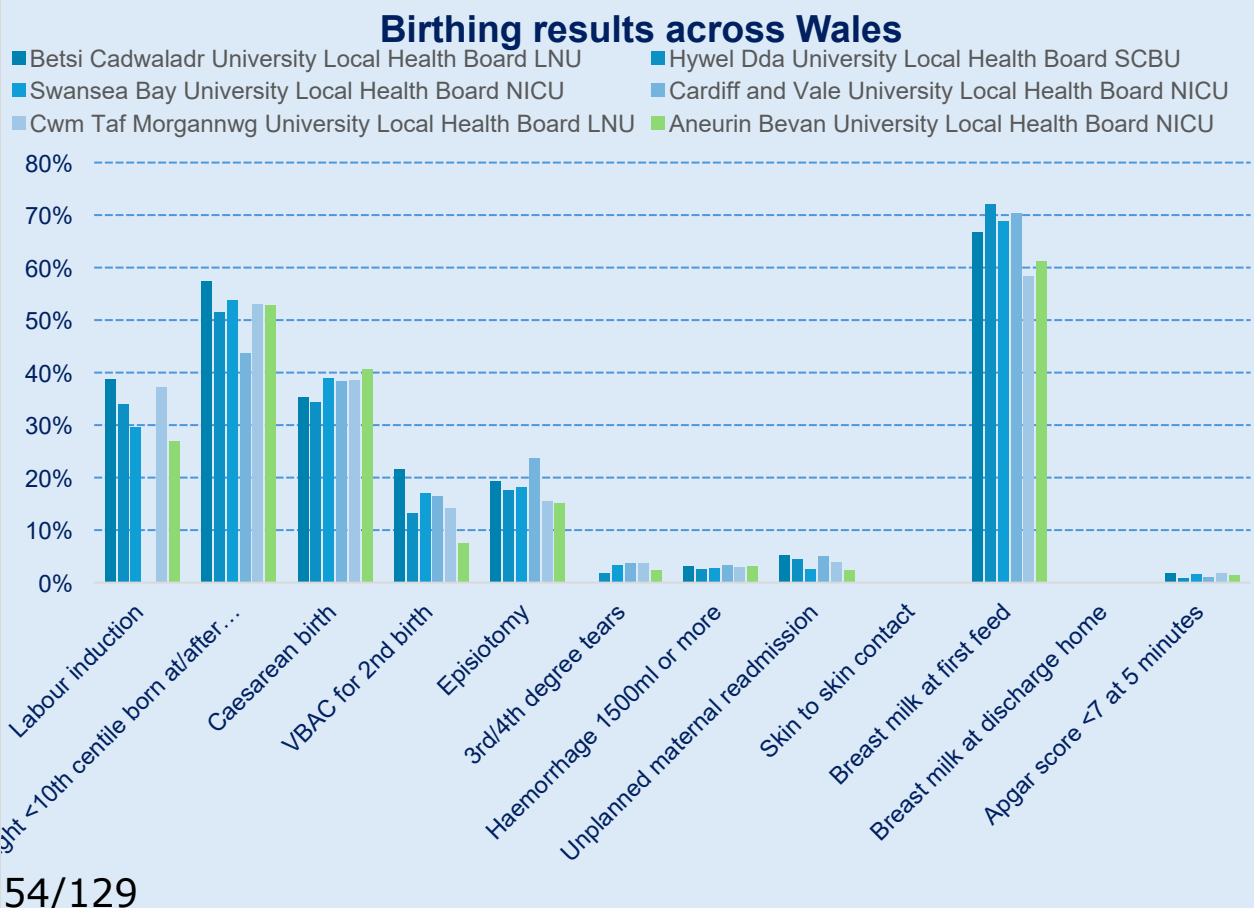
Report Successes:

1	Pathway in place for early thromboprophylaxis this includes from the first trimester for at risk women
2	Local peer groups in place to support women whose first language is not English for signposting
3	Interpretation service available, sign live, ipads, healthier together and digital platforms support multi language
4	Urgent referral pathway in early pregnancy high risk medical social conditions
5	Specialist perinatal mental health service

Report Concerns:

1	Initial assessment appointment for migrant women/multiple routes of access /rapid access

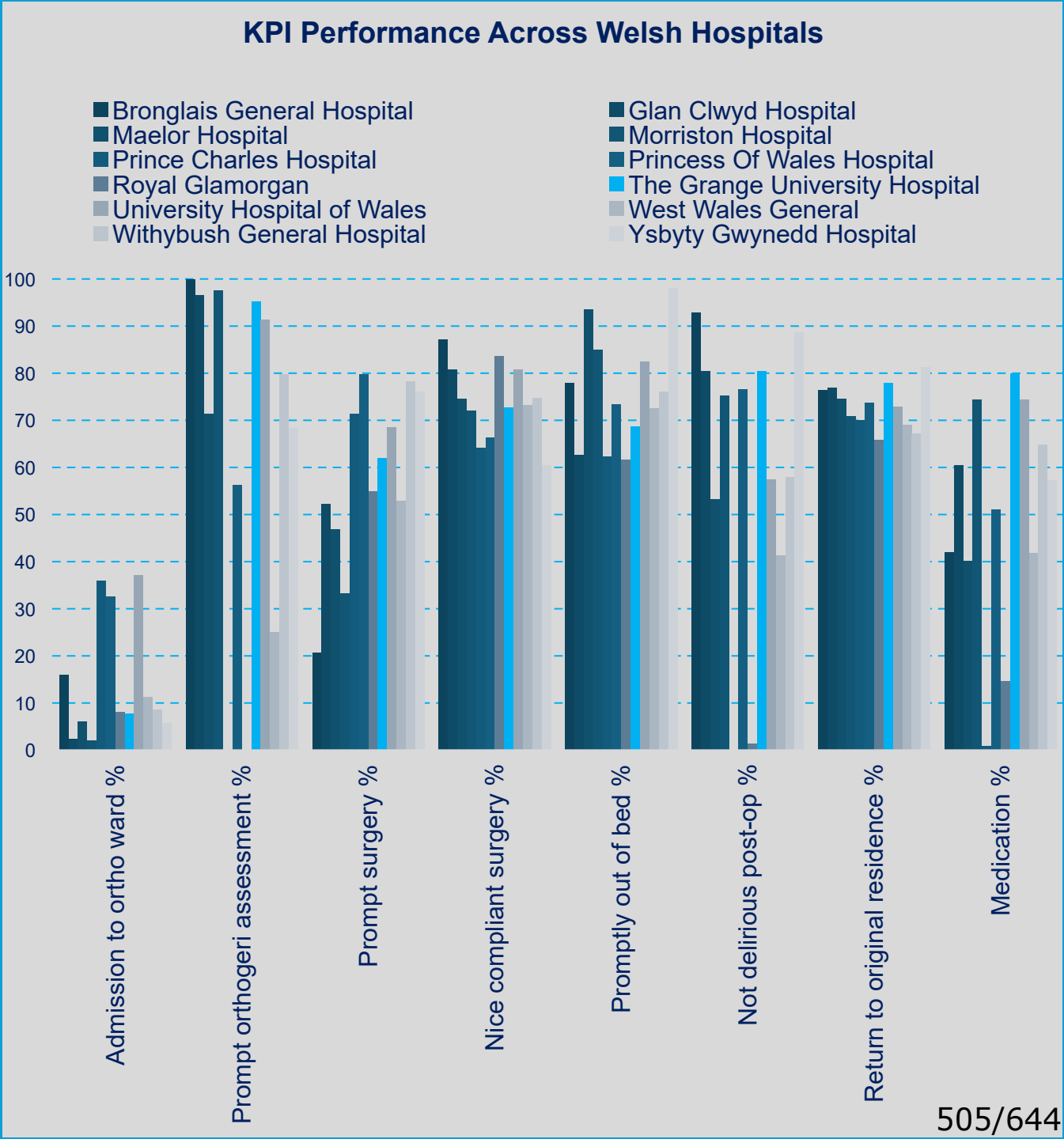
Rationale:	The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of NHS maternity services across England, Scotland and Wales. The NMPA uses information routinely collected as part of maternity care, combined with information collected when women and birthing people and their babies are admitted to hospital.
Objectives:	Results can be used to benchmark against national standards and recommendations where these exist, and to identify good practice among maternity care providers and specific clinical areas for quality improvement. Only records and maternity services which passed detailed data quality checks are included in these results. This means not every maternity service at every trust/board has results for every measure.



Assurance level		Description	Risk level		Description
Full		The project has fully achieved the standards or criteria being audited against	None		Standards met and findings demonstrate no risk to patient safety
Report Successes:			Report Concerns:		
1	Rates as expected : readmissions, vaginal tears, PPH, preterm birth,		1	Data completeness	
2	Rates lower than expected: induction of labour, term baby apgar scores < 7 , episiotomy rates,		2	Rates higher than expected : SGA, late booking after 10 weeks gestation	
3	Benchmarking		3	Lower rates of VBAC	

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Recommendation 1 – Timely pregnancy booking Government health departments should work with stakeholders to develop national and local level initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate		SPA referral implemented in 2025 to support direct and early booking for care Monitoring of booking data and direct feedback to lead midwives at bimonthly ELM Information provided in language of choice via digital format	HoM/Digital lead midwife	25/26	Current local data suggests a 12% increase of booking by 10 weeks since 2024 and is 60% overall compliance
Recommendation 2 – The impact of changing trends in maternity care and outcomes Government health departments should incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used to: Anticipate and respond with appropriate allocation of resources, such as workforce, bed/cot and obstetric theatre capacity, and finances, to optimise the options women and birthing people have for when and where they choose to give birth.		Implementation of the National perinatal workforce plan 3-month national mat/neo assessment Theatre capacity review Birth rate plus review	HEIW/local HB NHS improvement and performance HoM /SMM	03/26 12/25 07/25 03/26	Draft plan in place workforce review against priorities Underway for completion Complete increased RGN Planned for Q4 25
Recommendation 3 – Unwarranted variation Maternity care commissioners and maternity networks (the Wales Maternity and Neonatal Network) should use the evidence of variation in care processes and outcomes identified in this report, and the results for their local populations, when working with their constituent units to identify opportunities for improvements in service provision and clinical practice		Mat/neo discovery phase Mat/neo improvement phase Improvement lead in post	Mat/neo network	23 24/25 25/26	Health Board action plan measures in place Appointed

Rationale:	Hip fractures are the most common serious injury in frail older adults and the leading reason they require anaesthesia and surgery. For 16 years, the NHFD has reviewed the care of every person over 60 who sustains this injury. Hip fractures require hospital admission and occupy one in 30 hospital beds, costing around £2 billion annually. Most patients are over 80, and although demographic trends suggest numbers could double by 2060, improvements in population health- such as better osteoporosis management – may explain why this rise has not yet been observed.
Objectives:	Around 70,000 people in England, Wales and Northern Ireland sustain a hip fracture each year, a number that could double by 2060 as the population ages. Improving care and preventing these injuries remains essential. This report examines how 2024 are aligned with key patient goals: Admission - how soon will I be made comfortable and admitted to the right ward? Operation - how is my operation explained and supervised, so I can get up afterwards? Rehabilitation - how will I be supported to get back on my feet after surgery? Care quality - will I receive the same quality of care as other people? Care consistency - does every fracture lead to the same quality of care? While patient experience of care has improved enormously since the NHFD was created nearly 20 years ago, the report highlights variation. Most hospitals can be proud of their achievements, but this report shows how a number of hospitals have fallen behind in the care they are offering and discusses how the NHFD is helping them to catch up with the care being offered elsewhere.



Key performance GUH 2021-2024

		KPI 0	KPI 1	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7
		Admission to ortho ward %	Prompt orthogeriatric assessment %	Prompt surgery %	Nice compliant surgery %	Promptly out of bed %	Not delirious post-op %	Return to original residence %	Medication %
GUH	2021	2	91	67	72	76	77	73	56
GUH	2022	5.5	93.3	57.3	71.2	75.1	78.4	73.9	65.1
GUH	2023	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
GUH	2024	7.7	95.3	61.9	72.8	68.7	80.4	77.9	80
National	2024	9%	89%	58%	74%	82%	67%	75%	54%

Annualised values based on 767 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.

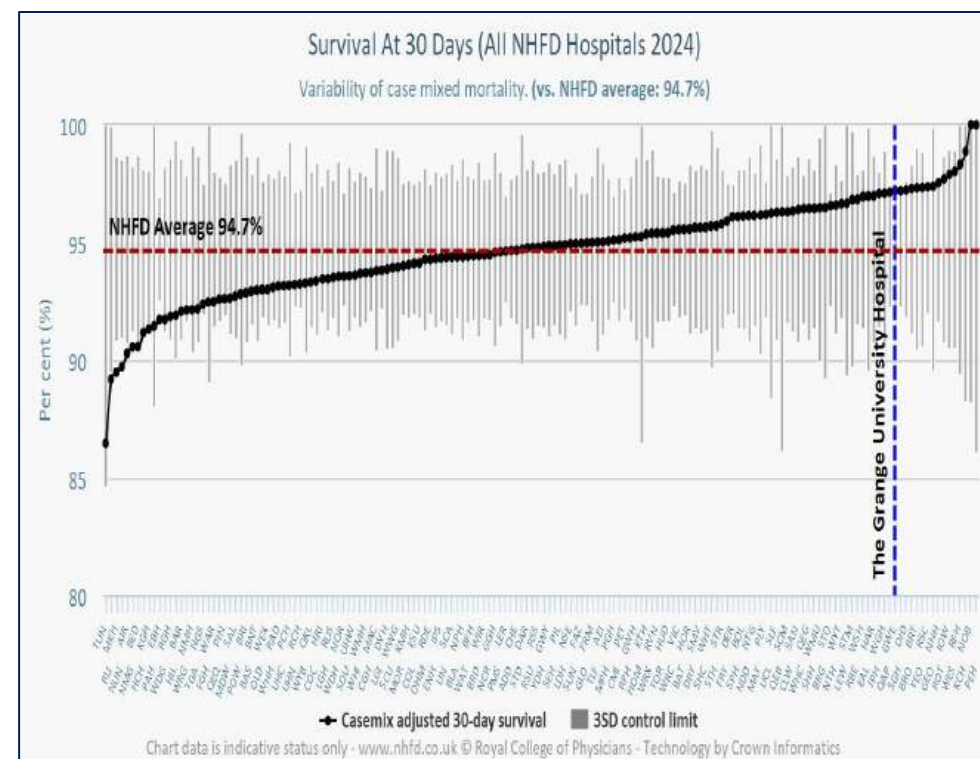
ABUHB data as at August 2025

KPI overview: GWE, The Grange University Hospital				KPI overview: [Wales]				KPI overview: [England]			
Annualised values based on 767 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.				Annualised values based on 4,037 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.				Annualised values based on 63,714 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.			
0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery	0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery	0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery
8%	95%	53%	68%	13%	67%	52%	66%	9%	90%	59%	71%
NHFD overall: 3%	NHFD overall: 82%	NHFD overall: 53%	NHFD overall: 70%	NHFD overall: 3%	NHFD overall: 82%	NHFD overall: 53%	NHFD overall: 70%	NHFD overall: 3%	NHFD overall: 82%	NHFD overall: 53%	NHFD overall: 70%
4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication	4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication	4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication
71%	82%	79%	73%	74%	56%	75%	53%	82%	69%	75%	57%
NHFD overall: 82%	NHFD overall: 60%	NHFD overall: 73%	NHFD overall: 57%	NHFD overall: 82%	NHFD overall: 60%	NHFD overall: 75%	NHFD overall: 57%	NHFD overall: 82%	NHFD overall: 60%	NHFD overall: 75%	NHFD overall: 57%

Assessment & Surgery Benchmark for ABUHB 2021, 2022, 2023, 2024.

Assessment benchmark		No. of cases submitted	Admitted to orthopaedic ward within 4 hours	4AT Test recorded on admission	Perioperative medical assessment	Physiotherapist assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment	Not delirious when tested post-op.	Received falls assessment	Received bone health assessment	Met best practice criteria
GUH	2021	685	4.2	60.4	91.1	97	76.4	99.7	78.4	99.3	99	37
GUH	2022	746	9.1	73.3	93.3	97.4	75.1	96.2	79.9	99.3	99.2	39.5
GUH	2023	811	21.9	66.1	96.4	95.7	69.4	98.6	80.2	98.3	98.3	36.5
GUH	2024	751	12	75.6	95.3	98.2	68.7	99.7	81.1	98	98.3	44.4

Surgery benchmark		No. of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic (not rated)	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic (not rated)	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
GUH	2021	685	66.9	47.3	30.8	89.7	68.4	89.4	99.4	24.4	81.3	92.1
GUH	2022	746	57.3	46.7	39.1	86.5	60.6	90.6	97.5	28	78.6	86.5
GUH	2023	811	56.9	44.3	40.7	95.3	59.3	92.1	99.5	30.9	71.9	81.8
GUH	2024	751	61.9	39.5	44.8	95.7	55	95.3	97.5	21.1	63.4	81



GUH - Mortality at one month post Hip Fracture Surgery 2024/25



Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

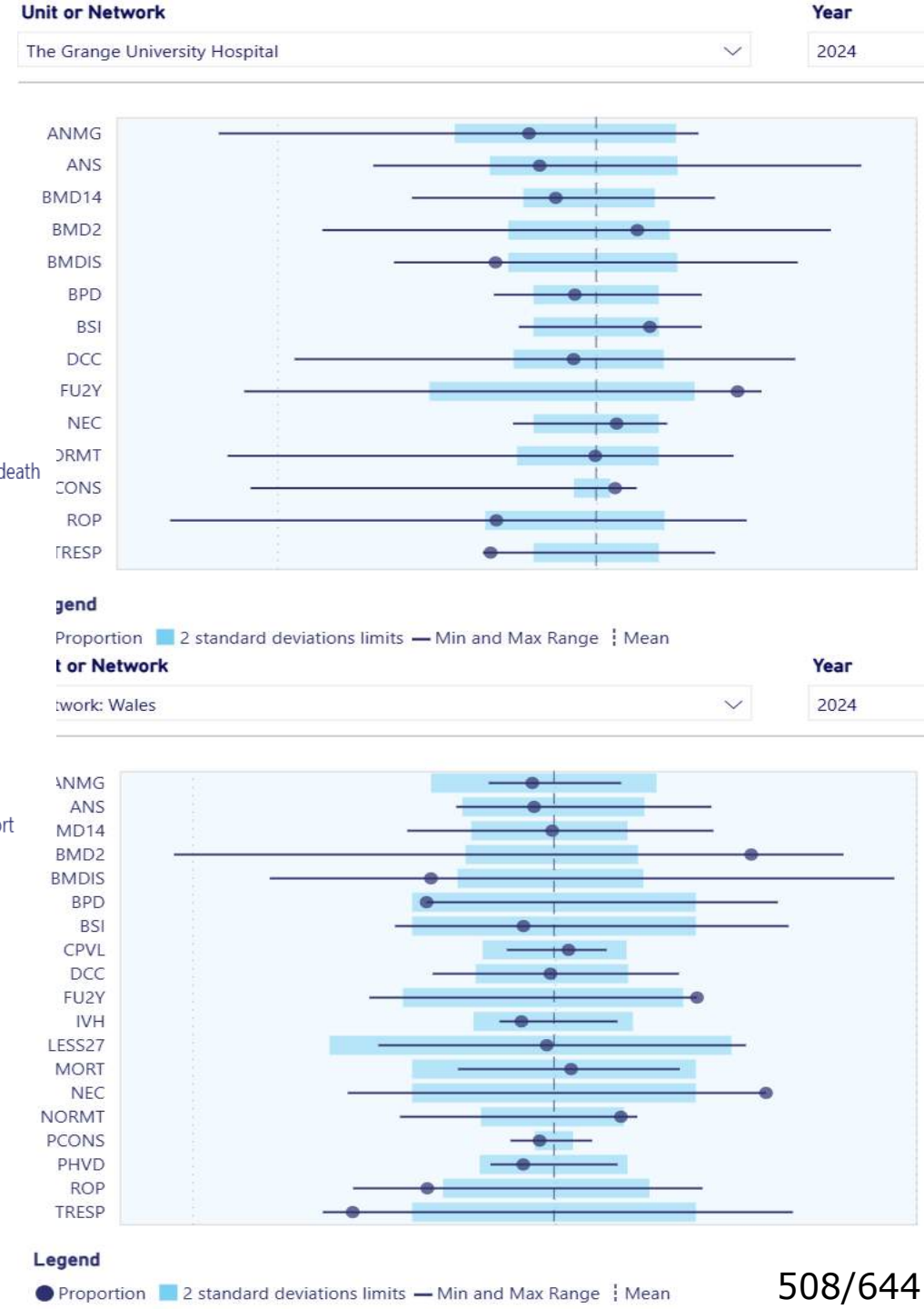
Report Successes:			
1	Prompt Orthogeriatric assessment (KPI 1)	4	Return to original residence (KPI 6)
2	Not delirious post OP (KPI 5)	5	Reduce mortality at one month
3	Bone Health Medication prescription on discharge (KPI 7)		
Report Concerns:			
1	Improvement in delay of the hip fracture from A&E to A0		
2	Compliance with 4AT recording in the clerking pro forma		
3	Surgery within 36 hours of admission. Hip fractures patients need to be prioritised with a consistent approach over semi-elective trauma		
4	Day 1 mobilisation (therapy staff not available at weekends and on bank holidays) QIP in place, human factor approach, nursing staff contribution		

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:
1	Require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture.	To undertake a review of the admission data to identify improvement in ward admission times	Orthopaedic/A&E	Update expected 30/09/2026
2	Review each hospital's NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as having been supervised by a senior surgeon and that it allows them to get up fully weightbearing.	Monthly clinical Governance meeting	Orthogeriatrics/ Orthopaedics	Ongoing
3	Require each hospital to commission appropriate physiotherapy capacity so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend.	Trauma review	Therapy Dept/ Orthopaedics	Fully complete
4	Require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are recorded to be on bone strengthening medication 4 months after a hip fracture.	Bone health assessment as part of Orthogeriatric assessment	Orthogeriatrics team	Ongoing
5	NHS England and Welsh government should use the results of the audit of pelvic ring fracture we will be piloting from January 2026 to challenge the main form of inequity in the management of fragility fracture which, as both the NHFD and GIRFT have shown, relates to the age of people with fractures at different sites.	Will be collecting the data from January 2026 and an update for Sep 2026	Dr Usman	Update expected 30/09/2026

Rationale :	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards.
Scope:	NNAP uses a range of measures to monitor neonatal care and highlight where improvement is required. These measures can vary from year to year and are categorised into the following themes: - Outcomes of neonatal care - Optimal perinatal care - Maternal breastmilk feeding - Parental partnership in care - Neonatal nurse staffing - Care processes - Overall network performance
Aims of the audit:	The NNAP has set out a series of supporting objectives, and approaches to stimulating healthcare improvement, which include: - High quality data outputs that identify areas for action and support stakeholders’ improvement initiatives. - Sharing best practice and quality improvement resources - Collaboration and engagement with regional and national initiatives - Parent and public engagement

Measures

MORT: Treatment effect of mortality
BPD: Treatment effect of bronchopulmonary dysplasia or death
NEC: Treatment effect of necrotising enterocolitis
BSI: Treatment effect of bloodstream infection
ANS: Antenatal steroids
ANMG: Antenatal magnesium sulphate
DCC: Deferred cord clamping
NormT: Normal temperature
BMD14: Breastmilk day 14
BMDIS: Breastmilk at discharge
BMD2: Breastmilk at day 2
PCons: Parental consultation in 24h
ROP: Retinopathy of prematurity
FU2Y: Two year follow up
TRESP: Treatment effect of non-invasive respiratory support





The Grange University Hospital is an outlier at **ALARM** level (3 or more std dev below expected performance)

Not seen any negative effect of the fact that our non-invasive ventilation rates in babies less than 32 weeks is low in the first week.

Assurance level		Description	Risk level	Description
Significant		The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Report Successes:			Report Concerns:	
1	Most of the measures within acceptable limits (close to national levels and within 2 SD)		1	NIV rates alarm level - (though not translating into poor outcomes) QI initiated
2	Excellent with 2 year follow up – commended by NNAP		2	Breast milk at discharge scope to improve- ongoing work
3	Improvement in ROP screening rates		3	Perinatal optimisation could improve- needs teamwork, PERIPREM work, data monitoring/ cleaning NNAP from maternity side
60/129 Neonatal outcomes rates good and better than network			509/644	

Report Recommendations:			S.M.A.R.T Actions: Responsible: Due Date: Progress:	
1	Neonatal networks should: a) Review their mortality data and, where rates are higher than expected, develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality, with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices. (Recommendation repeated from the 2023 data report). b) With their constituent units, undertake reviews of deaths in accordance with the BAPM Framework for Practice: Neonatal Mortality Governance (expected to be published in the second part of 2025) and engage with other statutory death review processes. Shared learning from these reviews should inform network governance and unit level clinical practice.		Data is continually reviewed using the NNAP online BI tool and performance data. All data is captured using BadgerNet. Engagement with SBUHB (Singleton Hospital) re NIV rates and processes.	
2	NHS England and health departments in Devolved Governments should: a) Issue clear guidance to neonatal services around the correct reporting of preterm brain injury including PHVD, so that robust data collection can support the achievement of the national ambition for neonatal brain injury. b) Develop a mandatory NHS neonatal information standard to ensure that clinical reporting systems are interoperable, ensuring robust data collection to support effective measurement and reporting of all neonatal processes and outcomes.			
3	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to regularly review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.	Data is continually reviewed using the NNAP online BI tool and performance data. All data is captured using BadgerNet.	Dr Reddy and Neonatal Team	
4	Neonatal networks and local maternity and neonatal systems should ask their constituent units with below average rates of breastmilk feeding by day 2 to: a) investigate reasons for variation in uptake locally b) with families, co-design targeted, quality improvement programmes	Breastfeeding rates drop after day 2 and at discharge. Breastfeeding support reinforced via Golden Drops project and discharge planning. Ongoing work with Breast Feeding Group to improve breast milk at discharge.	Dr Reddy and Neonatal Team	
5	Neonatal networks and local maternity and neonatal systems should work with the perinatal teams in their constituent neonatal units to: a) ensure that staff receive appropriate and consistent training to confidently ask families about their ethnicity and that of their baby, and to accurately record demographic information, b) use the NNAP dashboard to review how well NNAP process measures are delivered locally, and whether this differs by ethnicity c) where differences exist, seek to understand the underlying causes d) with families, co-design quality improvement programme that directly address those causes.		As above.	

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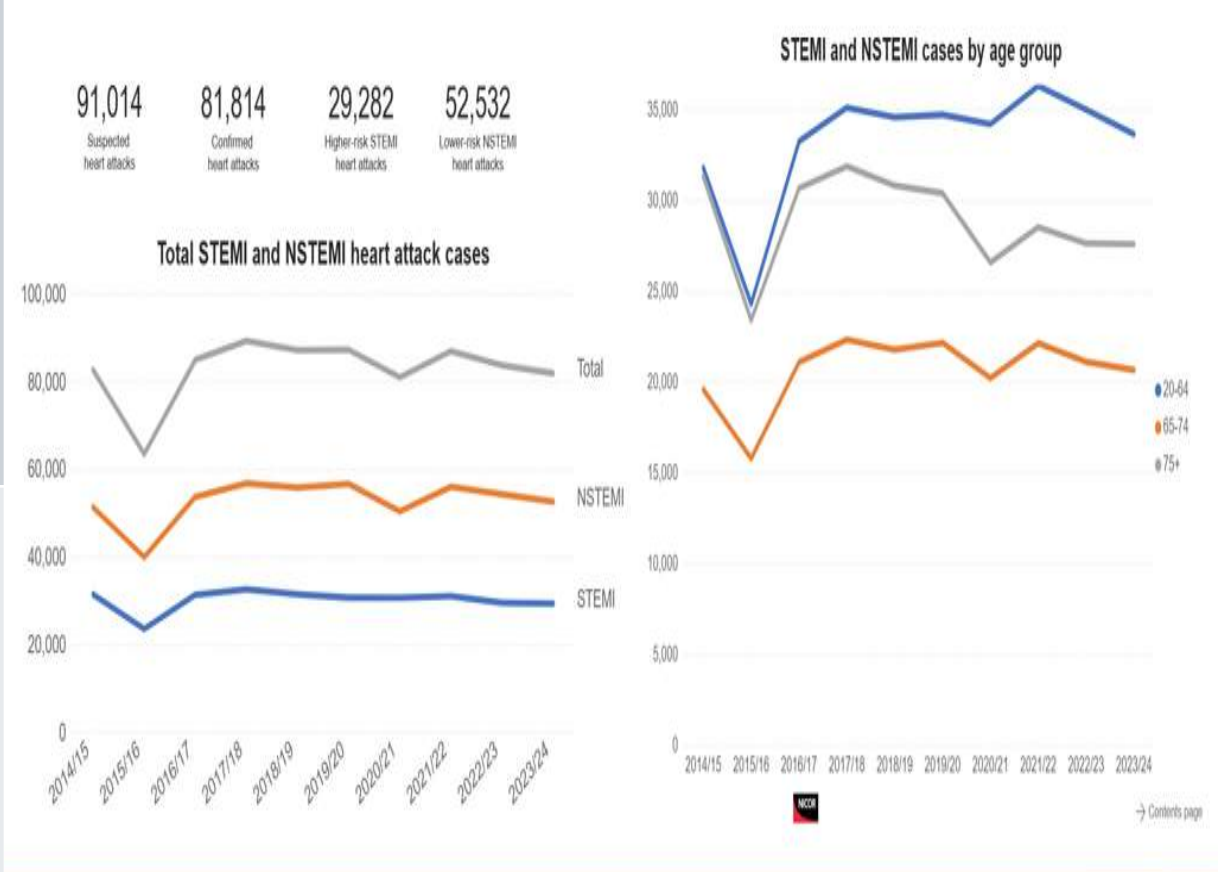
Rationale:

The Myocardial Ischaemia National Audit Project (MINAP) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR).

This report summarises the care provided within hospitals in England, Wales and Northern Ireland to almost 82,000 people who suffered a heart attack between April 2023 and March 2024.

- Objectives:
- A key focus of the audit is to support quality assurance and the improvement of services for people suffering a heart attack. The quality of care they receive is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with two types of heart attacks:

 - Higher-risk ST-segment elevation myocardial infarction (STEMI)
 - Non-ST-segment elevation myocardial infarction (NSTEMI).



8% reduction in heart attacks reported to MINAP compared with 2017/18 (2% fewer than 2022/23)

3 minutes improvement in median Call-To-Balloon (CTB) time for patients undergoing primary PCI compared to 2022/23 (first reduction in a decade but still 22 minutes longer than in 2014/15)

3 minutes improvement in Call-To-Door (CTD) time

1 in 10 proportion of patients with higher-risk STEMI heart attacks who self-presented to hospital (compared with 5-7% in the pre-pandemic years)

84 minute additional delay in Symptom-To-Balloon (STB) times for self-presenting patients compared with those brought directly to hospital by ambulance

Only 51% of eligible NSTEMI patients undergo angiography within 72 hours of admission (a 10-year low)

74% proportion of patients with poor heart function prescribed a mineralocorticoid receptor antagonist

Hospital	Local Health Board	STEMI cases (N)	NSTEMI cases (N)	Total MINAP submissions (N)	PEDW cases stringent (N)	Case ascertainment - Stringent (%)	PEDW cases non-stringent (N)	Case ascertainment - Non-stringent (%)
Grange University Hospital	Aneurin Bevan University Health Board	140	393	533	353	150.99	466	114.38

Confirmed quality data/completeness - even by non-stringent criteria ~ captured all cases

STEMI - context

- Not a Primary PCI Centre (even restricted hours)
- Ad hoc cases as able
- No dedicated lab for primary cases
- Only 49 cases for 2023-2024 (centres with < 20 excluded analysis)
- Skewed case mix (consequential delays)
 - Patients discussed by WAST declined by UHW (e.g. comorbidity concerns)
 - Diagnostic difficulty (WAST) and/or initial non-diagnostic ECG's
 - Concern to rule out other pathology e.g. ao dissection
 - Self presenters during working hours

Rare for us to be pre-alerted by WAST ~ that is changing

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Report Successes:		Report Concerns:	
1	Almost all patents are seen by a cardiologist and admitted to a cardiac ward	1	Poor door to needle times in STEMI reflect skewed case mix and lack dedicated service ** (BUSINESS CASE IN)
2	Angiography rates are high in NSTEMI and above the national average	2	Delays to IP angiography reflect staffing and lab time
3	Echocardiography and cardiac rehabilitation offer rates are high and exceed the national average	3	Slight concern re secondary prevention meds – requires further ix but may reflect less clear evidence base some medications in lower

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Given the increased rate of self-presentation, staff in emergency departments and other hospital admission areas should rapidly employ robust systems to identify patients with a heart attack. Hospitals must have agreed processes in place to ensure that patients with a probable higher-risk STEMI heart attack are transferred speedily to a cardiac catheter laboratory for primary PCI.		Clinical Director ED and cardiology	Ongoing work with ED	
2	In order to maintain ready access to an emergency ambulance response in the community, ambulance trusts should continue to work with receiving hospitals to facilitate safe and swift handover of patients who are brought to hospital by ambulance. N/A for now as not PPCI Centre				
3	Interventional hospitals should collaborate with local non-interventional hospitals to reverse the decline in the proportion of patients with lower-risk NSTEMI heart attacks who receive an angiogram within 72 hours of admission (e.g. through early identification of suitable patients, rapid electronic referral for angiography, providing weekend elective angiography lists, ring-fencing of beds for NSTEMI patients, and systems for 'treatment-and repatriation' between hospitals).	Increased staffing, support for BC to develop PPCI and upgrade of temporary pacing room to free up 2 nd cath lab space.	Clinical Director Divisional Director	Ongoing	
4	Staff in participating hospitals should use the audit data to examine their performance and compare it with others. Where performance for particular aspects of care appears suboptimal, they should first determine whether this reflects issues of data quality before moving on to implement quality improvement initiatives.	Work with team to undertake more detailed audit secondary prevention meds			
5	Staff in participating hospitals should use the audit data to examine their performance and compare it with others. Where performance for particular aspects of care appears suboptimal, they should first determine whether this reflects issues of data quality before moving on to implement quality improvement initiatives.	Work with team to undertake more detailed audit secondary prevention meds			

Rationale:
The National Audit of Percutaneous Coronary Intervention (NAPCI) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR).

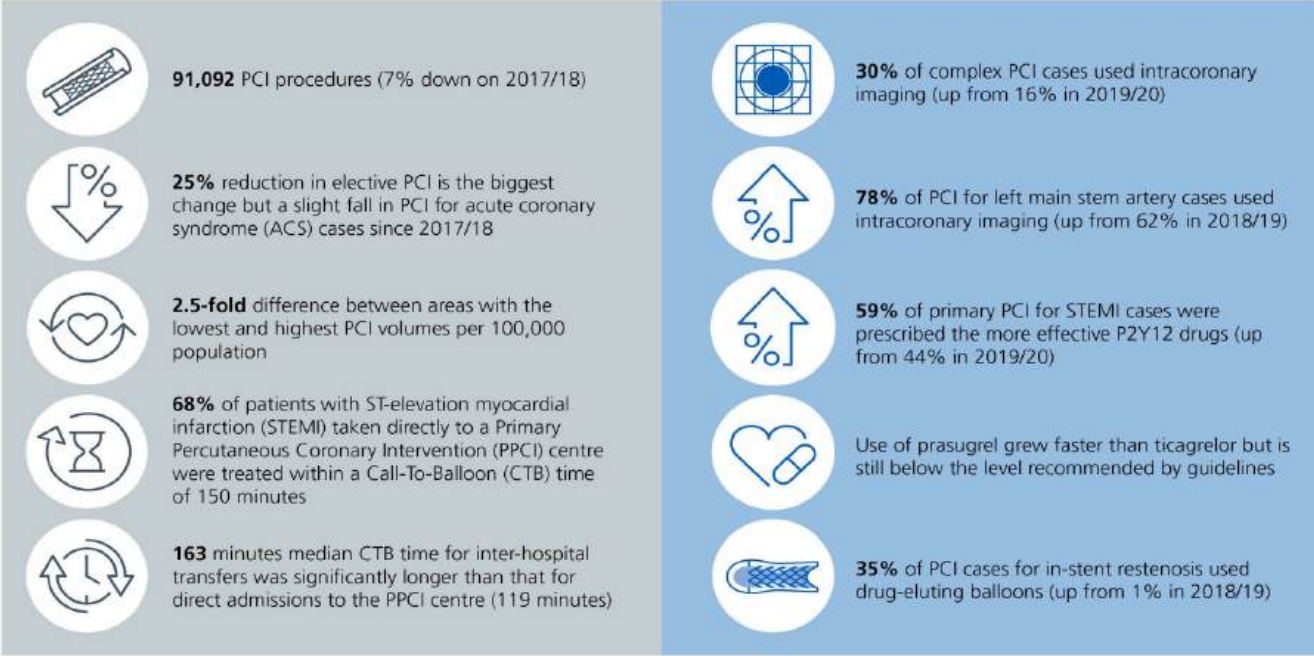
This report provides details of the percutaneous coronary intervention (PCI) procedures undertaken in England and Wales during the financial year 2023/24, along with longer-terms trends on the scale and the quality of PCI services. The report focuses on a number of specific quality improvement (QI) metrics in relation to the delivery of PCI services derived from national and/or international standards and guidelines. It is designed to be of value to a wide range of stakeholders and importantly it allows patients and their relatives to better understand how PCI services are delivered.

Objectives:
For most heart attack patients, optimal care includes a PCI procedure. NAPCI data are therefore also combined with that from the NCAP's Myocardial Ischaemia National Audit Project (MINAP) to create a report that focuses on the care given to people admitted to hospital with a heart attack. This includes time delays to treatment for patients presenting with ST-segment elevation myocardial infarction (STEMI) or non-ST-segment elevation myocardial infarction (NSTEMI).

- Primary PCI for ABUHB patients**

- Delivered by Cardiff and Vale University Health Board
 - Will require auditing of Cardiff and Vale figures
 - More work needed to minimise delays in interhospital transfers
 - Thrombolysis could be considered after discussion with Cardiff and Vale as part of SOP
 - Thrombolysis will be considered as part of the SOP when Primary PCI
 - services in ABUHB will be set up as per the ESC guidelines

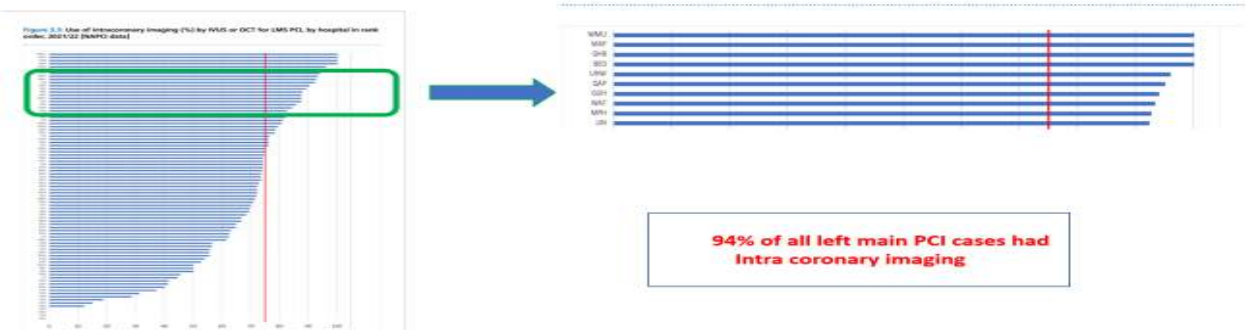
All data are for 2023/24 unless otherwise stated.



Recommendation 2 - Centres undertaking PCI for left main stem artery or complex lesions should use intra-coronary imaging in 75% or more of cases.

There is a growing use of intracoronary imaging in PCI for left main stem (LMS) lesions

Figure 3.3: Use of intracoronary imaging (%) by IVUS or OCT for LMS PCI, by hospital in order, 2021/22 [NAPCI data]



Recommendation 4 - Recording of drug-coated balloon use in the audit should be improved, as significant differences exist between the NAPCI data and that from the annual BCIS survey. Until randomised trials defining the role of drug-coated balloons begin reporting, outcomes will continue to be assessed using NAPCI data.

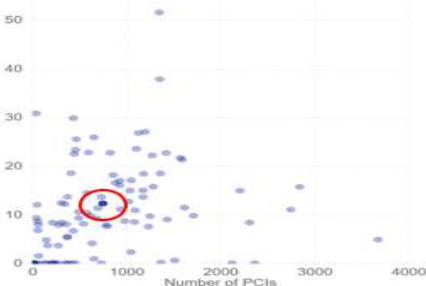
Drug-eluting balloon use varies between hospitals with many hospitals not using them and one hospital using them in >50% of cases

The rate of drug-eluting balloon use by hospital varies from zero to over 50% of cases.

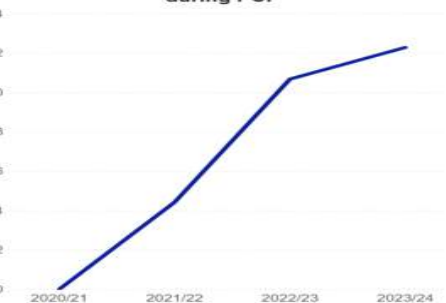
Select a hospital below to see its data or hover over a dot in the scatter plot.

Select hospital
All

Percentage use of drug-eluting balloons during PCI, by hospital (2023/24)



Percentage use of drug-eluting balloons during PCI



Percentage of PCI cases of Drug Eluting Balloon use



Drug eluting balloons

- Used as a stent free alternative
- Various case scenarios
- Good medium to long term data in small vessels
- Avoids the need for increased stent material in complex cases – like bifurcations, in stent restenosis
- More data required in double blind randomised clinical trials
- Most common drug eluting balloons is Paclitaxel eluting balloon
- Newer drugs namely sirolimus and biolimus are currently being tested
- ABUHB drug eluting balloon use has increased
- Planned to enter in Registry studies

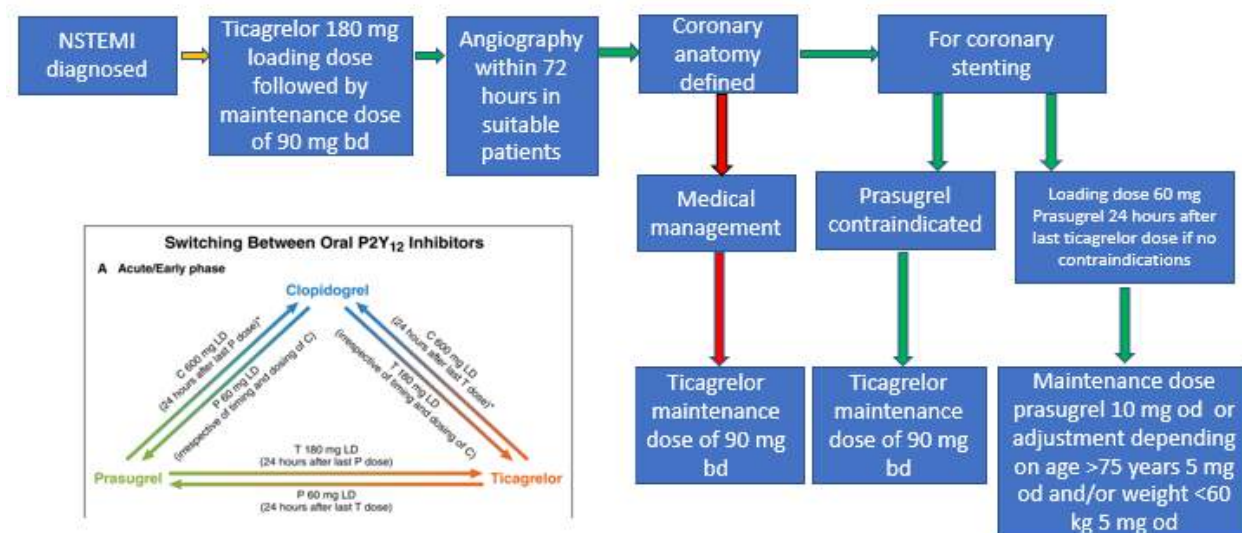
Recommendation 3 - Use of prasugrel is lagging that of ticagrelor, especially in NSTEMI cases. This is despite international guidelines recommending it in preference to ticagrelor in PCI undertaken for ACS indications. Prasugrel should be used in preference to ticagrelor and clopidogrel where there are no clinical contraindications.

There is considerable variation in the use of P2Y12 antiplatelet drugs after PCI for NSTEMI between hospitals

Potential Challenges with Proposed pathway

- Data capture reflects patient already on ticagrelor
- No system to document switch to Prasugrel
- Increase awareness of clinicians to change over medications
- Likely to have errors especially if switch happening after 24 hours
- Data capture can only be accurate on electronic discharge summaries
- No link between McKesson system (for NICOR) and CWS discharge summaries

Proposed Pathway for NSTEMI management within ABUHB



Assurance level		Description		Risk level	Description		
Full		The project has fully achieved the standards or criteria being audited against		None	Standards met and findings demonstrate no risk to patient safety		
Report Successes:							
1	The use of intracoronary imaging in unprotected left main coronary stenting is now mandatory in the standard practice. Both intracoronary imaging modalities namely intra vascular ultrasound (IVUS) and optical coherence tomography (OCT) are available. Trainees in Percutaneous coronary intervention are also encouraged to use these devices when performing left main coronary stenting.						
2	The treatment of left main coronary stenting with ICI in our centre is associated with favourable long term outcomes when compared with the national benchmark figures						
3	Trend of drug eluting balloon use is similar to national trend						
Report Concerns:							
1	Data capture for the use of P2Y12 remains a challenge						
Report Recommendations:			S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
1	Treatment times for primary PCI for STEMI are too long, particularly for inter-hospital transfers where there is a failure to achieve target Call-To-Balloon times. ESC guidelines currently recommend thrombolysis if primary PCI cannot be performed within 120 min of the first medical contact.		Currently not achievable until the Primary PCI services in ABUHB is established Once 24/7 PPCI services in ABUHB established, ESC guidelines will be incorporated into SOP		Lead in Interventional Cardiology services at UHW Divisional/Clinical Director of Cardiology at UHW Divisional Director/Lead in Interventional Cardiology for ABUHB	Undetermined – Require further dialogue between ABUHB and Cardiff and Vale UHB	Need to have access to UHW database identifying ABUHB patients
2	Centres undertaking PCI for left main stem artery or complex lesions should use intra-coronary imaging in 75% or more of cases.		Achieved – No risk to patients. Yearly assessment via the McKesson database		Dr. S. Bundhoo – Audit Lead in Interventional Cardiology	Next CSEG meeting 2026	Already achieved. 96% use of ICI in ABUHB cases versus the national benchmark of 75%
3	Use of prasugrel is lagging that of ticagrelor, especially in NSTEMI cases. This is despite international guidelines recommending it in preference to ticagrelor in PCI undertaken for ACS indications. Prasugrel should be used in preference to ticagrelor and clopidogrel where there are no clinical contraindications.		Proposed switch from Ticagrelor to Prasugrel needs to be discussed at Directorate level			To be confirmed	To be updated in next CSEG meeting
4	Recording of drug-coated balloon use in the audit should be improved, as significant differences exist between the NAPCI data and that from the annual BCIS survey. Until randomised trials defining the role of drug-coated balloons begin reporting, outcomes will continue to be assessed using NAPCI data.		Achieved. The Mc Kesson Database has an option for the use of drug eluting balloon usage. This can be audited			Next CSEG meeting in 2026	Already achieved as data capture is feasible

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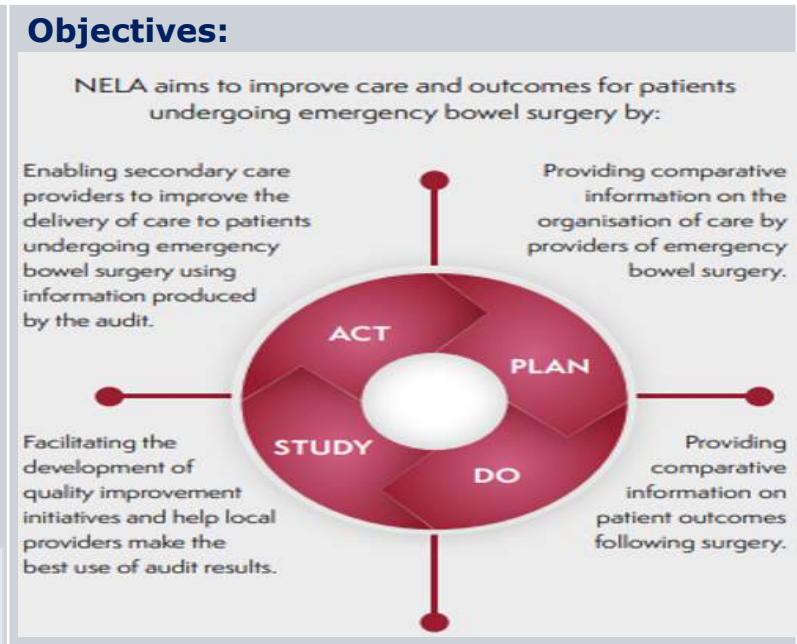
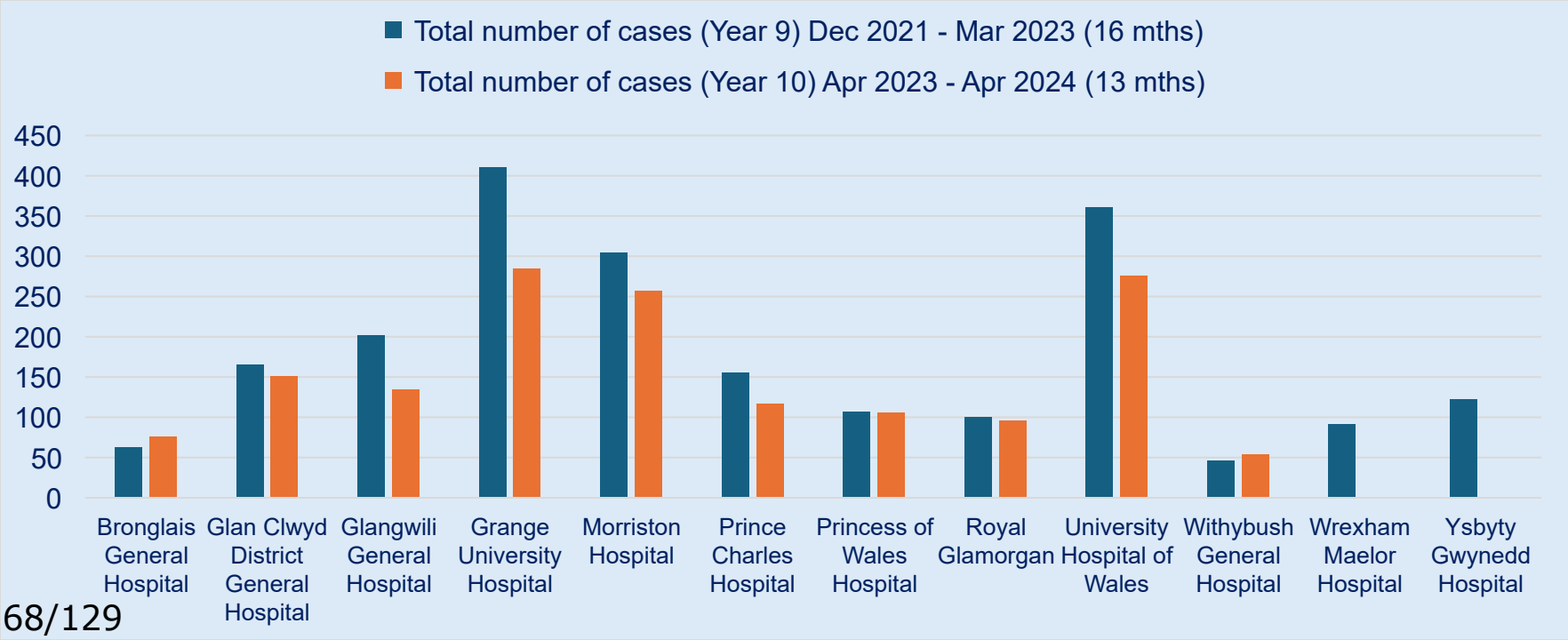
Rationale:

This is the tenth annual report of the National Emergency Laparotomy Audit (NELA) and it examines care received by 23,560 NHS patients in 176 hospitals across England and Wales admitted for emergency laparotomy (emergency bowel surgery, EmLap) between 1 April 2023 and 23 April 2024.

The report shows that clinical teams in many different hospitals were able to provide high quality care against a challenging background, with demand for access to emergency care frequently exceeding capacity.

- 30-day mortality fell to the lowest level in ten years of audit (8.1% compared to 11.7% in Year 1)
- Postoperative length of hospital stay fell back to a median of 10 days (compared to 11 days in Year 9).

The reduction in mortality represents around 1,150 fewer deaths per year amongst the estimated 32,000 patients who undergo emergency laparotomy, whilst a fall in median length of stay of one day could represent potential annual financial savings of more than £10million.

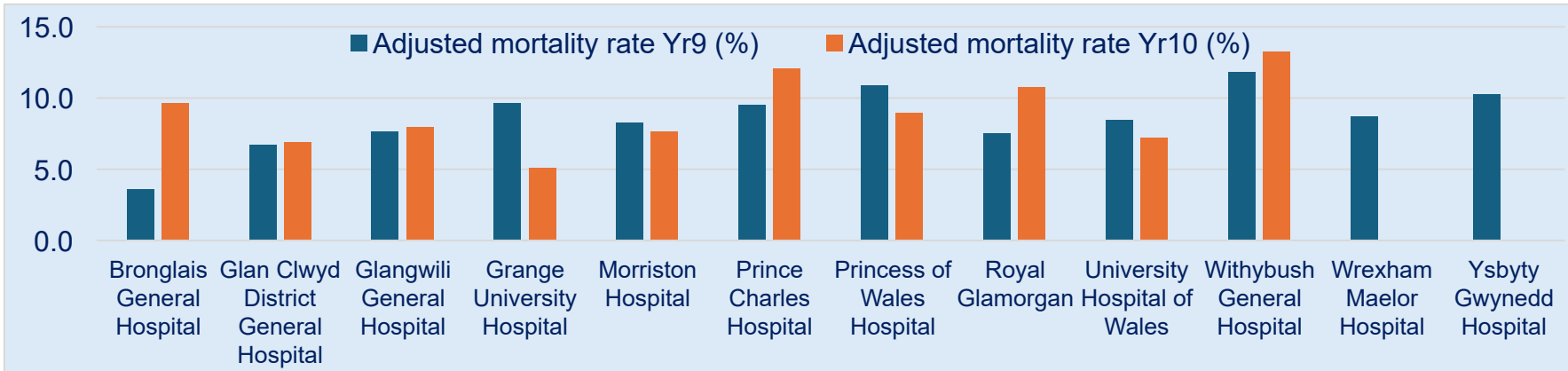


Please note that the reduction in cases from year 9 to year 10 will be impacted upon by the date range for each year. Year 9 is a total of 16 months data (Dec 21 – Mar 23) and year 10 is a total of 13 months data (Apr 23 – Apr 24)

Nationally 30-day mortality fell to the lowest level in ten years of audit 8.1% compared to 11.7%.

ABUHB 30-day mortality in year 9 was 9.6% and in year 10 was 5.1%.

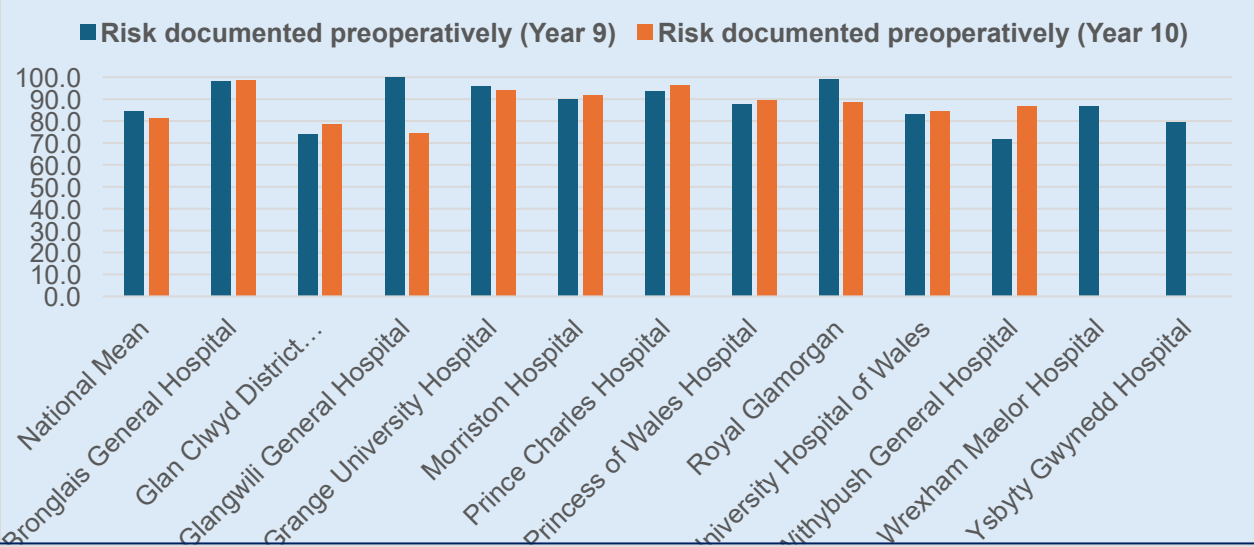
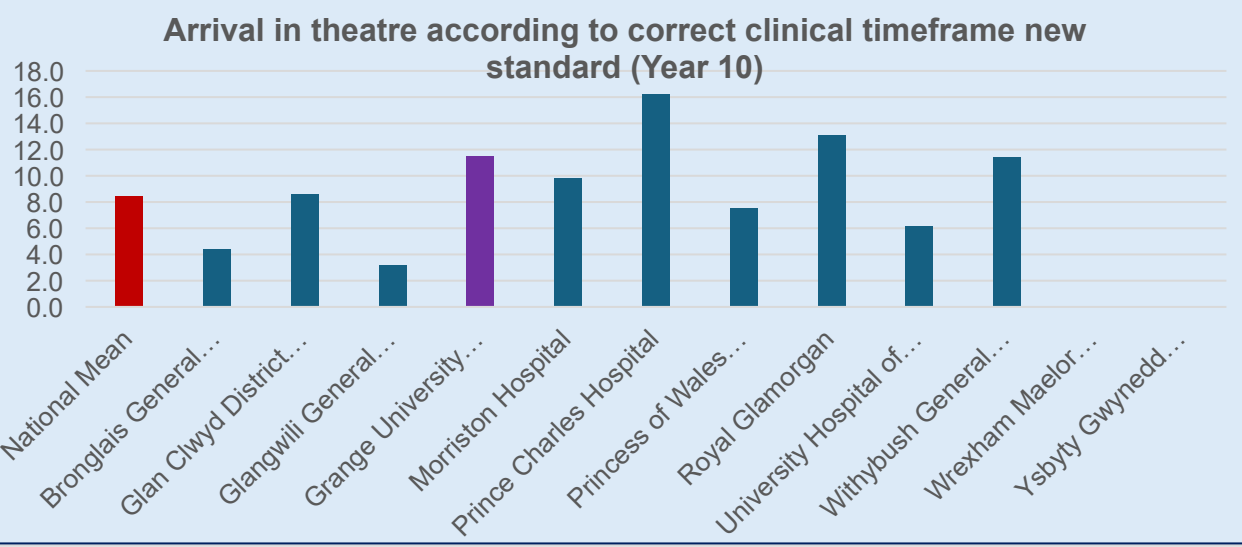
Although ABUHB not reported as a positive outlier (5), GUH is 23rd out of 169 hospitals.



Key messages and recommendations - Key Message 1a: Timeliness of diagnostic pathway following arrival at hospital

NELA Standards - Proportion (%) of patients who received (or should have received) immediate surgery (as per RCS definitions of immediate surgery) within 6 hours of arrival in hospital for Year 11 (@ Mar 25) for ABUHB 6.67%, national rate 10.81% and regional rate 12.65%.

NELA Standards - Proportion (%) of patients in whom a risk assessment was documented preoperatively for Year 11 (@ Mar 25) for ABUHB 91.67%, national rate 79.53% and regional rate 83.27%.



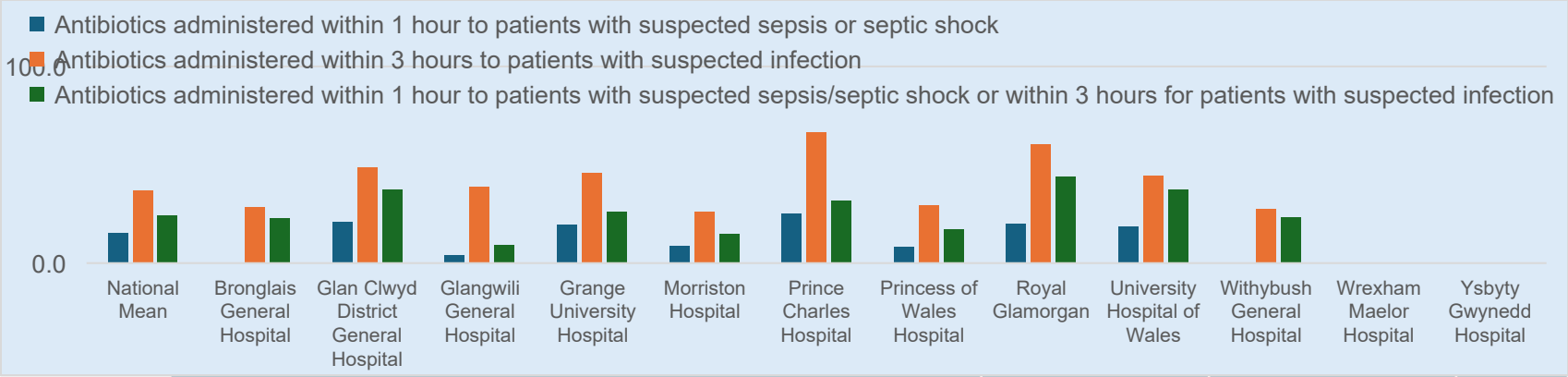
Timely assessment and management depend on the patient’s presenting pathology. Initial symptoms are often non-specific, leading to diagnostic delays—median time to theatre is nearly 22 hours, with nationally 75% of urgent cases waiting over 10 hours.

Any patient with physiological changes and signs of serious surgical conditions (e.g. sepsis, perforation, ischaemia, obstruction) should be treated as a surgical emergency.

Key Message 1b: Timeliness of antibiotic administration in patients with suspected infection and sepsis of surgical origin following arrival at hospital

Antibiotics should be given within 1 hour for sepsis and 3 hours for infection, but nationally only 15% of sepsis cases and a third of infection cases met these targets. A quarter of patients waited over 5.8 hours, with wide variation in performance across hospitals.

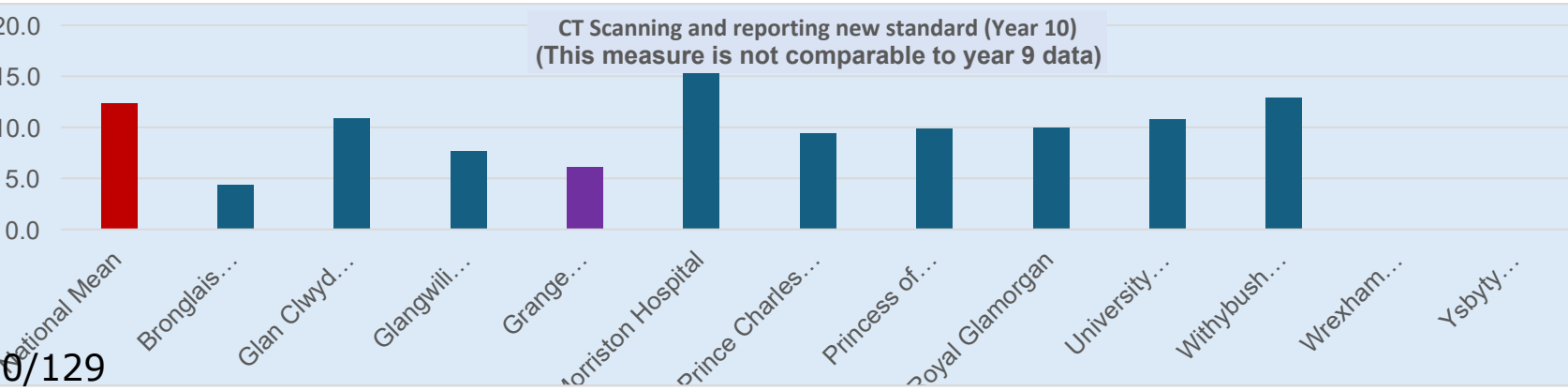
NELA Standards - Proportion (%) of patients with suspected sepsis and/or septic shock at arrival and at decision to operate who receive antibiotics within 1 hour of first recorded NEWS2 abnormality of 5+ or >=3 in any one variable, Year 11 (@ Mar 2025) for ABUHB is 20%, national mean 14.49% and regional mean is 22.59%.



Year 10		Note that the data completeness for the 1-hour sepsis and 3-hour infection are not full data completeness		Data completeness	%
Antibiotics administered within 1 hour to patients with suspected sepsis or septic shock				66.7	19.6
Antibiotics administered within 3 hours to patients with suspected infection				69.6	45.9
Antibiotics administered within 1 hour to patients with suspected sepsis/septic shock or within 3 hours for patients with suspected infection				100	26.2

Key Message 2: Direct communications between requesting and reporting teams around CT scanning

Urgent CT findings that impact surgical decisions should prompt direct communication between the clinician and radiologist. While 98.7% of 'RCS Immediate' patients had senior radiologist reports, only 24.7% had documented direct discussions. Two-way communication is vital when time-critical pathology is suspected.

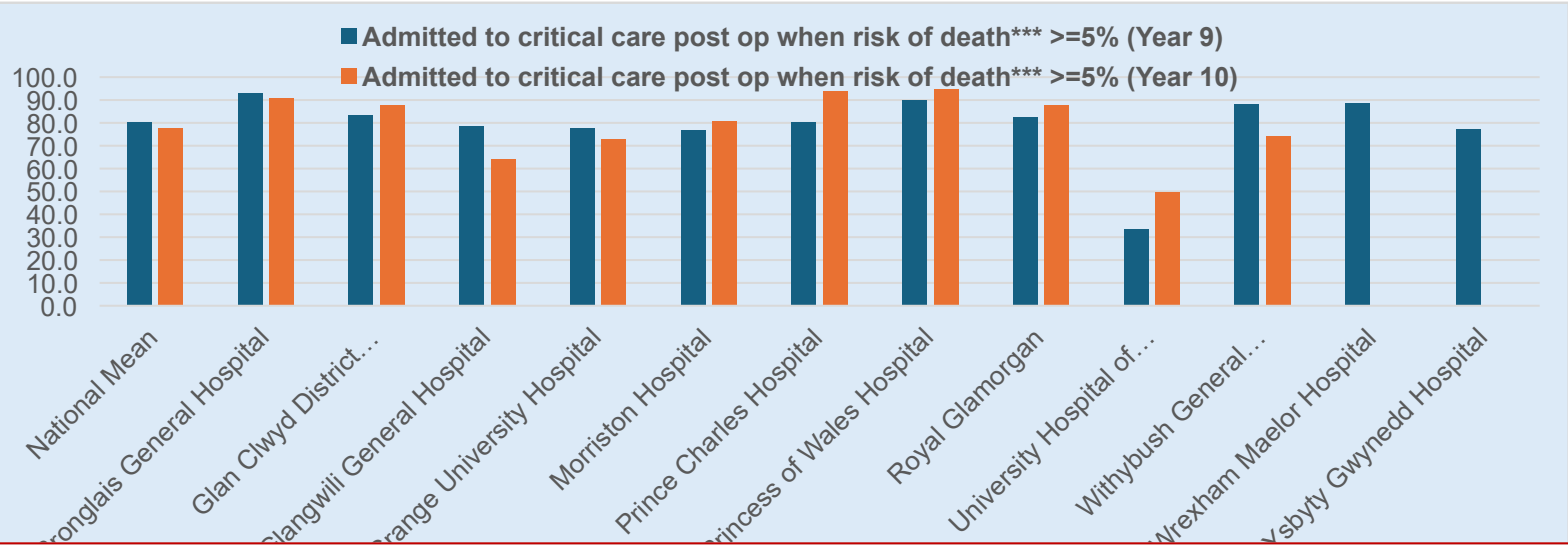


NELA Standard - ABUHB for Year 11 (@ March 2025) 11.76%, nationally 13.89%, regional mean 8.39% for patients who are categorised as immediate (as per RCS definitions of immediate surgery) who undergo preop CT scanning and where there is direct communication between radiologist (ST3 and above) and surgeon (ST3 or above), either via phone or in person to discuss CT findings

Key Message 3: Critical care bed capacity

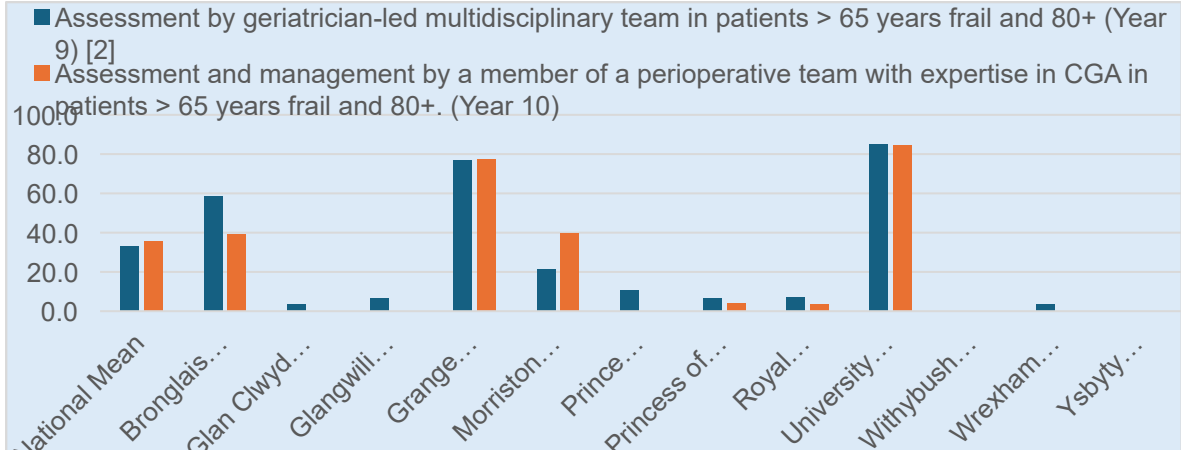
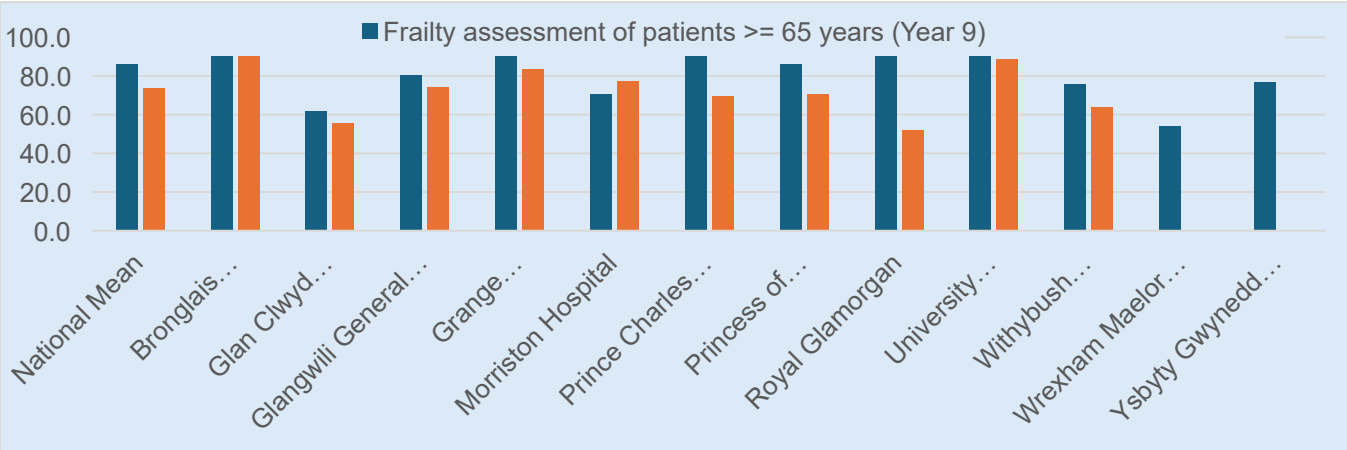
High-risk patients aren't always admitted to critical care post-surgery—16.5% received ward-level care, of which 4.3% died in hospital. Guidance recommends critical care for these patients. With 30–40 emergency laparotomy cases per 100,000 adults annually needing critical care, hospitals must plan accordingly. Research is needed to understand variation in admission rates and explore cost-effective enhanced care models.

Unexpected CC admissions from the ward < 7 days post op has decreased from 1.5% in year 9 to 0.7% in year 10.



NELA Standards - Proportion (%) of postoperative high-risk patients (risk of death of ≥5%) admitted directly to critical care postoperatively, Year 11 (@ Mar 2025) ABUHB 78.57, national rate 71.26% and regional rate 77.98%,

Key Message 4: Specialist care for older patients, Best Practice Tariff, and incentivising better postoperative care for older patients



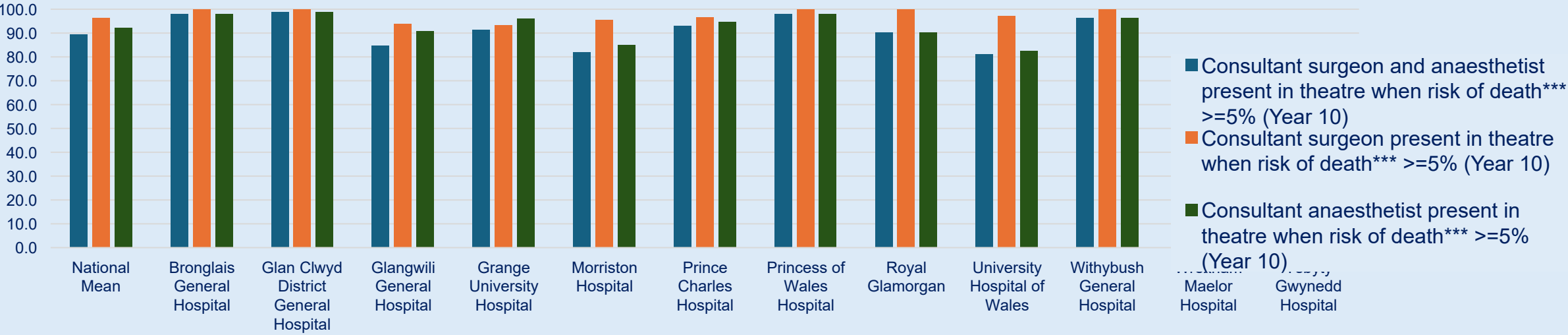
NELA Standards - Proportion (%) of patients aged 65 or older and living with frailty, or aged 80 and older who receive postoperative assessment and management by a member of a perioperative frailty team with expertise in CGA. In Years 1-9 this standard was met when the patient was assessed by a specialist/consultant in the care of the older person (with a change in Year 6 in the wording in question 7.3 from specialist geriatrician to consultant geriatrician). In year 10 the standard changed to include geriatrician-led service, OR a perioperative medicine-led team with expertise in CGA and with established referral pathways to geriatrics, ABUHB rate for Year 11 (@ Mar 2025) 80%, national rate 40.24% and regional rate 23.64%.

Key Message 5: Variation in processes and outcomes of care

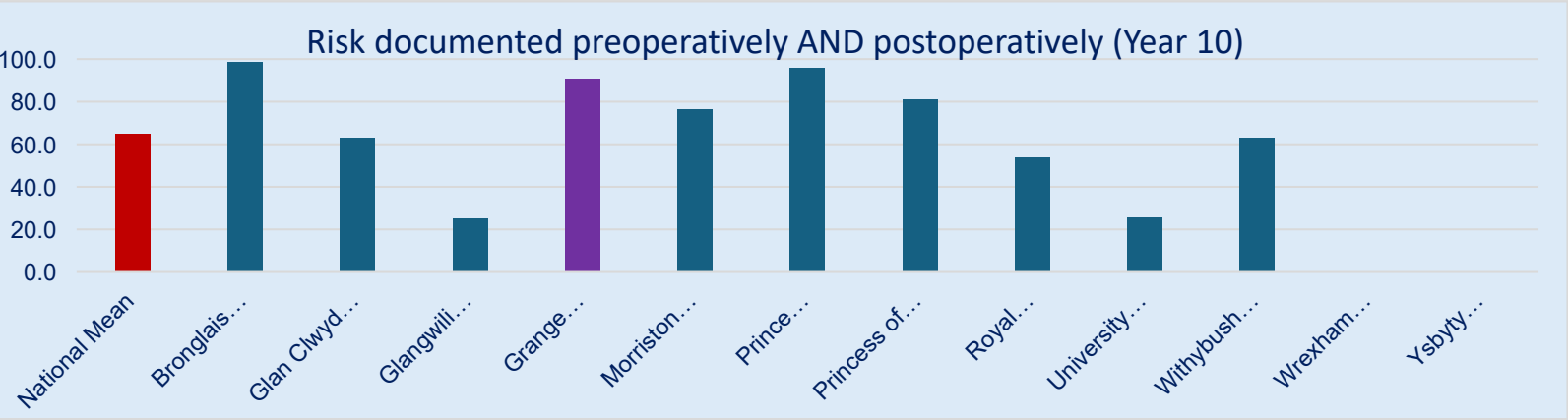
Key Message 6: Apparent differences in timeliness of care for female and male patients

This report does not explore in depth the metric of consultant presence in theatre as this is now well established

NELA Standard - ABUHB for Year 11 (@ Mar 2025) at 100% for Consultant Surgeon and Consultant Anaesthetist present in theatre, compared to the national rate of 86.25% and regional rate 88.89%.



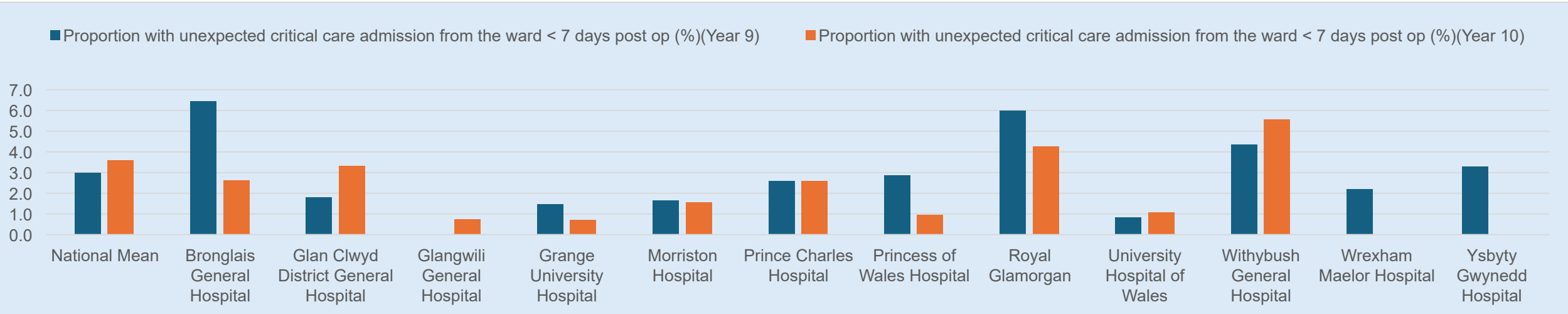
Additional Information:



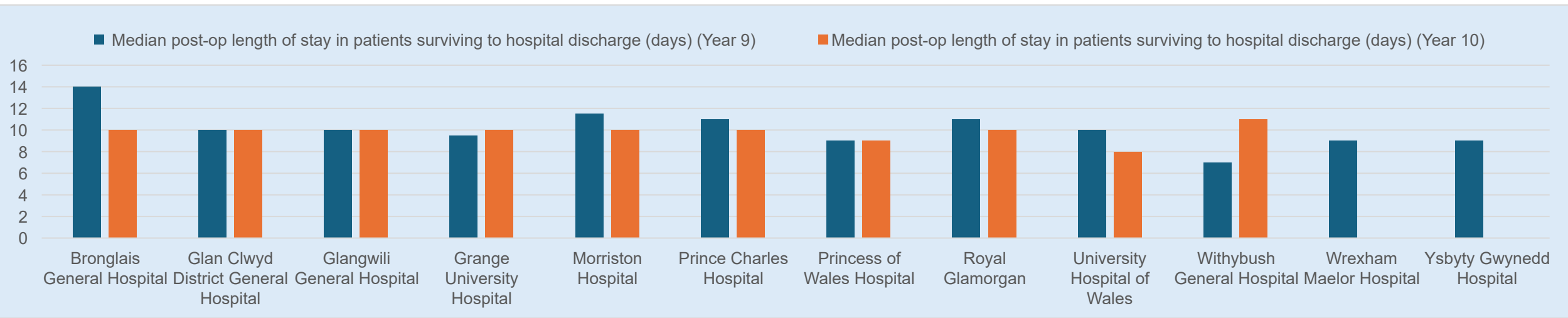
NELA Standards - Proportion (%) of patients in whom a risk assessment was documented postoperatively for Year 11 (@ Mar 25) ABUHB 91.67%, national rate 62.6% and regional rate 68.55%.

Nationally Postoperative length of hospital stay (LoS) fell back to a median of 10 days (compared to 11 days in Year 9)

ABUHB median post-op LoS for year 9 was 9.5 days compared to year 10 which has increased to 10 days, which is aligned to the national result, however a decrease in performance for ABUHB of 0.5 of a day.



Nationally unexpected returns to critical care from the ward < 7 days post op in Year 9 was 3.0% which increased in Year 10 to 3.6%. ABUHB has a better rate of return in Year 9 at 1.5% and this improved further in Year 10 to 0.7%.



NELA Standards - Median length of stay in days Year 11 (@ Mar 2025), ABUHB 15 days, national 11 days and regional 13.6 days.

Assurance level		Description		Risk level	Description	
Significant		The project has mostly achieved the standards or criteria being audited against		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	
Report Successes:				Report Concerns:		
1	Reduction in risk adjusted mortality from 9.6% to 5.1%			1	Frailty assessment and accuracy needs improving	
2	Improved rates of COTE review post operatively (vs. national mean)			2	More COTE involvement for frail older patients with need to expand team	
3	Preoperative risk assessment remains high			3	Poor time to theatre from presentation to hospital and need to streamline pathway	
4	Consultant anaesthetist and consultant surgeon presence in theatre for high-risk patients remains high			4	Need for NELA nurse practitioner to help pre-op pathway and COTE consultant	
5	Successful running of the NELA M&M meetings throughout the year			5	Communication between radiologists and clinical team regarding CT findings	
Report Recommendations:			S.M.A.R.T Actions: Responsible: Due Date: Progress:			
1	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Radiologists, and Royal College of Surgeons of England – should continue to work together to update and develop consensus pathways of care for patients who might require emergency abdominal surgery. Pathways should contain statements around seniority of key decision makers and ideal timeliness of key steps including antibiotic administration and timing of definitive surgery.				Royal College Recommendations	
2	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Radiologists, Royal College of Surgeons of England – should highlight current guidelines around the need for effective two-way direct communication between referrer and reporter whenever the patient’s condition or CT predicted findings suggest the patient has developed time-critical pathology.					
3 a	NHS England, Integrated Care Boards, and Welsh Health Boards – should evaluate variations in critical care bed capacity for patients undergoing emergency laparotomy, factoring a predicted need of 30-40 EmLap-related critical care admissions per year per 100,000 adult population served.			- Current evaluation on ‘unmet demand’ for all patients needing critical - care including those post emergency laparotomy - Hayden Stephenson (CD CC)/Directorate Management Team - Ongoing		
3 b	National Institute for Health and Care Research – should consider commissioning research into optimum placement and management of patients at the margins of risk categories to better understand potential early interventions that could mitigate the risk of dying after surgery				NICE Recommendation	
4	Royal College of Anaesthetists, Royal College of Nursing, Royal College of Physicians, Royal College of Surgeons of England and British Geriatrics Society – should work together across the blended workforce to develop common competency-based training and education around optimising perioperative care for older patients and those living with frailty, such that the unmet need for specialist care can be more reliably delivered.				Royal College/Society Recommendation	

74/129

523/644

National QI suggestions

QI suggestion: Widespread variation in delivery of key processes of care for emergency laparotomy patients is seen in different hospitals across both England and Wales. Challenges and potential solutions will likely vary between units. Driving local service development requires strong engagement with NELA, which in turn requires locally funded clinical leadership time.

QI suggestion: Surgical, medical, emergency medicine and radiology teams should ensure effective communication between requesting and reporting teams takes place, rather than relying on availability of written reports in isolation. Requesting teams must remain cognisant of the need to seek prompt expert radiology opinion following urgent CT scanning whenever there is an apparent mismatch between a patient’s clinical condition and the CT report, especially when this information is critical to whether surgery should be undertaken.

QI suggestion: If there has been direct communication between referring and reporting teams, this should be included in the text of the CT report, ensuring documentation of best practice.

QI suggestion: Local teams should quality-assure recorded ASA grades for all NELA patients. An inappropriately low or high ASA grade in the PRS may result in under- or overestimation of mortality risk and as such, patients may not receive appropriate levels of postoperative care.

QI suggestion: Sites should review the appropriateness of EmLap cases admitted under medicine and investigate any potential avoidable delays in the time to theatre from time of arrival in hospital.

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Improve door to theatre time, and look at pathway development	On going QI project	All NELA leads	July 2026	On going
2	Improve communications and documentation between Radiology and Surgery	Gethin Williams to liaise with Radiology	All NELA leads	March 2026	

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2025 Data Collection Period: 1 April 2024 – 31 March 2025 - Year 7		Clinical Lead:	Dr Non Pugh – Consultant Rheumatologist
		NICE :	QS33 – Rheumatoid arthritis in over 16s
Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), is a significant disease burden in the UK, affecting over 400,000 people. Delays in treatment can lead to significant disability, reduced quality of life, and loss of productivity in the workforce. Treatment delays for rare autoimmune rheumatic diseases (RAIRDs) such as systemic vasculitides are also associated with adverse outcomes including permanent disability(4), organ failure and death.		
Objectives:	The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients over the age of 16 in rheumatology departments across England and Wales. Diagnoses required for enrolment in the audit include inflammatory arthritides, systemic vasculitides and connective tissue diseases. By collecting this data, the audit aims to recommend standardised, effective, and patient-centred care pathways The performance of individual healthcare providers is measured against the National Institute for Health and Care Excellence (NICE) quality standard [QS33] ‘rheumatoid arthritis in over 16s’, last updated in 2020(5).		

National Early Inflammatory Arthritis Audit (NEIAA)

Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis

QS1 Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 working days of presenting in primary care

QS2 Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met

Also assesses how inflammatory arthritis affects people’s day-to-day function, mobility, sleep, wellbeing and ability to work. Rheumatology clinical teams provide information about patient care over the first 3 months. This includes:

- Referral times
- Time to treatment
- Clinical response to treatment
- Patient Reported Outcome Measures (PROMs) for 12 months

Also collecting data re referral times on other conditions:

- **SLE/CTD**
- **Axial Spondyloarthritis**
- **Systemic vasculitis**
- **GCA- further information re: USS & treatment**

ABUHB results April 2024- March 2025 - Number of patients : 104

QS1 Referral to specialist rheumatology service within three working days
ABUHB 60 % National 53 %
Patients seen for their first appointment within 3 weeks of receipt of referral
ABUHB 66% National 43%
QS2 Patients receiving treatment within 6 weeks of receipt of referral
ABUHB 80% National 60 %
Average time from referral to appointment
ABUHB 21 days National 32 days
Average time from referral to treatment
ABUHB 31 days National 56 days

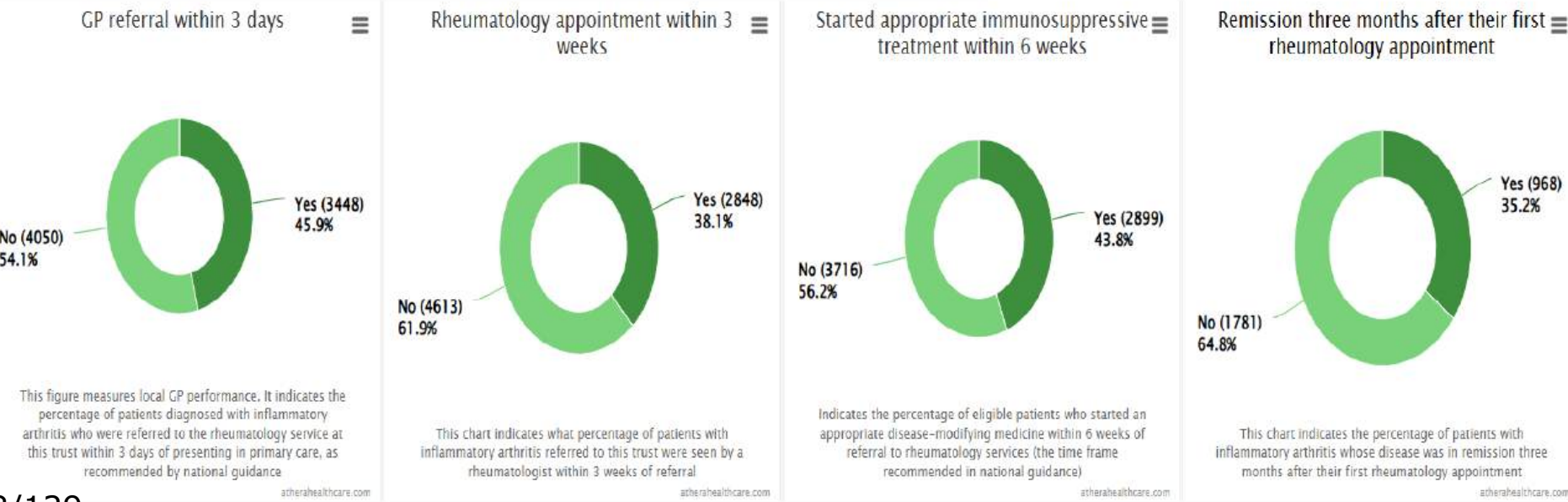
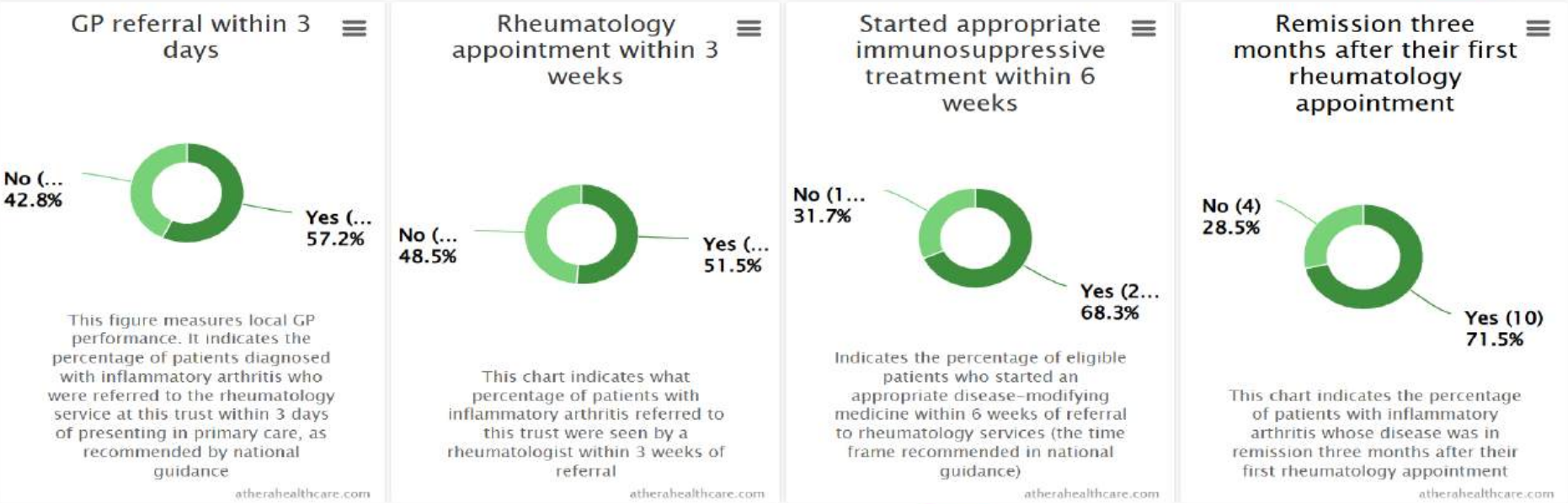
	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	SBUHB	National
QS1 %	60	73	15	22	74	100	53
Seen within 3 weeks %	66	86	18	17	14	38	43
New QS2 %	80	96	59	36	0	64	60

other conditions	2024-25	2023-24
CTD	7	0
GCA	8	3

NEIAA continues to be on the agenda for our directorate meetings with discussion of the new public facing performance dashboard reports

The NEIAA dashboard auto populates Quality Metric performance, based upon the data provided by NHS trusts (in England) and Health Boards (in Wales). There are some important caveats to consider.

- 1. Referral, assessment, and treatment figures are based solely on data entered for EIA patients.
- 2. Delay to starting a DMARD is calculated as the number of patients starting a DMARD within 6 weeks of referral as the numerator, and the number of people marked as eligible for EIA follow up as the denominator. As not all patients selected for EIA follow up will have passed the 6 week cut off for starting a DMARD, it is possible you will underestimate your performance.
- 3. No attempt is made to adjust for case-mix, and it is not possible to calculate whether you are an outlier from these data alone.
- 4. Referral figures are solely based on patients referred by GP with a diagnosis of EIA.



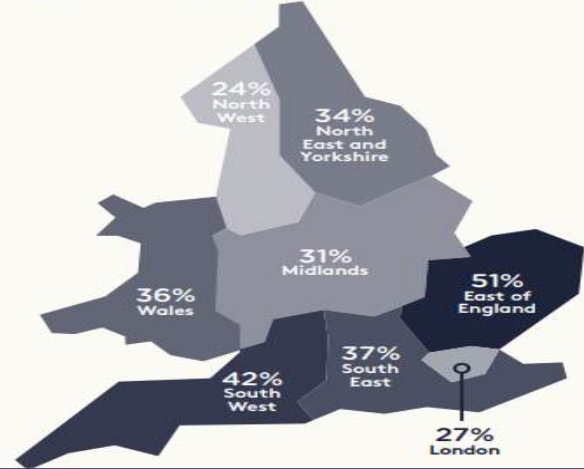
GP referral within 3 days:

ABUHB	-	57.2%
National	-	45.9%
(Performance in Wales 4 th of 6)		

Appointment within 3 weeks:

ABUHB	-	51.5%
National	-	38.1%
(Performance in Wales 2 nd of 6)		

Overall remission rates at 3 months remain static at 34% but this disguises significant geographic variation



Immunosuppressive treatment within 6 weeks:

ABUHB	-	68.3%
National	-	43.8%
(Performance in Wales 2 nd of 6)		

Remission 3 months after 1st Rheum appt:

ABUHB	-	71.5%
National	-	35.2%
(Wales 36%)		

Assurance level	Description
Full	The project has fully achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety

Report Successes:	
1	Continue to start DMARD treatment in 80% within 6 weeks and meeting audit standards
2	ABUHB results better than national average and second in Wales
3	Increasing number of other conditions included

Report Concerns:	
1	None

Over the past several years, the service has undergone a significant and measurable transformation, progressing from a position of **negative** outlier status in national benchmarking to becoming a recognised **positive** outlier for clinical quality and patient outcomes.

National recommendations:

1

Provision of specific funding to support awareness-raising of the importance of early presentation to primary care of people with symptoms of suspected EIA. **Key message 3**
 Action by: Department of Health and Social Care/NHSE and Welsh Health Boards



2

NEIAA dashboard data should be used to support rheumatology departments and specialist centres to pinpoint unwarranted variation, track improvement over time and inform planning and investment. **Key messages 4, 5, 6, 11 and 12**
 Action by: Integrated Care Boards, Welsh Health Boards



3

Patient-reported outcome measures (PROMs) should be integrated into clinical pathways to identify individuals experiencing significant psychological burden and facilitate their timely referral to appropriate mental health support services. **Key messages 7 & 8**
 Action by: Integrated Care Boards, Welsh Health Boards



4

National guidance should be developed and implemented to ensure timely treatment of EIA and minimise regional disparities in care delivery. **Key messages 5, 6 and 7**
 Action by: British Society for Rheumatology, DHSC/NHSE, GIRFT and Welsh Health Boards



5

Widespread implementation of the Getting it Right First Time (GIRFT)/National Axial Spondyloarthritis Society (NASS) National Playbook on Axial Spondyloarthritis within primary care. **Key message 9**
 Action by: Royal College of General Practitioners, Integrated Care Boards



Catching our breath: Time for change in respiratory care	Clinical Lead:	Marcus Pierrepoint – Consultant Paediatrician
	NICE:	NG245 , QS25

Rationale:	The <i>Catching our breath</i> report from the National Respiratory Audit Programme (NRAP) presents important insights into the current state of the nation of respiratory care across England and Wales. Its rationale is to shine a light on ongoing gaps in respiratory care, promote evidence-based interventions, and drive systemic improvements across England and Wales to reduce preventable harm and improve outcomes for people with asthma and COPD
Objectives:	Objectives in relation to children and young people (CYP) are to improve the quality and consistency of asthma care by ensuring timely interventions during hospital admissions, addressing risk factors such as smoking and second-hand smoke exposure, and reducing regional variation in care delivery. It aims to strengthen discharge planning through inhaler technique checks, personalised asthma action plans, and specialist follow-up, while promoting better data collection to understand the full care pathway. These objectives support national standards and bundles of care to improve outcomes and prevent avoidable harm for CYP with asthma.

Presented at Clinical Standards and Effectiveness Group – 26th February 2026



Concerns were raised in the report in relation to CYP receiving all three elements of discharge planning, ie checking inhaler technique, providing a Personalised Asthma Action Plan (PAAP) and a specialist review being requested within 4 weeks of discharge. The graph shows how Wales has been performing in two of these elements compared to England

Our publication marks over 10 years since the landmark National Review of Asthma Deaths, which highlighted important deficiencies in asthma care and made 19 key recommendations to improve outcomes and avoid preventable harm and deaths.

In that context, it is of genuine importance that this report identifies continued and highly significant deficiencies in the delivery of many of the key interventions for patients with asthma and chronic obstructive pulmonary disease (COPD) that are known to improve health and transform important clinical outcomes. This pattern has changed little in recent years and, in many aspects, has not recovered to pre-pandemic levels. Recognition and understanding of these deficiencies is vital to inform new models of care and appropriate use of resources.

Key Findings and Priorities for Improvement Relating to Children & Young People in Wales

Admissions due to asthma exacerbations during 2023–24:

- 456 admissions for CYP aged 1–5
- 308 admissions for CYP aged 6+

Risk Factor Recording:

Smoking status and second-hand smoke exposure are poorly documented for CYP in Wales, despite these being key risk factors for asthma exacerbations.

Tobacco Dependence:

Very low rates of intervention for parents/carers who smoke, even when CYP are exposed to second-hand smoke. **(this relates to both England and Wales)**

Call to Action:

- Welsh health boards should prioritise improving discharge planning for CYP, address tobacco dependence in families, and ensure compliance with the National Bundle of Care for CYP with Asthma.

Making an impact

NRAP works with patients to ensure our audit programme focuses on improvements in the areas most important to people living with respiratory conditions.

Royal College of Paediatrics and Child Health

The Asthma &Me Ambassadors are aged 14–24 and have joined together from across the country with a shared mission to improve asthma care and services for children and young people. Some of them have personal experiences of asthma, while others have an interest through family or friends – all have a passion to make a difference.

This year, we worked with the Asthma & Me ambassadors to produce two resources:

- > What should you expect to receive when discharged from hospital after an asthma attack? – For children, young people and their families/caregivers. (see slide 5)

- > A checklist for elements of care given at discharge from hospital after an asthma attack – For hospitals and medical staff. (see slide 5)

What should you expect to receive when you're discharged from hospital after an asthma attack?

Checking your inhaler technique

Why is this important?

This can help to ensure that the medication can do its job properly, which can help to reduce symptoms of asthma.

Questions you can ask your doctor/nurse:

- How do I know if I'm using my inhaler well?
- Can you please check if I'm using my inhaler correctly?
- If I struggle to use this inhaler are there other inhalers I can switch to?
- How do I know my inhaler is empty?

Reviewing or giving you a personalised asthma action plan (PAAAP)

Why is this important?

This can help to lower the risk of an asthma attack and help you know what to do if you have one.

Questions you can ask your doctor/nurse:

- Please can we review my asthma plan?
- How do I know what triggers my asthma?
- What can I do to control my triggers?
- When should I ask for help while having an asthma attack?

Booking your follow-up appointments

Why is this important?

You should see a doctor or nurse once you leave the hospital after an asthma attack. This can help to check that your asthma is getting better with your medication. This is also a good place for support and advice on how to lower the chance of having another asthma attack.

Questions you can ask your doctor/nurse:

- When is my next appointment and what will happen there?
- Will I speak to another doctor or nurse about this asthma attack once I go home?

Created by the Asthma &Me Ambassadors youth project at a design day with NRAP

Royal College of Physicians | National Respiratory Audit Programme (NRAP) | RCPCH&Us

Children and young people's asthma: checklist for discharge from hospital after an asthma attack

Please tick when completed	You can write any notes here
Inhaler technique checked	
Personalised asthma action plan (PAAAP) issued or reviewed (four main trigger medication in document or app)	
Follow-up appointments (2 day community check-up, 4-week specialist review)	
Extra support?	

Created by the Asthma &Me Ambassadors youth project at a design day with NRAP

Royal College of Physicians | National Respiratory Audit Programme (NRAP) | RCPCH&Us

ABUHB has had an Asthma and Wheeze Education Bundle in place for some time:

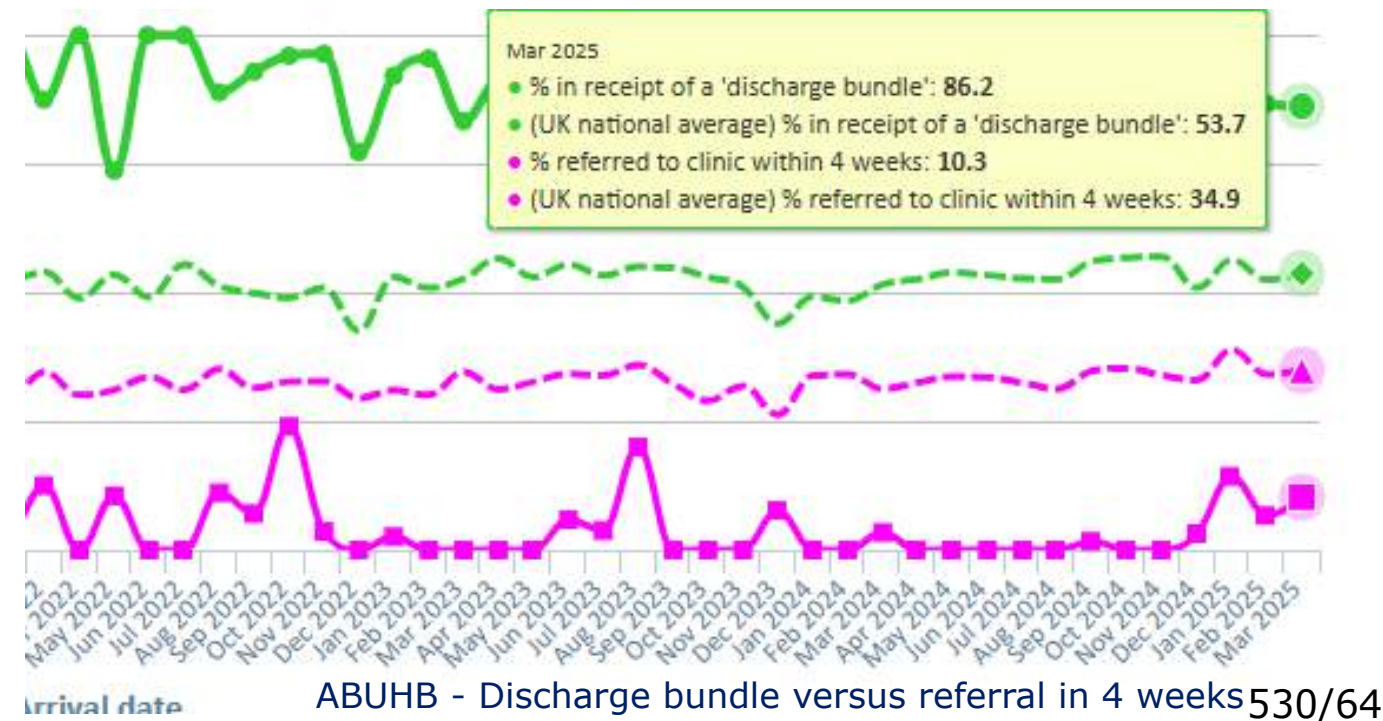
❖ Containing a checklist for parents and nursing team.

Your child is on 4 hourly inhalers (Salbutamol) at the time of discharge	
You have been given a spacer and shown how to give your child their inhaler with the spacer	
You have received information on how to clean and look after your child's spacer	
You have a prescription for a course of oral steroids (if indicated)	
If your child is on regular medications for asthma/viral wheeze, these have been reviewed by the doctors and changed if necessary	
You have received advice on when to seek medical advice if your child is unwell with a wheeze	
You have received a completed Personalised action plan for asthma & pre-school wheeze which has your child's details on it.	
You have discussed with the doctor about whether your child needs a follow-up appointment with the GP or in hospital after discharge	

urses to complete at discharge

		Signed
sted and checked parent's inhaler technique?		
s been dispensed?	WP10 Pharmacy Ward stock	
plan been completed and given to the family?		
Has the NHS Wales Asthmahub been signposted?		
Has the parent's checklist above been completed?		
Have any parental questions been answered?		
Has the discharge summary been completed?		

Has the discharge summary been completed?



Elements of care received by children admitted with near-fatal asthma

NRAP clinical audit data show variability in the care of children and young people (CYP) with asthma, including for those who were most unwell and received intravenous (IV) medication and/or were admitted to the intensive care unit (ICU) or high dependency unit (HDU).

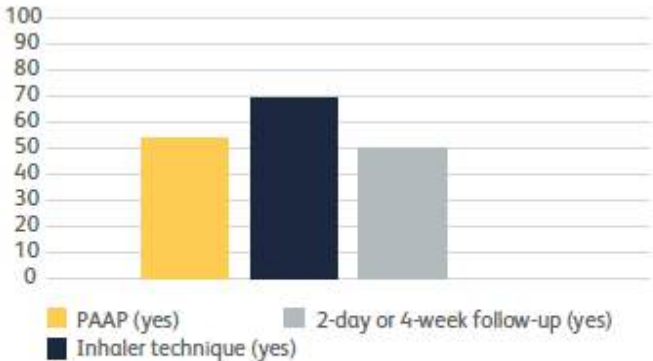


Fig 2. The percentage of CYP who received IV medication during their admission and received each element of discharge planning.

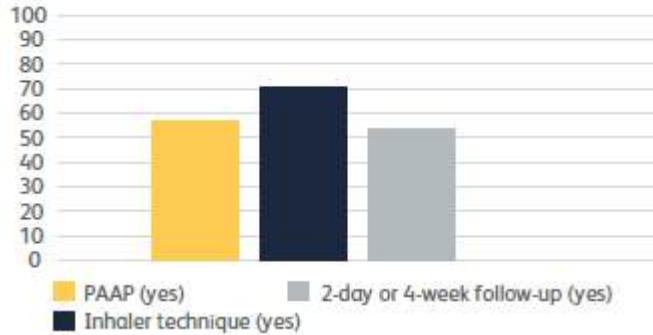


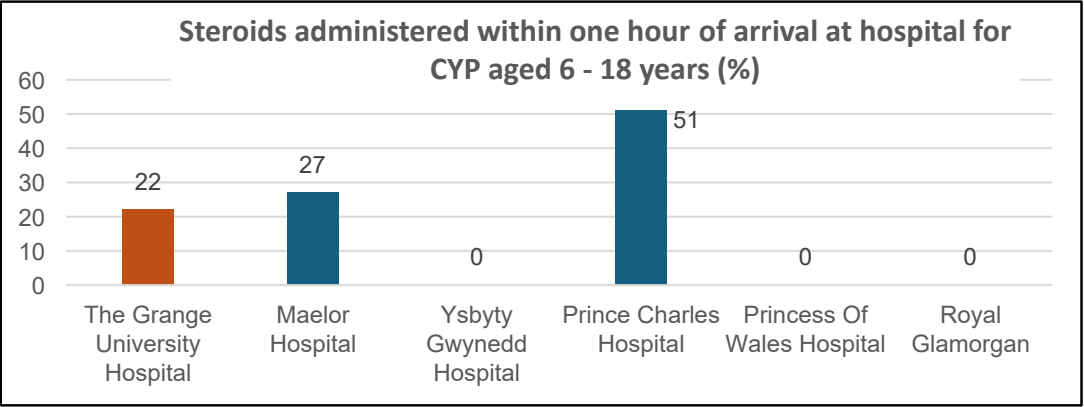
Fig 3. The percentage of CYP who were transferred to ICU or HDU during their admission and received each element of discharge planning.

Why is this important?

A recent National Child Mortality Database report highlighted that there were 54 CYP asthma deaths between 2019 and 2023.⁷ It is extremely important that all children, and particularly those with near-fatal asthma, receive all core elements of care to prevent death.⁸ Furthermore, 65 % of those who died had an emergency department visit or emergency admission in the preceding year, which indicates that there was an opportunity for prevention.⁷

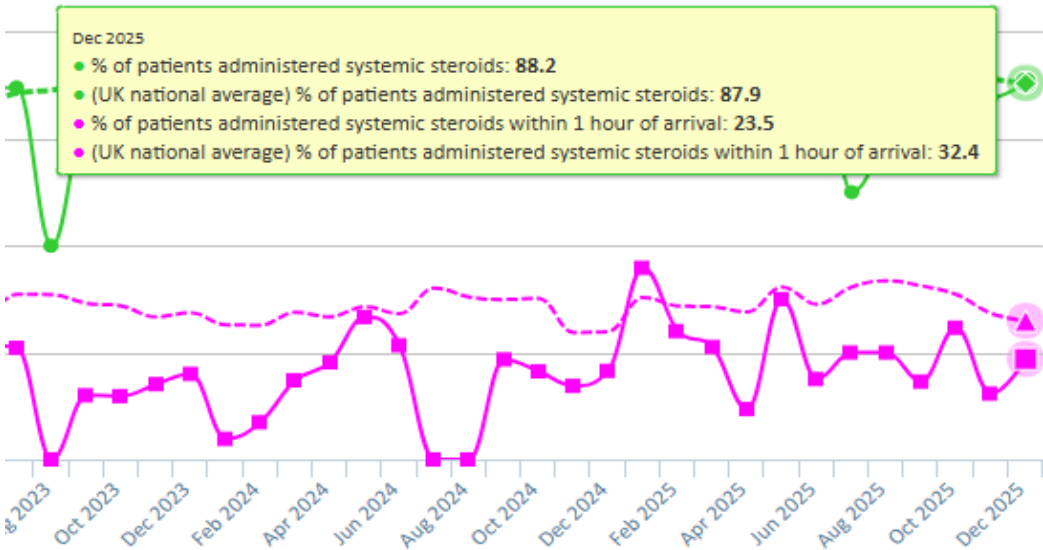
Reviewing or issuing a PAAP, checking patient inhaler technique, and providing a referral for a follow-up with asthma-trained clinicians are all core elements of the discharge bundle as recommended by the National Bundle of Care for Children and Young People with Asthma.⁹

The administration of systemic steroids within 1 hour of arrival is known to reduce the likelihood of hospital admission and is recommended by the guidelines. NRAP data indicate that approximately half of children with near-fatal asthma did not receive systemic steroids within 1 hour of arrival.^{9,10}

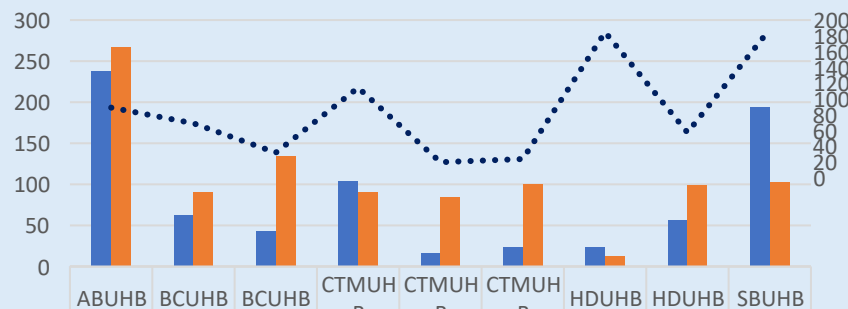


Steroids within 1hr

- Not everyone should get steroids
- Clock starts at booking, via triage to clerking and then prescription and dispensing and administering.
- 1hr is not possible within the current model, we have pushed education.
- We are hoping to use a PGD to administer at triage

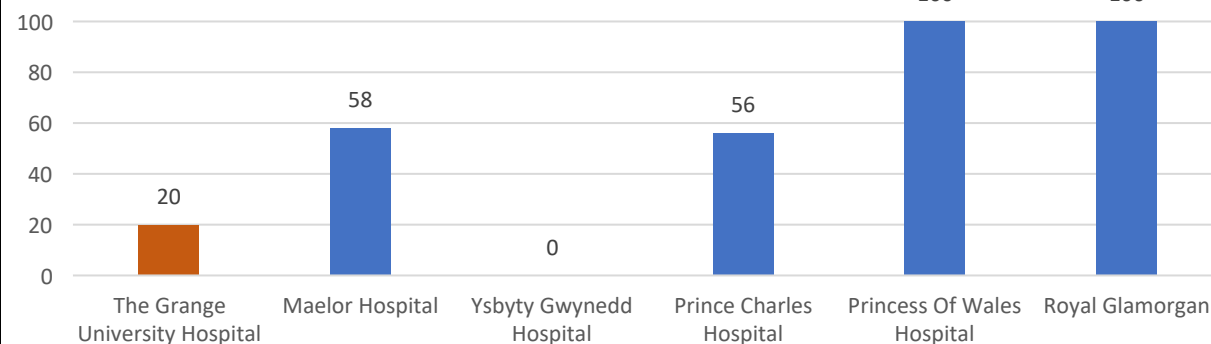


Case Ascertainment



Total number of patients entered into the audit	238	63	43	104	17	24	24	57	194
Number of eligible patients reported PEDW (Wales)	267	91	134	91	85	100	13	99	103
Case ascertainment percentage	89.1	69.2	32.1	114.3	20	24	184.6	57.6	188.3

Parent/carer with tobacco dependency addressed (%)



Smoking addressed? – ABUHB Resources

Family history:

	Asthma	Eczema	Hay fever
Patient			
Mother			
Father			
Siblings			

Smoking *: Ask children >11yrs about personal history of smoking

Parent/Carer Smoking *

Name:

Unit No:

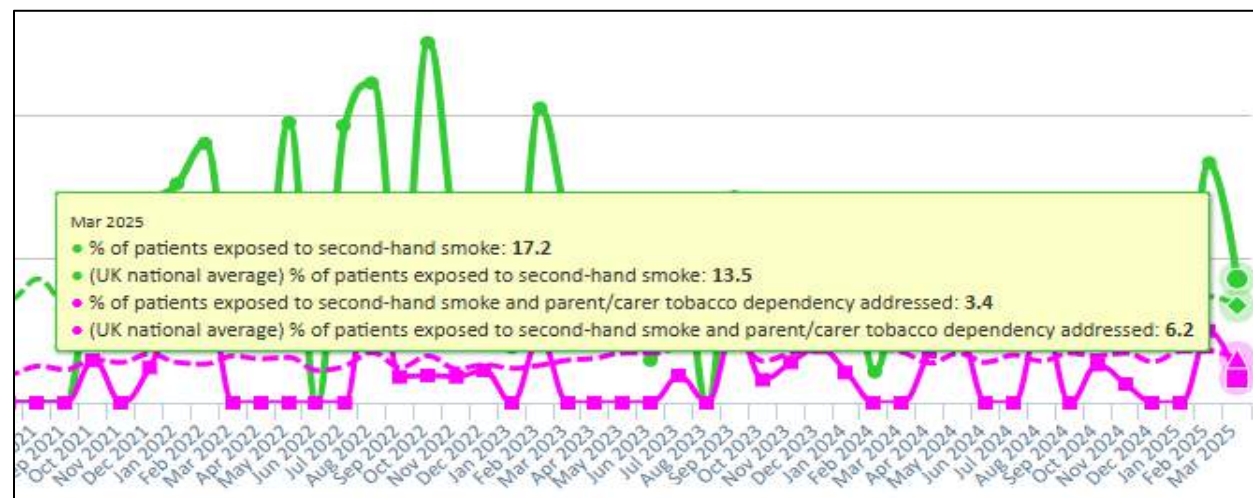
Date of Birth:

Address:

(Place addressograph here)

Pets:

Allergies:



Useful-Resources

www.asthma.org.uk
Offers a variety of resources to help you and your child manage their asthma. There are helpful videos on using inhalers correctly.



[NHS-Wales-Asthma App for Parents](https://www.nhs.uk/health-apps/nhs-wales-asthma-app/)
NHS-Wales self-management App for parents of children with Asthma.

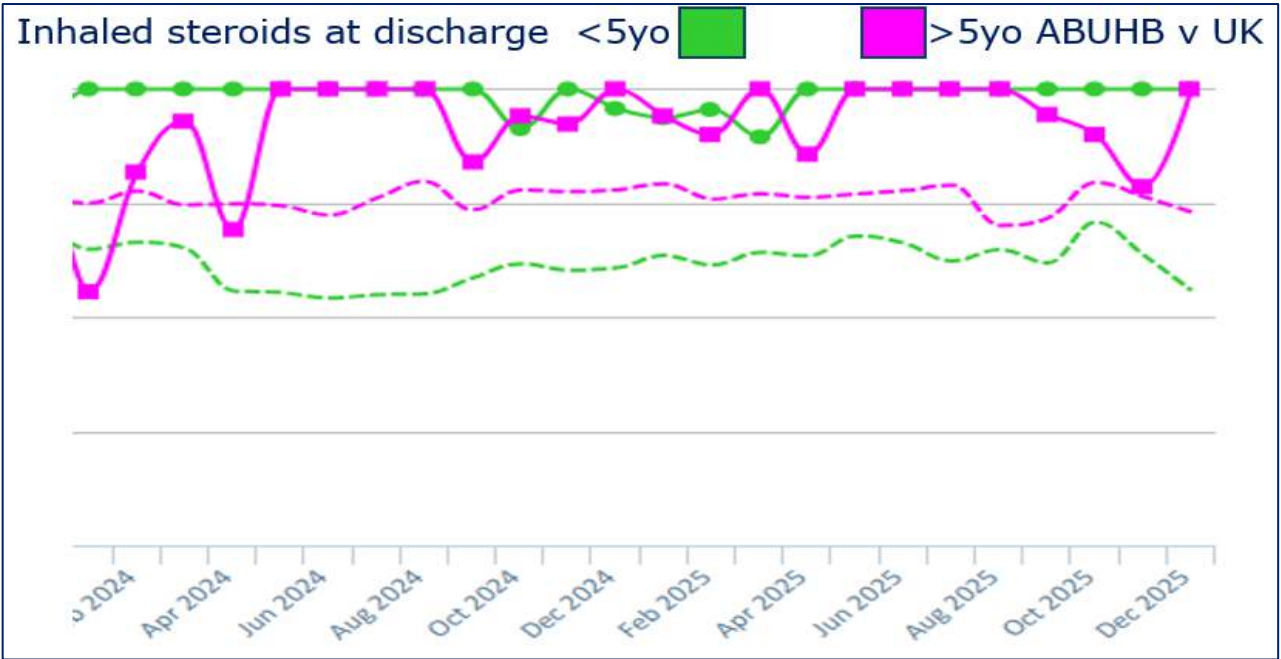
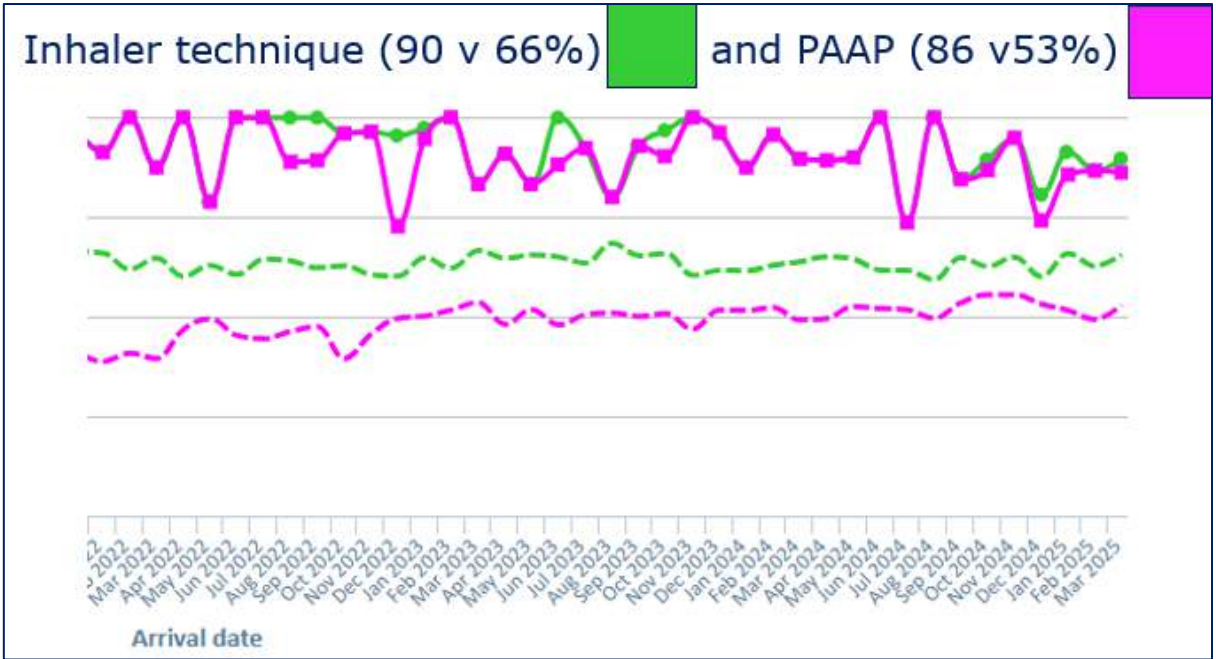
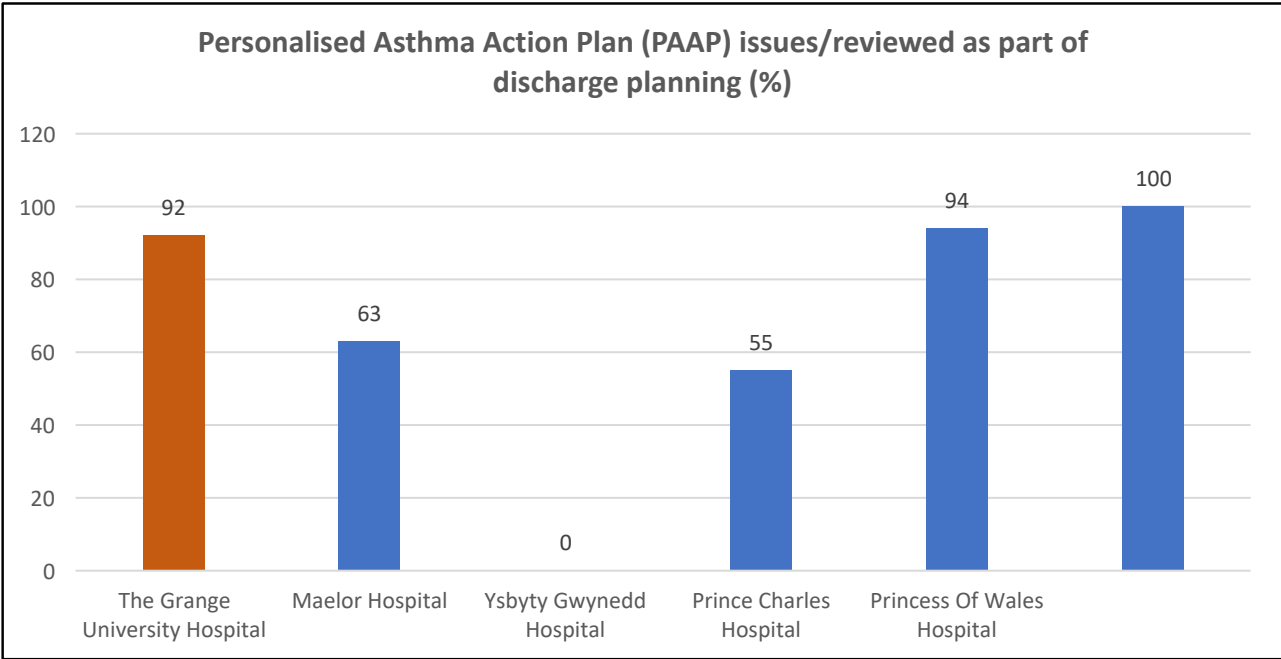
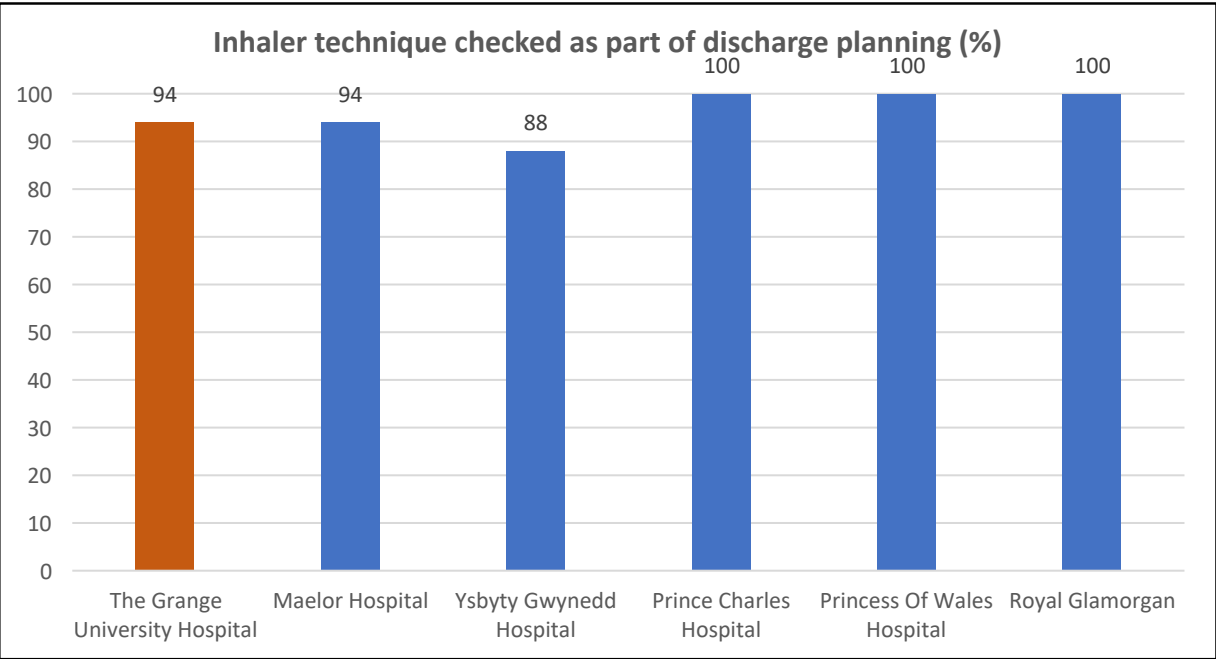


www.ash.org.uk
Health-effects-of-Second-hand-smoke.



www.helpmequit.wales
Free advice and support with smoking cessation.





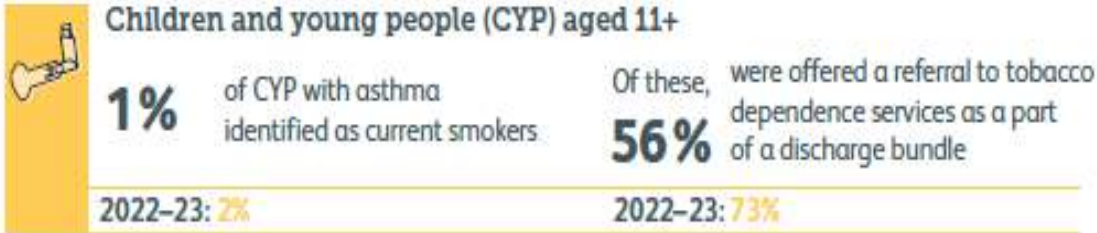
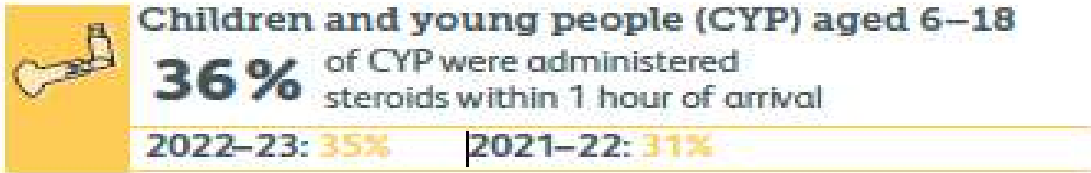
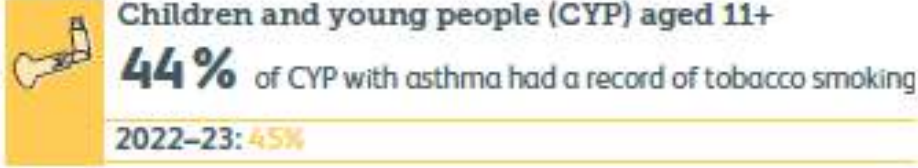
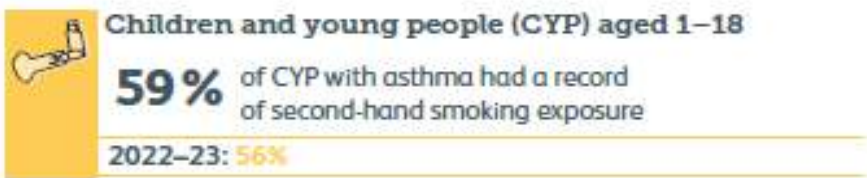
Improving data availability and quality to drive change

Data completion

Data completion is low for certain questions of the acute care audits. For example, only 44% of children and young people (CYP) have a smoking status recorded in the audit, and only 59% of children and young people had a record of whether they are exposed to second-hand smoke in the home. Tobacco smoke and environmental exposure both increase the risk of an acute asthma exacerbation, however these risk factors are not being routinely captured or acted on for a significant proportion of CYP during an acute admission.²

All local health boards should regularly review NRAP data on discharge planning for CYP and adult asthma and COPD with their providers. If data indicates gaps in care, or poor data quality, they should collaborate to identify solutions.

Information relating to data/audit in respect of CYP across England and Wales



Assurance and Risk

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Primary care education days	1	Prednisolone within 1 hr
2	New pathway adopted with recent audit interactions	2	Primary care follow up with 2 days
3	Better, earlier diagnosis of asthma	3	Hospital FU with 4 weeks
4	Data capture	4	Documentation of smoking and interventions

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	We reiterate the importance of our <i>Breathing Well</i> recommendation which is maintained for this year’s report: Integrated care boards and local health boards should mandate all eligible services to participate in NRAP to achieve 100% service participation and a minimum of 50% case ascertainment by all services in NRAP audits by May 2026. This will require all services to have named NRAP clinical leadership and dedicated audit support				fulfilled
2	The British Thoracic Society, as the expert body, should lead the development of a standardised acute care bundle for patients with asthma and COPD on arrival to hospital, working towards May 2026. This should involve consultation with other bodies such as the Royal College of Emergency Medicine, Society for Acute Medicine, and NRAP. NRAP will measure the implementation of the acute care bundle by tracking the percentage of patients receiving timely and optimal care.				fulfilled
3	We reiterate the importance of our Breathing well recommendation which is maintained for this year’s report: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	Present at next audit day Junior education in PED and paed		3 months	
4	PGD for prednisolone for wheeze - Pharmacy constraints	Already initiated	M Pierrepoint		
5	Nurse-led asthma FU clinics - Cost constraints	Already submitted			

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Develop more transition joint working	2 meetings per yr	Dr Gupta		actioned
2	Liaise with primary care about 2-day FU		M Pierrepoint	3 months	

NICE guideline [NG151] Quality Standards DG27

Performance Indicators:	
PI 1:	Seen by Clinical Nurse Specialist
PI 2:	Trust/MDT volume for rectal cancer surgery
PI 3:	Adjusted 90-day mortality after major resection
PI 4:	Adjusted 30-day unplanned return to theatre after major resection
PI 5:	Adjusted 30-day unplanned readmission after major resection
PI 6:	Adjusted 18-month unclosed ileostomy after anterior resection
PI 7:	Stage 3 colon cancer receiving adjuvant chemotherapy
PI 8:	Severe acute toxicity after adjuvant chemotherapy for colon cancer
PI 9:	Rectal cancer patients receiving neo-adjuvant therapy
PI 10:	Adjusted 2-year survival rate after major resection.

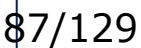
Trust/MDT volume for rectal cancer surgery

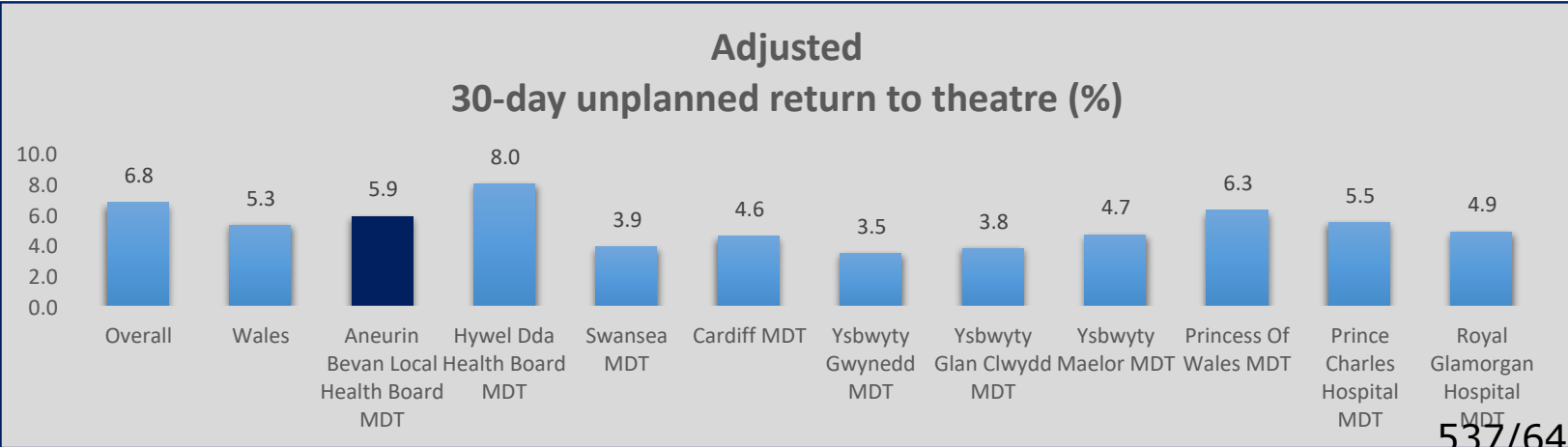
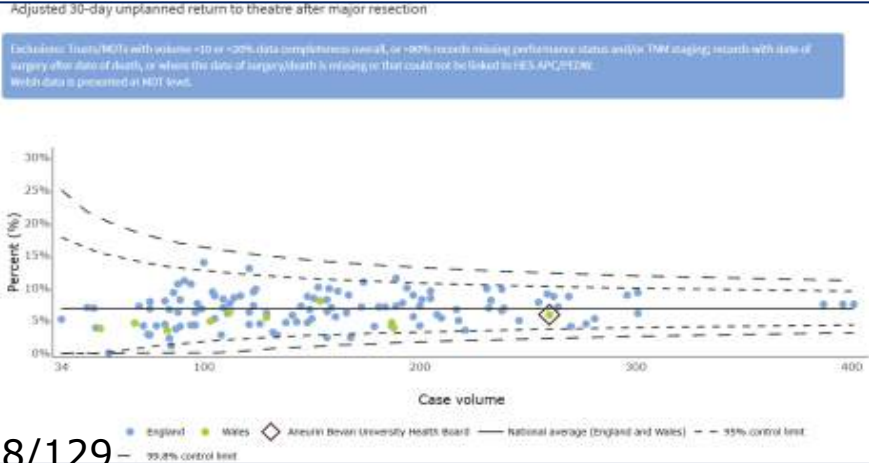
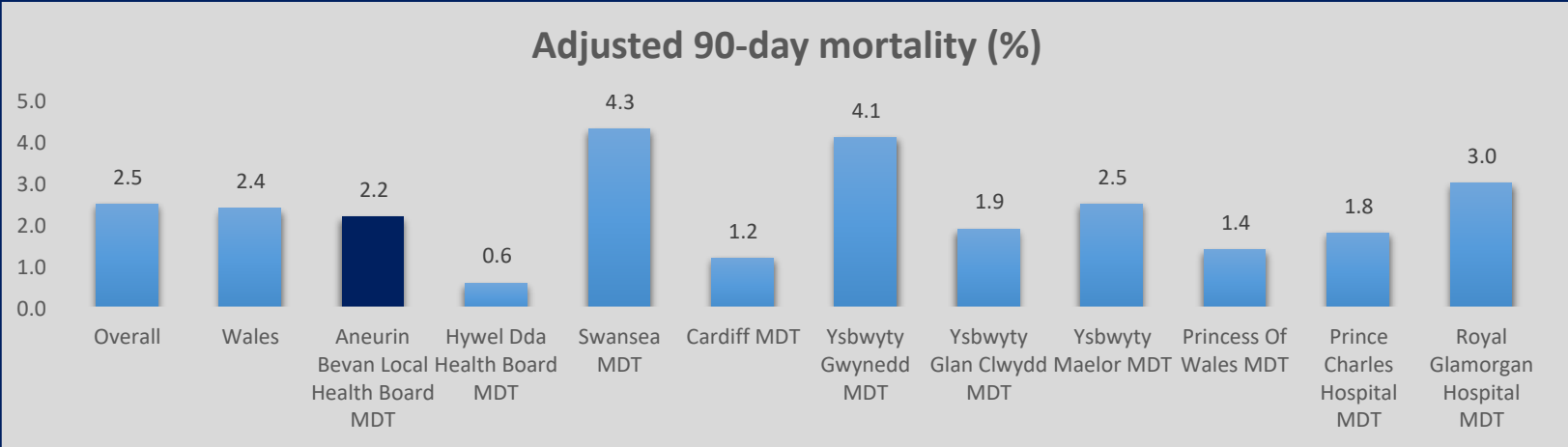
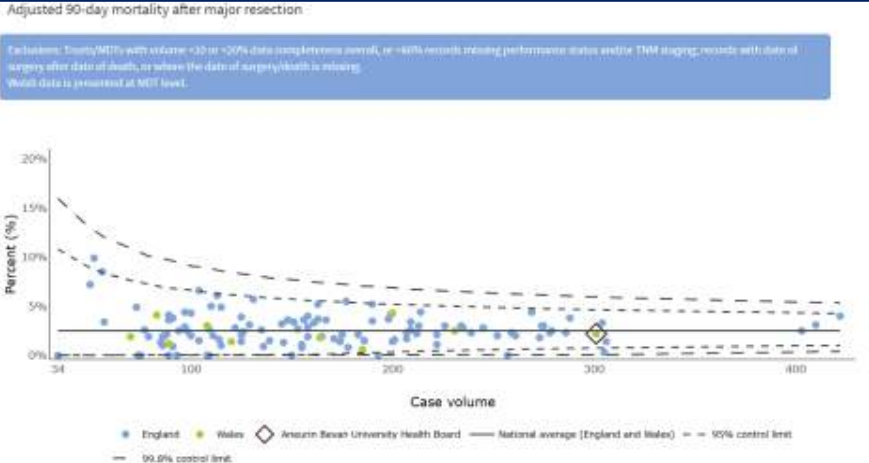
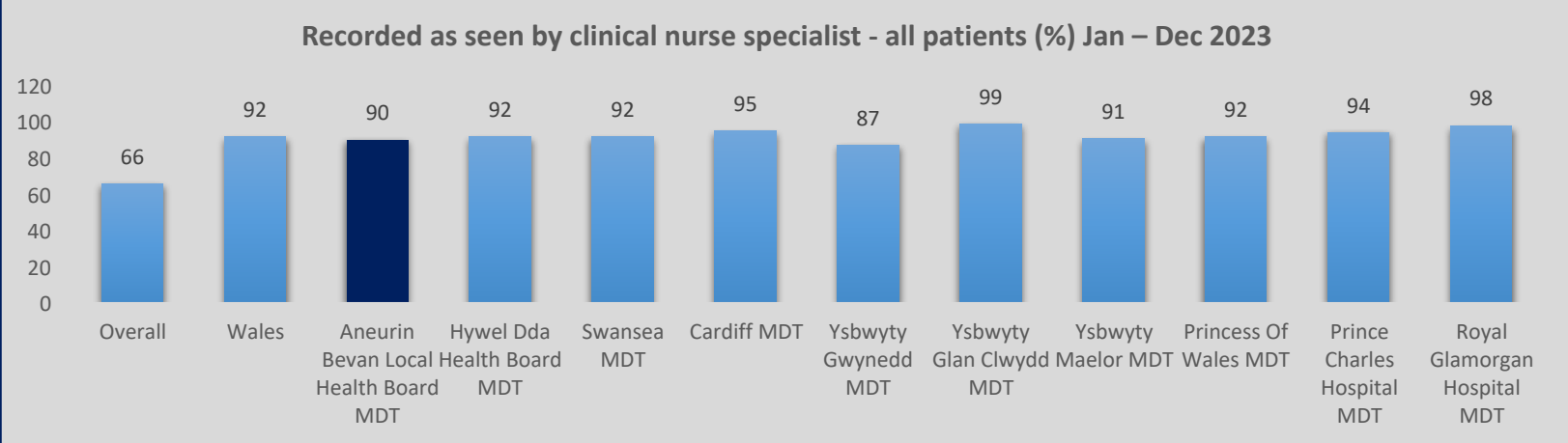
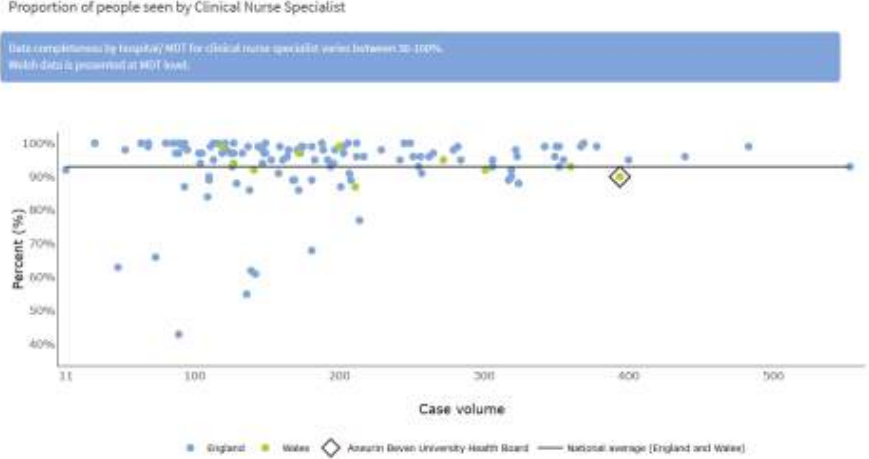
95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.
Only England-level data is available for this indicator.
Exclusions: Trusts (England) /MDTs (Wales) with volume <10.
Webb's data is presented at MDT level.

Case Volume

Rank

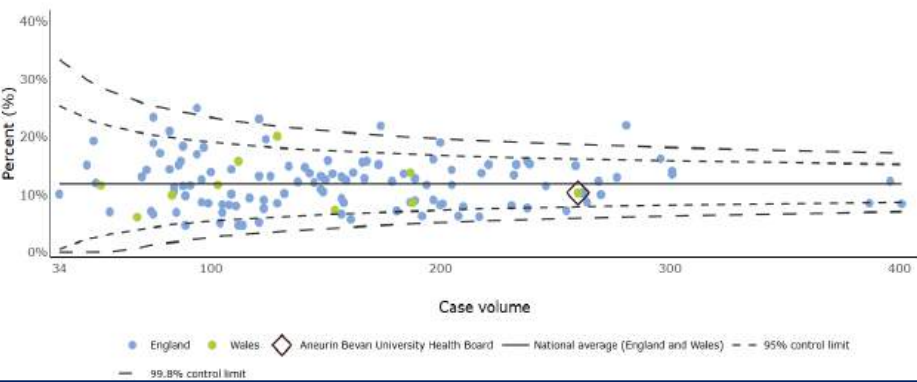
Legend: England (blue), Wales (green), Aneurin Bevan University Health Board (black)



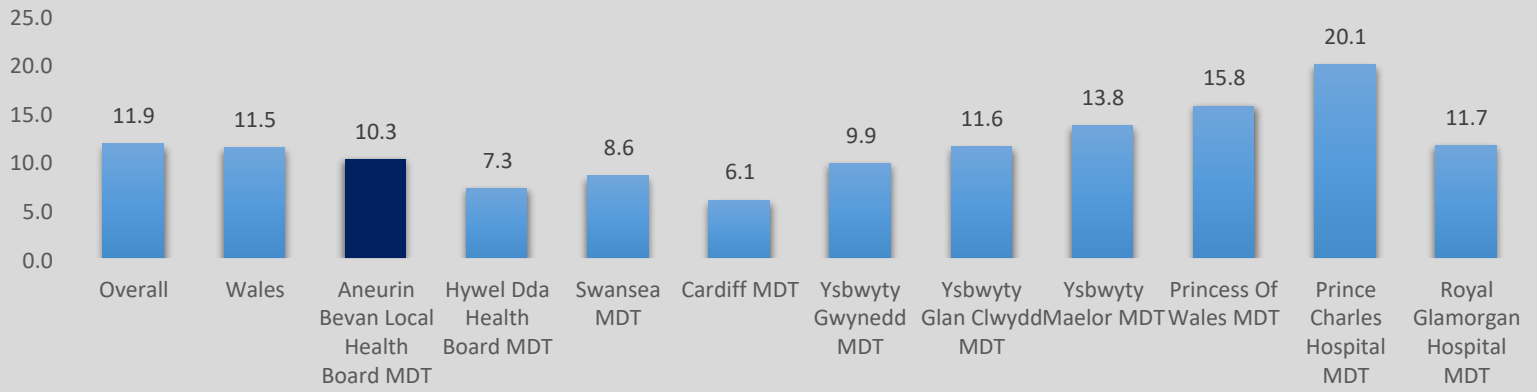


Adjusted 30-day unplanned readmission after major resection

Exclusions: Trusts/MDTs with volume <10 or <20% data completeness overall, or >80% records missing performance status and/or TNM staging; records with date of surgery after date of death, or where the date of surgery/death is missing or that could not be linked to HES/APC/PEDW. Welsh data is presented at MDT level.

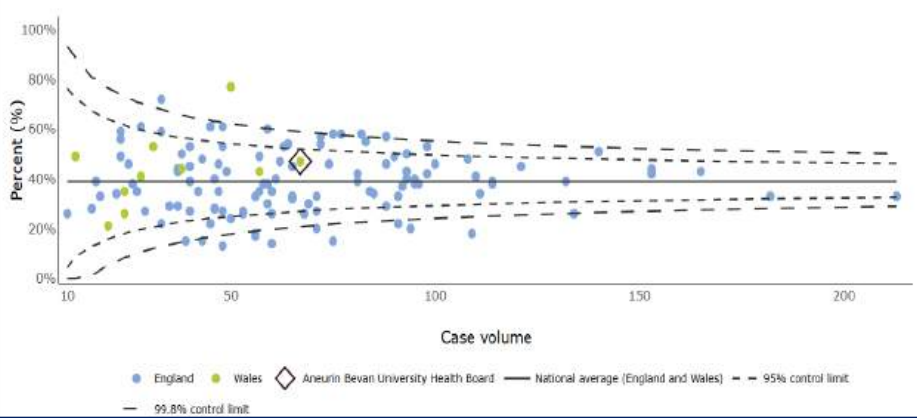


Adjusted 30-day unplanned readmission (%)

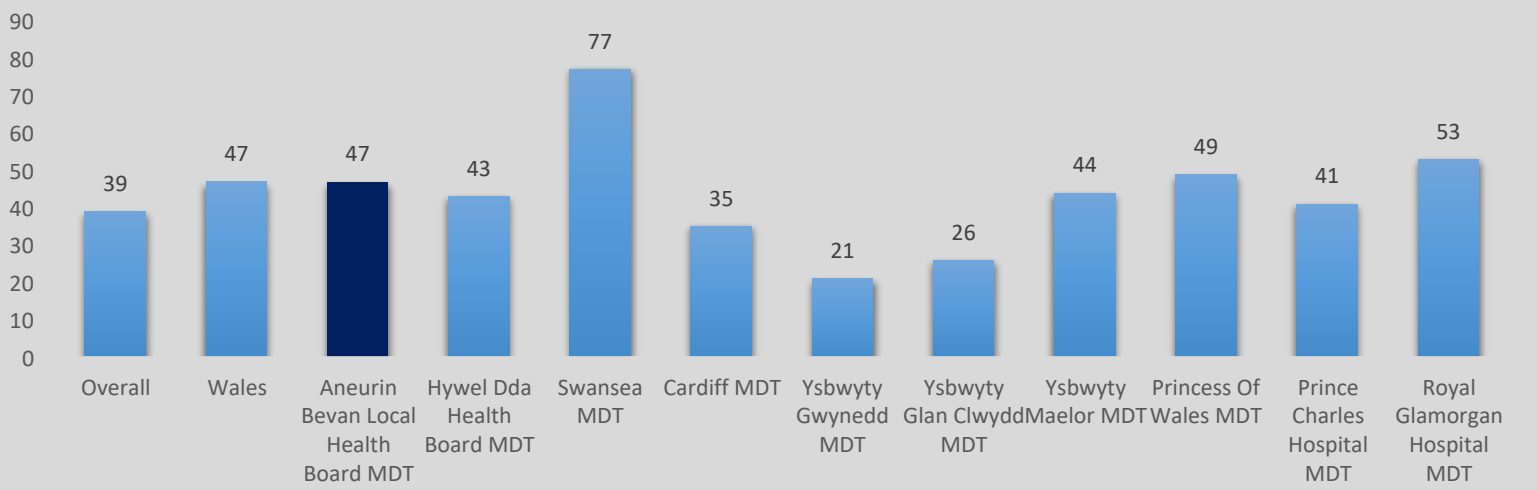


Adjusted 18-month unclosed ileostomy after anterior resection

Exclusions: Trusts/MDTs with volume <10 or <20% data completeness overall, or >80% records missing performance status and/or TNM staging; records with date of surgery after date of death, or where the date of surgery/death is missing or that could not be linked to HES/APC/PEDW. Welsh data is presented at MDT level.



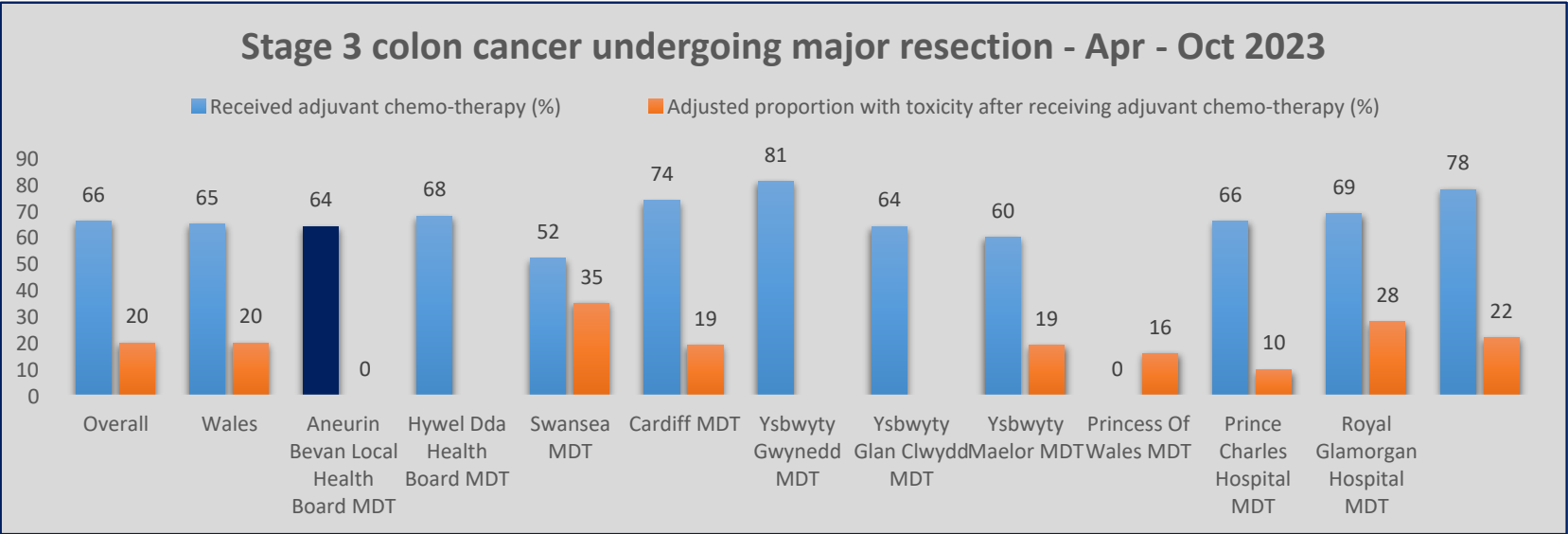
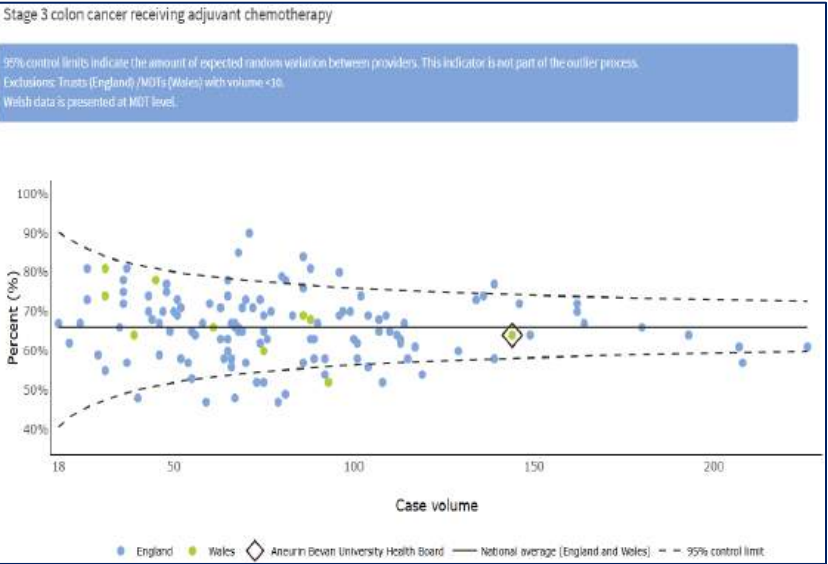
Adjusted 18-month unclosed ileostomy using HES/PEDW (%)



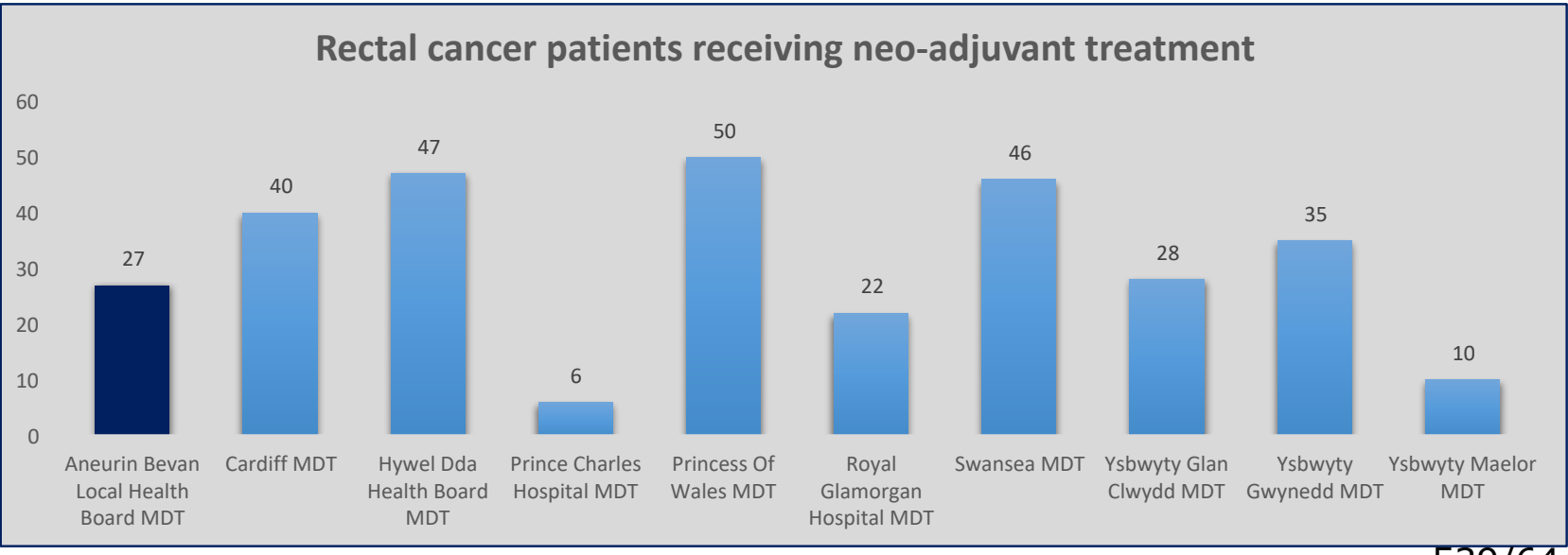
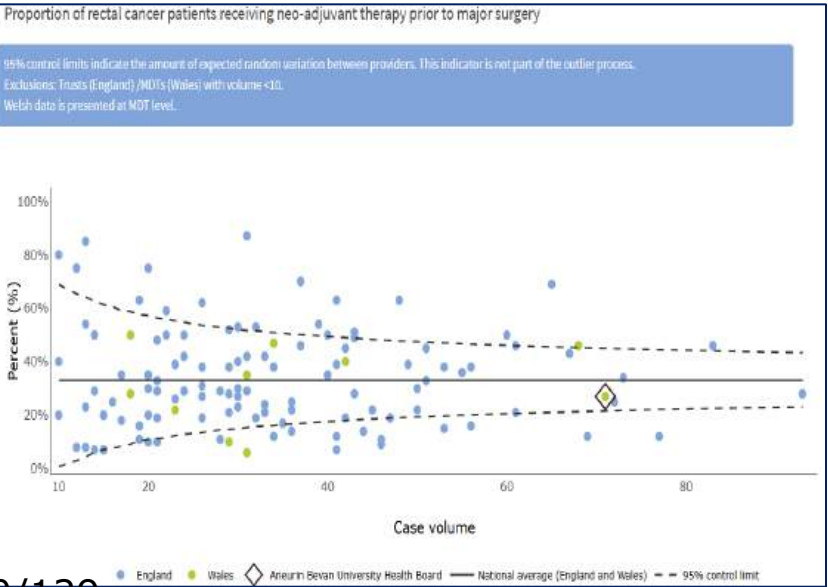
Report findings:

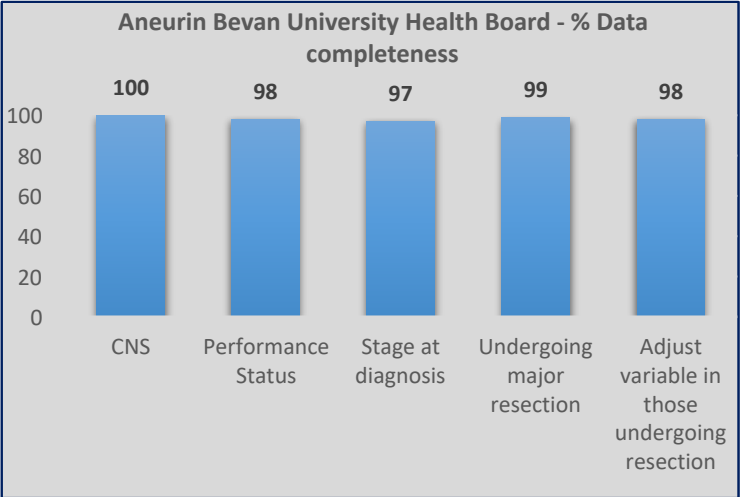
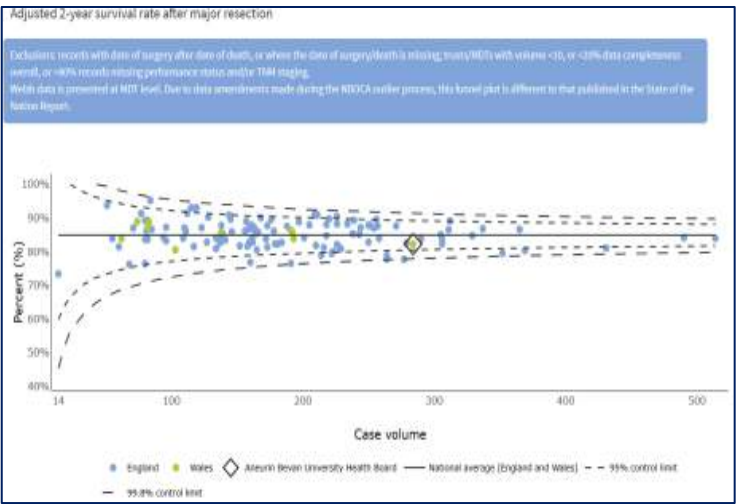
- Performance Indicator and local target: Less than 35% of people with unclosed diverting ileostomy 18-months after anterior resection
- Approximately 38% of people with unclosed diverting ileostomy 18-months after anterior resection. This has not improved since last year's report. Please see ppt in relation to '**reducing the time to reversal of temporary ileostomies following anterior resection**' presented by Mr Swarnkar to the surgical directorate (slides have also been added to the end of this ppt)

- More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy
- In England and Wales, 14 NHS trusts/HBs were below the local target. Considerable between-unit variation in the use of adjuvant chemotherapy remains with 15 (12%) NHS trusts/MDTs below the 95% funnel limit.



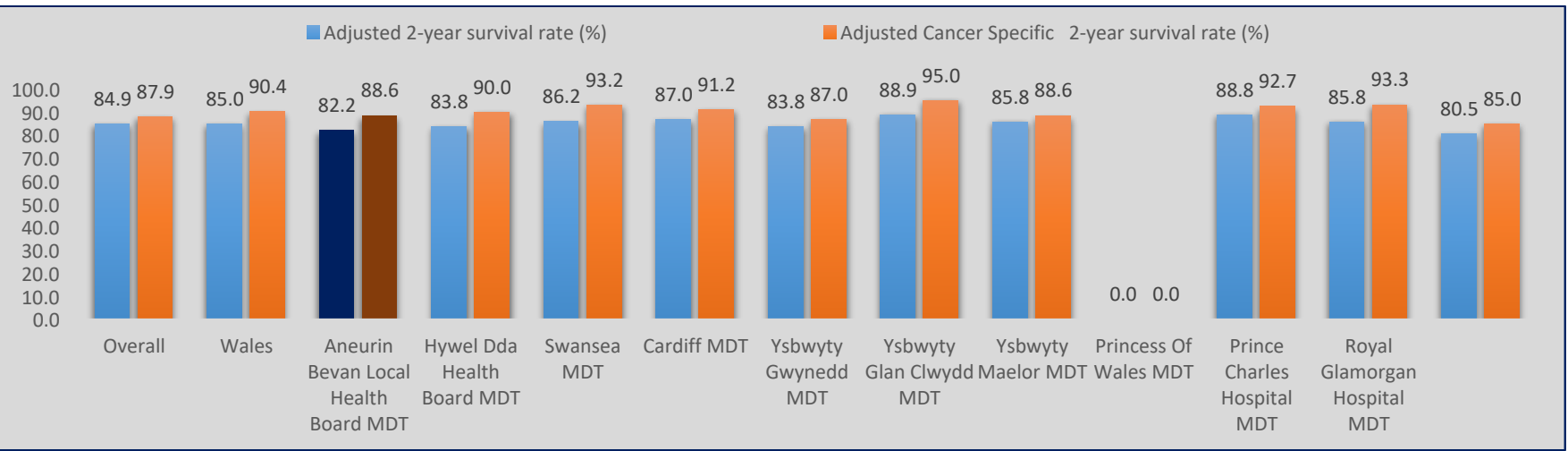
10-60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment.
Overall, 33% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs from 6% to 87%.





Key Success and Concerns

Report Successes:	
1	Data completion and submission is high quality. Good administrative support for Cancer coordinator.
2	Perioperative Surgical quality of care and outcomes meet and, in some criteria, exceed national standards
3	Good input into the MDT from Oncologists, gastroenterology and Liver surgical team to help with complex cases .
4	Established Early rectal cancer assessment and surgery within ABUHB through SPECC MDT and dedicated surgeons undertaking TAMIS procedure. Introduction of Robotic surgery for CRC.



Assurance and Risk Level

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
Has this audit been placed on a Risk Register (N/A if above risk is None)	
NO	
If not on a risk register, why not: The unmet standard has been audited locally and agreement reached with appropriate directorates (General Surgery & Radiology) to facilitate the process and achieve the target.	

Report concerns:	
1	Delay in Diagnostic pathway, mainly endoscopy. This is being addressed through vetting.
2	Delay in Ileostomy closure- now being addressed with renewed process in place.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support NHS trusts/ multidisciplinary teams (MDTs) to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support NHS trusts/MDTs to participate and engage with the local and national quality improvement initiatives to enable more timely reversal of ileostomy. For example, NBOCA & Royal College of Surgeons of England’s CloseItQuick Collaborative.	Presented data to surgical directorate on the recent audit of 2-year data and suggested – WSCE to be done at 4-6 weeks post low anterior resection. This was identified as the crucial step in the pathway affecting Target outcome. Agreed by MDT and Radiology department. QI project to assess progress in 1 year.	K Swarnkar Jo Hamill	Jan 2027	Action plan agreed
2	In units with chemotherapy utilisation following resection of stage 3 colon cancer below 55%, conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. If the resulting findings identify under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include integration of geriatric expertise and or rehabilitation into shared chemotherapy decision making.		Dr H Williams No action needed. 64% patients received adjuvant chemotherapy.		
3	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer alliances and health boards to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. An example guideline is provided as a basis for regional discussions. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.		Dr H Williams No action neededWe have good support from oncologist and Liver surgeons to support our decisions about neoadjuvant chemotherapy in rectal cancer patients with or without liver metastasis.		
4	Ensure robust sustainable pathways are in place to provide timely genomic assessment where clinically appropriate. To inform personalised treatment options and/or identify those with Lynch syndrome, optimise the proportions of people undergoing: - MMR or MSI testing in stage 1 to 4 cancer - RAS and BRAF assessment in stage 4 cancer	Both MSI and MMR testing is routinely done in all patients diagnosed with colorectal cancer. This guided our MDT outcome in planning treatment. RAS and BRAF are specifically requested for stage 4 cancers at the request of oncologist in MDT.	Dr J Harrison(Pathologist) Dr H Williams (Oncologist) No action needed.		
5	Data Quality Recommendation Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk-adjustment of performance indicators. - Provision of a clinical local data lead responsible for working with relevant local teams (e.g. Clinical Effectiveness/Audit) to ensure the quality of data submissions to national datasets. - Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists’ (ASA) grade and performance status.	Our data set in all essential fields is 97% and above Continued support to MDT coordinator during periods of leave with alternative personnel is crucial to avoid gaps in real time data collection.	Mr K Swarnkar (MDT lead) Julie Watkins (MDT coordinator) No action needed.		

Rationale:

The aim of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people with primary breast cancer in England and Wales, and to support services to improve the quality of care. The 2025 State of the Nation report publishes information on the care received by people diagnosed with breast cancer during 2020-22 in England and Wales. It is the audit’s second annual assessment of NHS breast services and shares examples of good practice, as well as highlighting where care needs to improve. Breast cancer care described for the patients diagnosed in the period 2020-22 will reflect the changes introduced in the NHS during 2020 because of the COVID-19 pandemic and will be atypical to some degree.

Objectives:

The management of people with breast cancer is informed by various national guidelines. From these guidelines, and in consultation with its professional and patient advisory groups, the NAoPri has developed five quality improvement (QI) goals and a set of associated indicators, details of which are published in the [NAoPri-Quality-Improvement-Plan](#). Some indicators outlined in the QI Plan remain in development.

Presented at Cancer Board – 26/02/2026

NAoPri Quality Improvement goals

The NAoPri Quality Improvement Plan describes the approach taken across the NATCAN cancer audits to develop improvement goals and performance indicators / metrics, aiming for these to be measurable, actionable and improvable. The NAoPri Quality Improvement goals, developed following a thorough [scoping exercise in 2023](#) and in consultation with stakeholders in the [Audit Advisory Committee](#), are as follows:

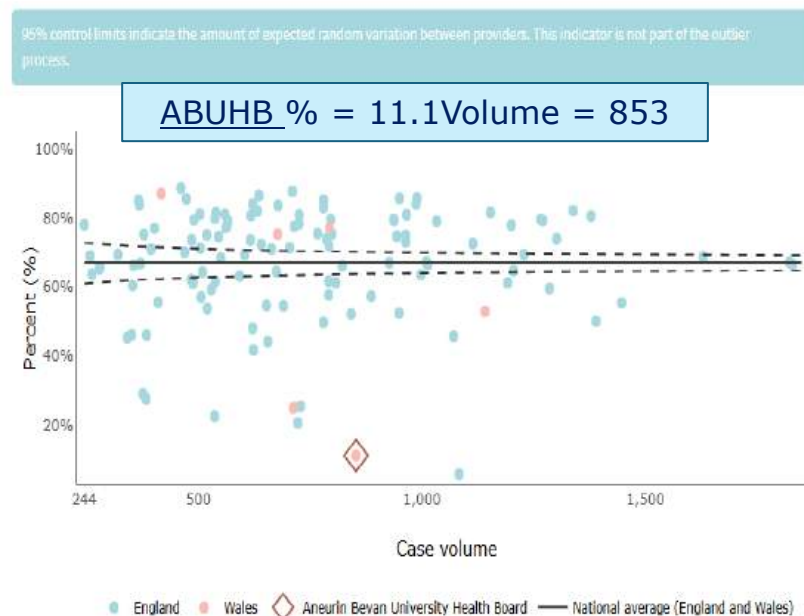
1. Improve the movement of patients through the care pathway.
2. Reduce unwarranted variation for patients undergoing surgery.
3. Reduce unwarranted variation for patients having non-surgical oncological treatments.
4. Improve access to breast reconstruction after mastectomy.
5. Improve and reduce unwarranted variation in primary breast cancer outcomes.

The NAoPri has identified ten indicators / metrics to monitor progress against these five improvement goals and how they map to clinical guidelines and standards. A range of improvement methods and improvement activities to help deliver the Quality Improvement Plan are also described.

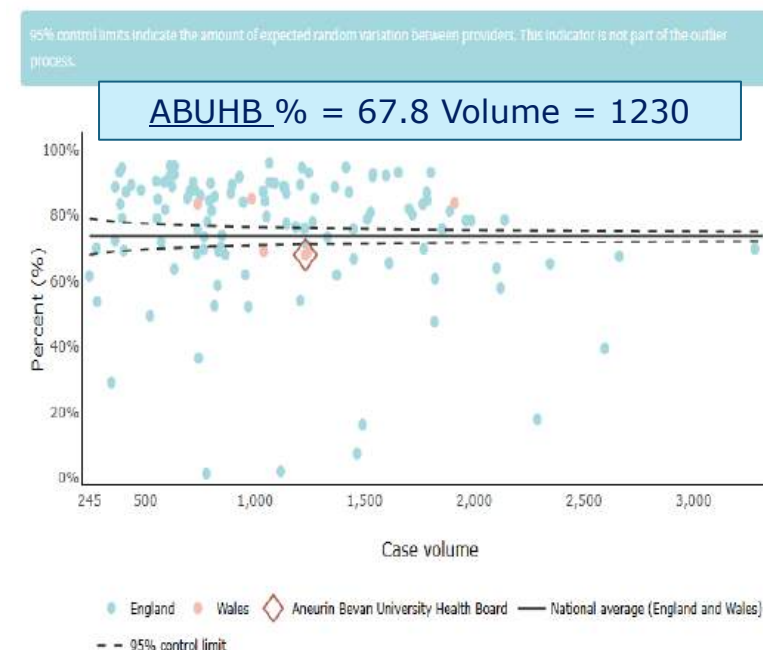
Table 1. *Performance Indicators (PIs) *		
	England ^	Wales #
PI 1: Percentage of patients who underwent triple diagnostic assessment (TDA) in a single hospital visit	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 2: Percentage of patients who had contact with a Clinical Nurse Specialist (CNS) recorded after diagnosis.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 3: Percentage of patients who had i) breast-conserving surgery within 12 months of diagnosis, or ii) mastectomy within 12 months of diagnosis.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 4: Percentage of patients who received neo-adjuvant chemotherapy.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 5: Percentage of patients who received adjuvant radiotherapy following i) breast-conserving surgery, and ii) mastectomy	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 6: Percentage of patients who received any chemotherapy.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 7: Percentage of patients who had an immediate reconstruction following a mastectomy.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 8: Percentage of patients who had re-operation within 12 months of their initial breast-conserving surgery.	Yes (01/20 – 12/22)	Yes (01/20 – 12/22)
PI 9: Percentage of patients who had an overnight hospital admission for treatment-related toxicity within 30 days of a systemic anti-cancer therapy (SACT) cycle.	No (Indicator under development)	No (Indicator under development)
PI10: Percentage of patients who survived their breast cancer for at least 3 years from their initial breast cancer diagnosis	Yes (01/21 – 12/22)	Yes (01/21 – 12/22)

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
Percentage of people with data for CNS	75.6	6
Percentage of People with data for ER status or ER score	74.1	6
Percentage of people with data for PR status or PR score	25.9	6
Percentage of people with HER2 status	53.7	6
Percentage of people with data for stage	69.7	6
Percentage of people with data for T stage	76.4	6
Percentage of people of people with data for N stage	100	all HB's achieved 100%
Percentage of people with data for grade	97.8	6
Percentage of people data for WHO performance status	0.2	6
Percentage of people with data for triple diagnostic assessment (TDA)	11.1	6

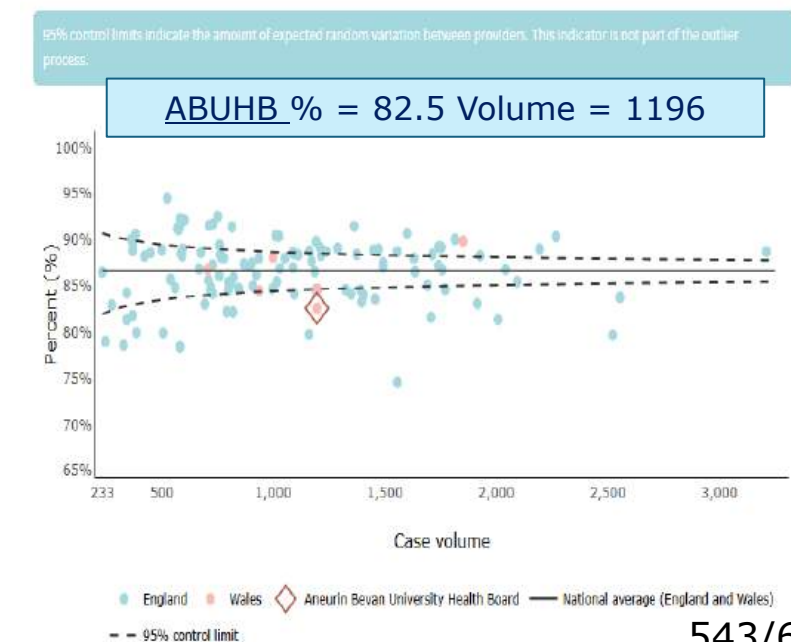
Percentage of people who underwent triple diagnostic assessment (TDA) in a single hospital visit



Percentage of people who had contact with a Clinical Nurse Specialist (CNS) recorded as 'yes'

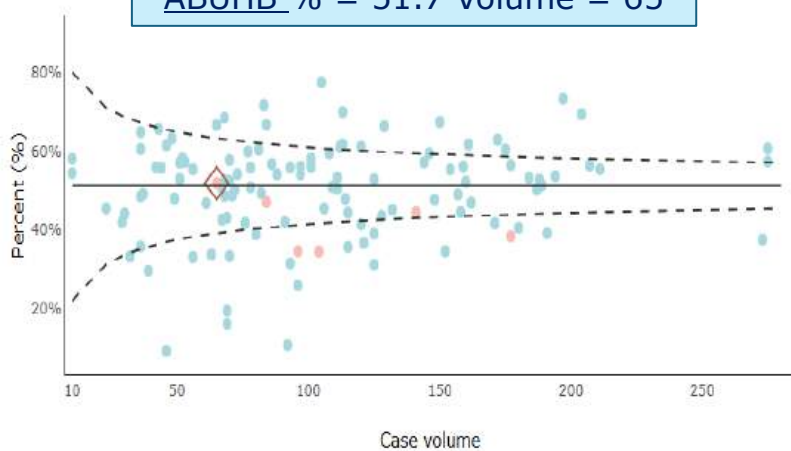


Percentage of people who had i) breast-conserving surgery, or ii) mastectomy, within 12 months of diagnosis



95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

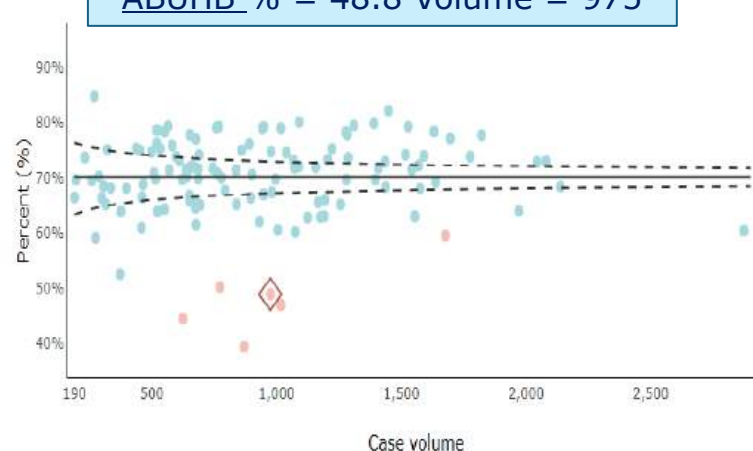
ABUHB % = 51.7 Volume = 65



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

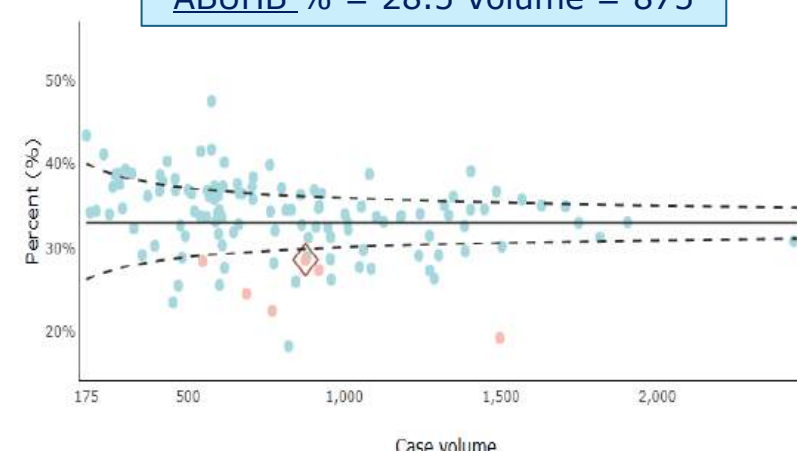
ABUHB % = 48.8 Volume = 975



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

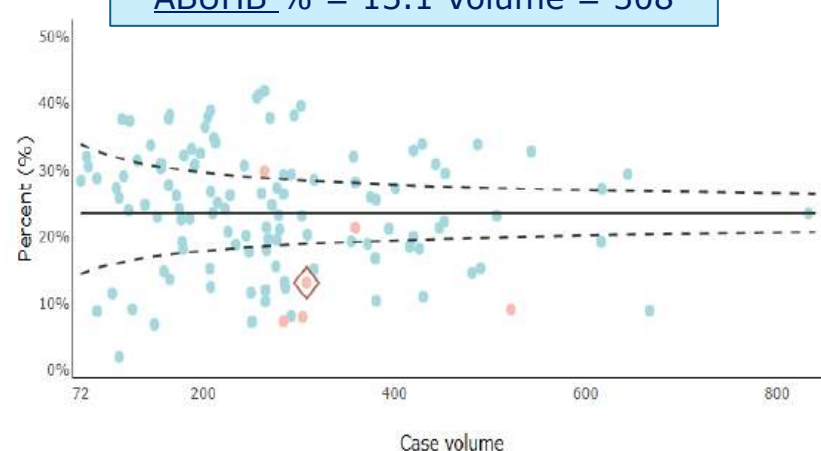
ABUHB % = 28.5 Volume = 875



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

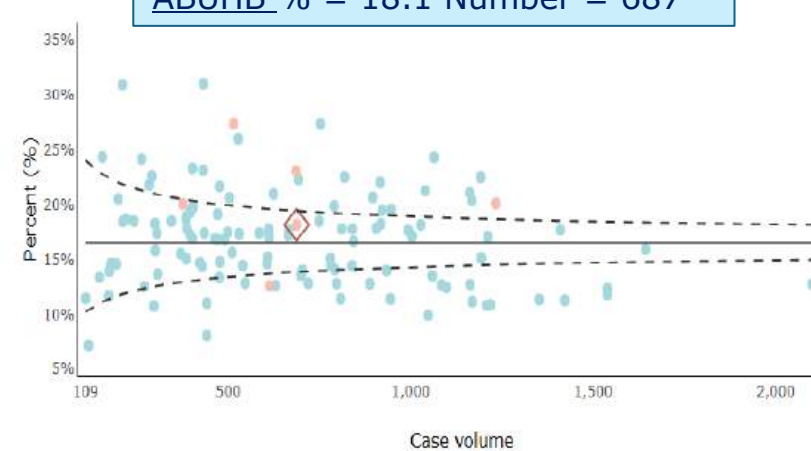
ABUHB % = 13.1 Volume = 308



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit

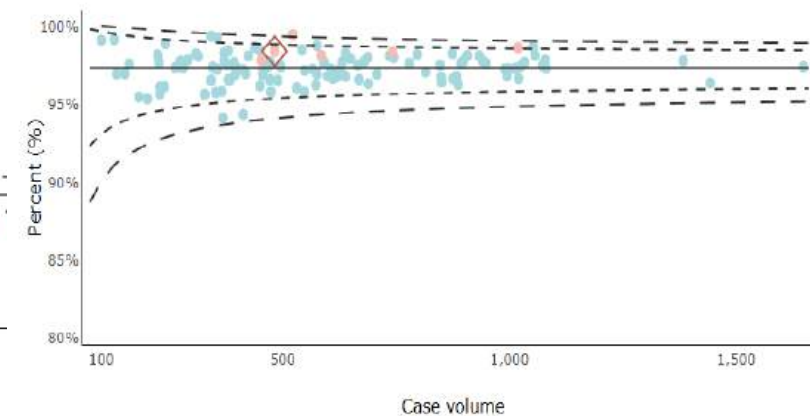
95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

ABUHB % = 18.1 Number = 687



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit

ABUHB % = 98.4 Volume = 482



● England ● Wales ◆ Aneurin Bevan University Health Board — National average (England and Wales)
-- 95% control limit -- 99.8% control limit

Assurance and Risk Level

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			NO

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Patients now have one stop triple assessment service this data will improve once we get to 2024 data point	1	Data inputting to the audit remains an issue. It is too much work for one person and does not reflect the service
		2	Data for performance status difficult to capture
2	Excellent 3-year breast cancer specific survival	3	Low rates of immediate breast reconstruction being offered – but unlikely to be captured correctly and also likely lower due to the COVID pandemic

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service.	Aim for 95% of all patients to receive single visit TDA	Michael Rees/Rhiannon Foulkes/oncology team and wider breast care and management team	Achieved since the breast unit switched to one stop TDA in April 2024	
2	Review the use of neo-adjuvant chemotherapy for people with triple negative and HER2+ early invasive breast cancer. Reduce the levels of unexplained regional variation, with particular emphasis in increasing use among those showing low rates and ensuring neo-adjuvant chemotherapy is offered to eligible patients in line with guideline recommendations			2026	Achieved - All cases discussed at the MDT with oncology presence and all those eligible offered neoadjuvant chemotherapy
3	Review rates of immediate breast reconstruction (IBR) and, where rates are lower than expected, act to improve access by ensuring it is offered to all women as part of a balanced shared decision-making process, unless precluded by comorbidity or adjuvant therapies.	Aim for >20% rate for IBR post mastectomy. IBR to be offered to all patients who meet the criteria for immediate reconstruction			In progress All patients eligible for IBR are offered IBR. COVID happened during this time period and immediate reconstruction was not routinely offered. The next audit should show an improvement in this number. However, there are now a number of patients having local flaps as opposed to mastectomy therefore that may contribute to a decrease in mastectomy rate within the Health Board.

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Review rates of re-operation following breast conserving surgery (BCS) and, where rates are higher than expected, units should review local protocols with the view to complying with best practice.	Aim to reduce the reoperation rate to below 16% which is the average	Michael Rees/Rhiannon Foulkes/Wider breast care and management team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the NABCOP fitness assessment data items (people aged 70+ years) and contact with clinical nurse specialists (CNS)	Aim for >95% completeness of data for tumour characterisation and contact with clinical nurse specialists. New MDT proforma to help to collect difficult data such as performance status. PR testing is now done on all patients previously only when ER (-) by some pathologists Look at the way that data is collected by the health board			

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry as these seem to be often missing	Rhiannon Foulkes, Michael Rees and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing. Essential to reduce the delay in the patient pathway	Michael Rees	2026	In progress

Rationale:

The aim of the National Audit of Metastatic Breast Cancer (NAoMe) is to evaluate the patterns of care and outcomes for people with metastatic breast cancer (MBC) in England and Wales, and to support services to improve the quality of care for these people. This State of the Nation report publishes information on the care received by women and men diagnosed with MBC during 2020-22 in England and Wales. The breast cancer care described for the period 2020-22 will reflect the changes introduced in the NHS during 2020 because of the COVID-19 pandemic and will be atypical to some degree.

Objectives:

The management of people with MBC is informed by various national and international guidelines1-2. From these guidelines and in consultation with its professional and patient advisory groups, the NAoMe team has developed five quality improvement (QI) goals and a set of related indicators, details of which are published in the [NAoMe-Quality-Improvement-Plan](#). Some indicators outlined in the QI Plan remain in development.

Presented at Cancer Board 26/02/2026

NAoPri Quality Improvement Goals

The NAoMe Quality Improvement Plan describes the approach taken across the NATCAN cancer audits to develop improvement goals and performance indicators / metrics, aiming for these to be measurable, actionable and improvable. The NAoMe Quality Improvement goals, developed following a thorough [scoping exercise in 2023](#) and in consultation with stakeholders in the [Audit Advisory Committee](#), are as follows:

- 1. Improve the movement of patients through the care pathway.
- 2. Reduce unwarranted variation in access and timeliness to systemic anti-cancer treatment.
- 3. Reduce unwarranted variation in access and timeliness to palliative treatments.
- 4. Improve access to nursing support.
- 5. Improve and reduce variation in metastatic breast cancer outcomes.

The NAoMe has identified ten indicators / metrics to monitor progress against these five improvement goals and how they map to clinical guidelines and standards. A range of improvement methods and improvement activities to help deliver the Quality Improvement Plan are also described.

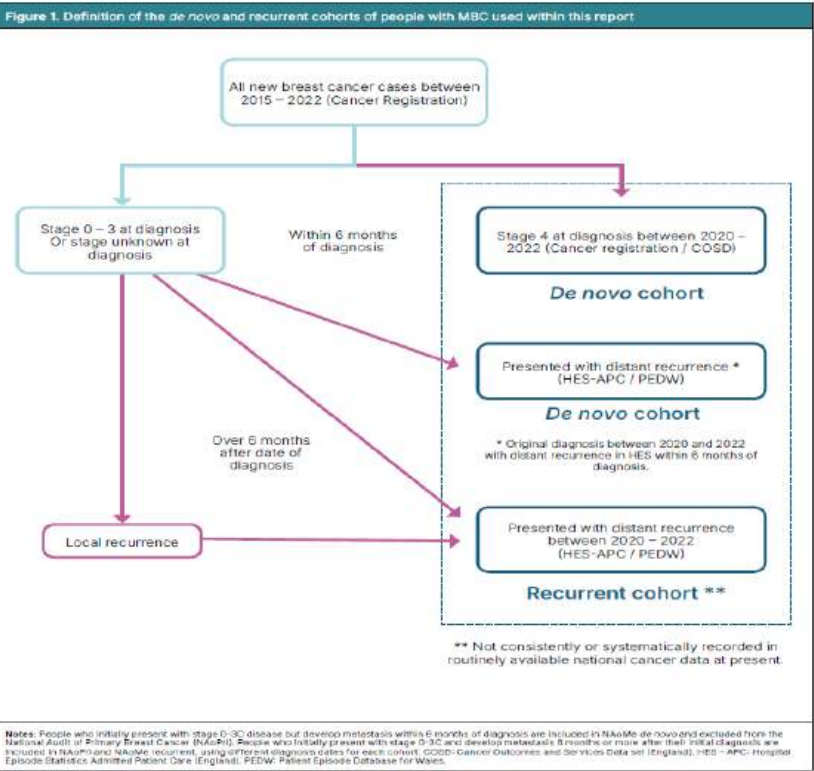
Table 1. Performance Indicators (PIs) *

	England^	Wales#
PI 1: Percentage of patients with newly diagnosed <i>de novo</i> metastatic breast cancer (MBC) discussed in a multi-disciplinary team (MDT).	Yes (01/20– 12/22)	Yes (01/20– 12/22)
PI 2: Percentage of patients with recurrent MBC who had a biopsy to inform care.	Yes (01/20– 12/22)	No (Data not available)
PI 3: Percentage of patients with ER positive <i>de novo</i> MBC who received CDK 4/6 inhibitors.	Yes (01/20– 12/22)	No (Data not available)
PI 4: Percentage of patients with HER2 positive <i>de novo</i> MBC who received anti-HER2 therapy.	Yes (01/20– 12/22)	No (Data not available)
PI 5: Percentage of patients who received chemotherapy.	Yes (01/20– 12/22)	Yes (01/20– 12/22)
PI 6: Percentage of patients with bone metastases who received a bisphosphonate or denosumab.	No (Under development)	No (Under development)
PI 7: Percentage of patients with MBC who received radiotherapy.	No (Under development)	No (Under development)
PI 8: Percentage of patients with <i>de novo</i> MBC with clinical nurse specialist (CNS) contact recorded as "Yes".	Yes (01/20– 12/22)	Yes (01/20– 12/22)
PI 9: Percentage of patients with death recorded within 30 days of a chemotherapy cycle.	Yes (01/20– 12/22)	Yes (01/20– 12/22)
PI 10: Percentage of patients with <i>de novo</i> MBC who survived for at least 1 or 3 years after diagnosis.	Yes (01/20– 12/22)	Yes (01/20– 12/22)

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
People with data for CNS	81.3	6
People with data for ER status or ER score	73.3	6
People with data for PR status or PR score	34.7	6
People with data for HER2 status	61.3	6
People with data for stage	52	6
People with data for grade	89.3	6
People with data for WHO performance status	5.3	5

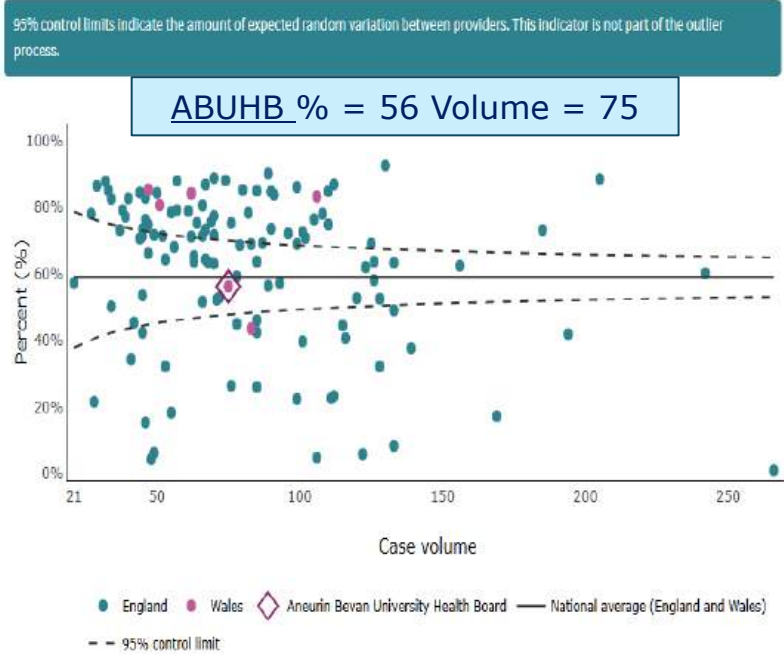
Lack of a robust mechanism to detect recurrence after a previous primary breast cancer diagnosis within national cancer datasets is the greatest challenge faced by the NAOme. Data quality is therefore a key focus for the NAOme team. We urge NHS organisations to prioritise recording new non-primary breast cancer as a new COSD episode, rather than continuation of an existing primary breast cancer record, to enable accurate analysis of this population.

Figure 1. Definition of the de novo and recurrent cohorts of people with MBC used within this report

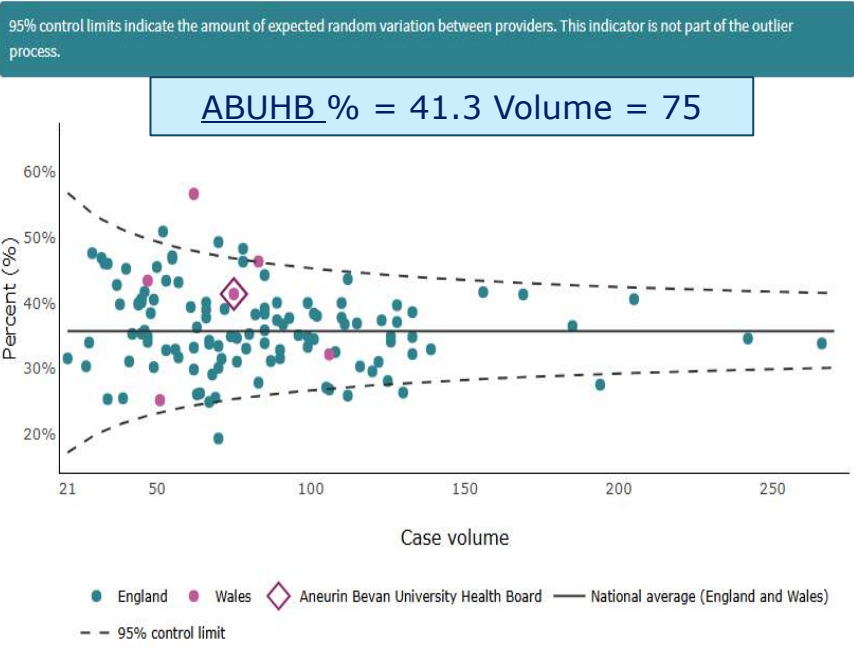


The report distinguishes between people with de novo MBC and recurrent MBC (definitions opposite). The National Disease Registration Service (NDRS) is attempting to improve collection of data about recurrence in individuals with an existing primary breast cancer record. However, for the years covered in this report, the data on distant recurrence is not of sufficient quality or completeness to be included. As an interim solution, while the data quality is being improved, we have used diagnosis codes for metastatic breast cancer in inpatient hospital records to identify the recurrent cohort. This approach does not identify all people diagnosed with recurrent MBC. In particular, those who have not been admitted to hospital will not be captured, thereby limiting the representation of this population.

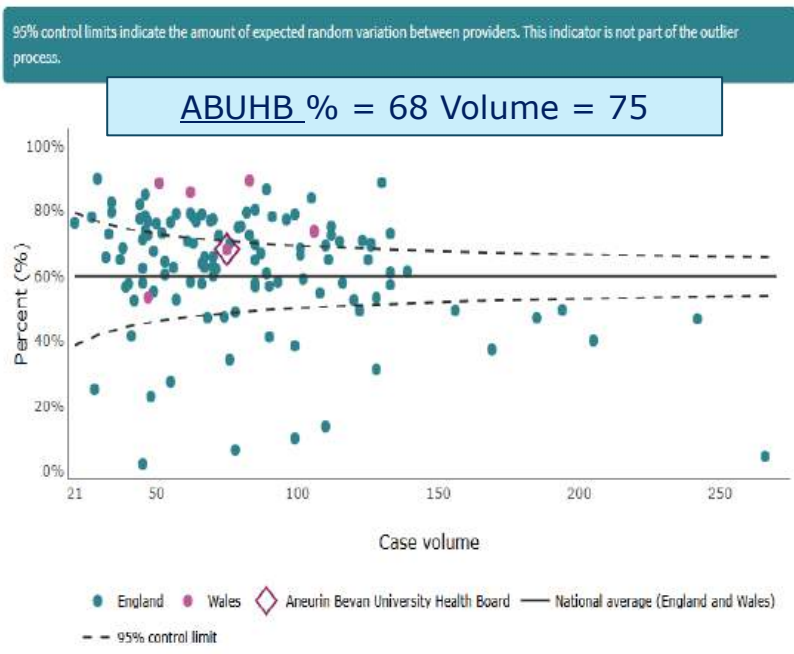
Percentage of people with newly diagnosed metastatic breast cancer discussed in a multidisciplinary team (MDT)



Percentage of people who received chemotherapy (de novo cohort)



Percentage of people with Clinical Nurse Specialist (CNS) contact recorded as "Yes"



For each performance indicators below, the data dashboards show that only England data was available. However, when we look at the data dashboards, the case volume for ABUHB is shown but there is no unadjusted or risk adjusted percentage provided and the Welsh Health Boards are not shown on the charts

- Percentage of:-
- People with recurrent metastatic breast cancer who had a biopsy to inform care (case volume = 680)
 - People with ER positive, HER2 negative, de novo metastatic breast cancer who received CDK 4/6 inhibitors (case volume = 208)
 - People HER2 positive de novo metastatic breast cancer who received anti-HER2 therapy (case volume = 70)
 - People who received chemotherapy (recurrent cohort) (case volume = 680)
 - People with death recorded within 30 days of a chemotherapy cycle (de novo cohort) (case volume = 185)
 - People with death recorded within 30 days of a chemotherapy cycle (recurrent cohort) (case volume – none recorded)

Assurance and Risk Level

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			
NO			

Key Success and Concerns

Report Successes:		Report Concerns:	
1	There is now a metastatic breast cancer clinical nurse specialist in post this has made a significant difference to patients and indeed the identification of patients who present acutely to other specialities	1	Good access for patients receiving chemotherapy de novo
2	Good documentation of contact with a clinical nurse specialist, this will only improve with our new metastatic breast cancer nurse in post	2	Still awaiting in house testing of Her 2
3	Good access for patients receiving chemotherapy de novo	3	Need to improve documentation of WHO performance criteria

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure the care for all people newly diagnosed with Metastatic Breast Cancer (MBC) (either de novo or recurrent) is discussed within a breast MDT meeting	Aim for >90% of patients to be discussed at MDT	Clinical breast team/oncology team/wider medical teams including general practice	2026	In progress
2	Examine rates of treatment with CDK4/6 inhibitors within 12 months of diagnosis in people with ER+ HER2- MBC. Consider variation in care, especially in low use centres, to try to identify underlying causes and opportunities for improved quality of care	All patients who are eligible for CDK4/6 inhibitors are offered them by oncology	Oncology team		
3	Assess 30-day mortality rates following chemotherapy and, in trusts with rate outside the 95% control limits of the national average, conduct outcome reviews and evaluations of local prescribing practices to ensure appropriate consideration of chemotherapy risks and benefits	This is done locally by the oncology team	Oncology team		

Report Recommendations: DATA QUALITY		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure accurate recording of date and type of breast cancer recurrence by reviewing and optimising the process of capturing and uploading to the Cancer Data Form (CDF)	Accurate data entry to reflect recurrence, this could also be looked at on our data collection proforma to facilitate recording of recurrence.	Clinical management team, cancer services team and breast team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the <u>NABCOP fitness assessment data items</u> (people aged 70+ years) and contact with clinical nurse specialists (CNS)	- Aim for >95% documentation rate for ER, PR and HER2 status - Change to MDT proforma to collect performance status routinely - In house testing of HER2 - Path testing PR on all tumours	Michael Rees/Rhiannon Foulkes Breast care teams and clinical management in Welsh NHS Health Boards.	2026	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry	Rhiannon Foulkes, Michael Rees and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing	Michael Rees	2026	In progress

NICE Clinical Guideline (CG) & Quality Statement (QS), British National Formulary (BNF) & Technology Appraisal (TA):
CG146, NG249, QS86, QS149, TA161, TA204, TA464, TA791, TA991,

Rationale:	In England and Wales there are around 180,000 fractures each year as a result of osteoporosis. One in three women and one in five men will sustain a fracture in their lifetime. The rationale of the FLS-DB 2026 Annual Report is to evaluate and improve the quality of secondary fracture prevention for adults aged 50+ by measuring how effectively Fracture Liaison Services identify, assess, and treat patients with fragility fractures. The report aims to highlight national performance against evidence-based standards, reduce unwarranted variation between services, identify inequalities in access and outcomes, and support improvements in patient care by providing actionable data for clinicians, commissioners, and health boards. Ultimately, its purpose is to ensure timely assessment and appropriate osteoporosis treatment to reduce future fractures and improve outcomes across England and Wales.
Objectives:	Using 11 national KPIs, the audit evaluates how well services identify patients, provide timely bone health and falls assessments, recommend and initiate appropriate osteoporosis treatment, and monitor adherence over time. By benchmarking services against NICE, NOGG and ROS standards, the audit aims to highlight variation, identify gaps in care, expose inequalities, and provide actionable data to support service improvement, commissioning decisions, and national policy. This annual report focusses on whether fracture patients at highest risk of osteoporotic fractures are prioritised and provided with appropriate treatment or prevent future fractures.

Presented at Clinical Standards and Effectiveness Group – 26 February 2026

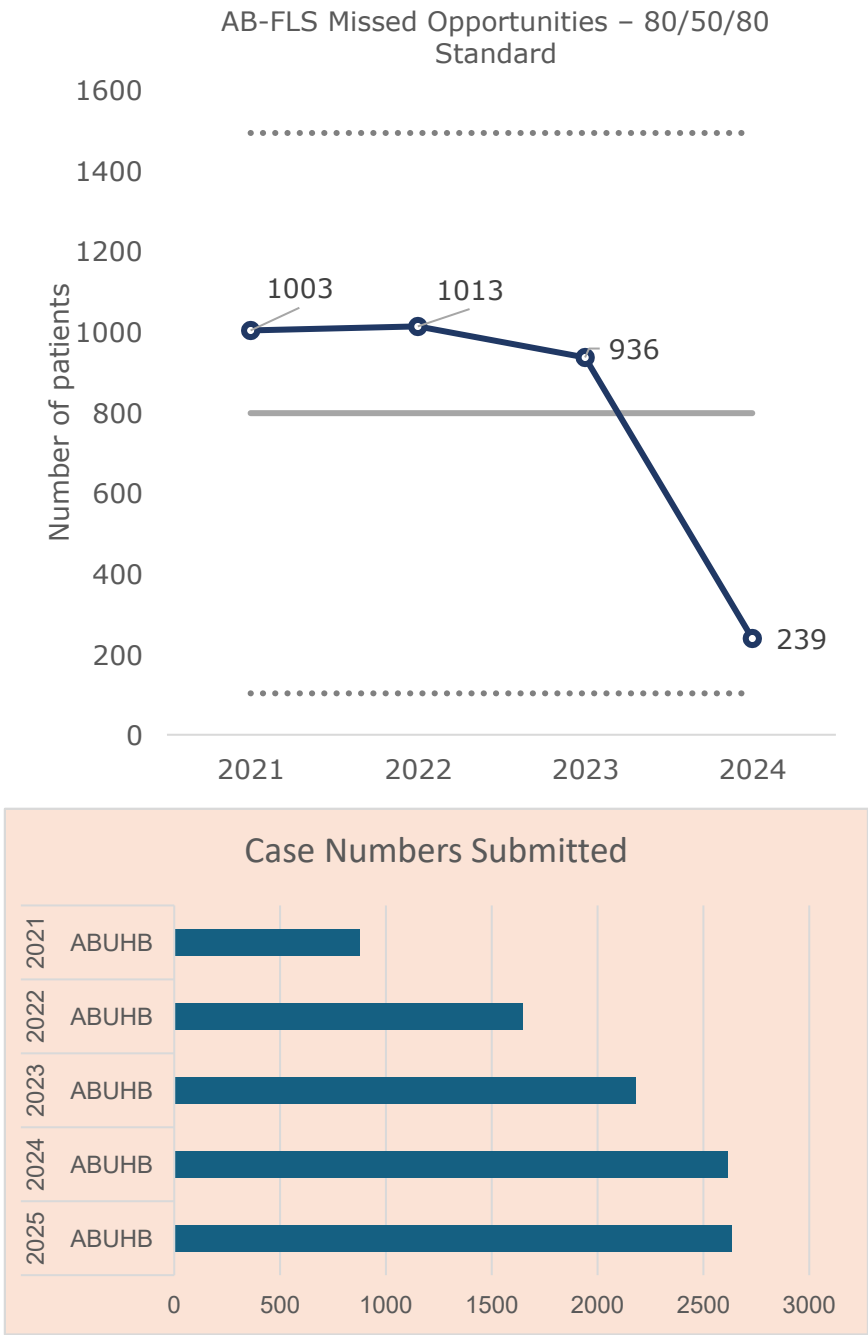
Winners of the MediWales Innovation Awards 2024 for
their overall contribution to healthcare delivery in
Wales



WINNER ☆ Let The First Fragility Fracture
be the Last!



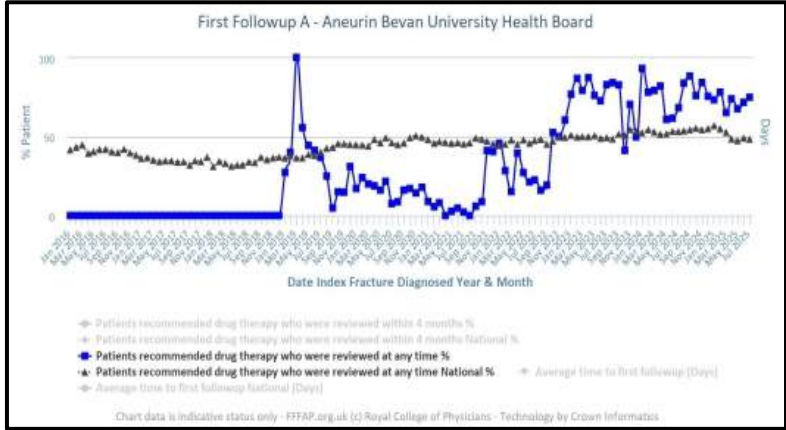
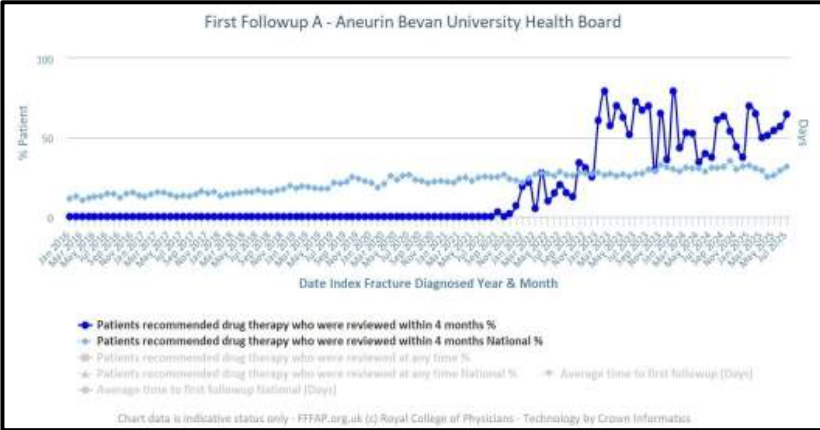
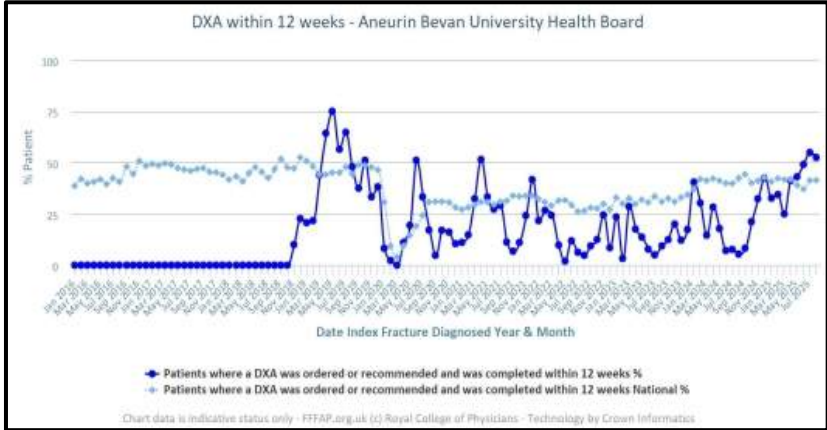
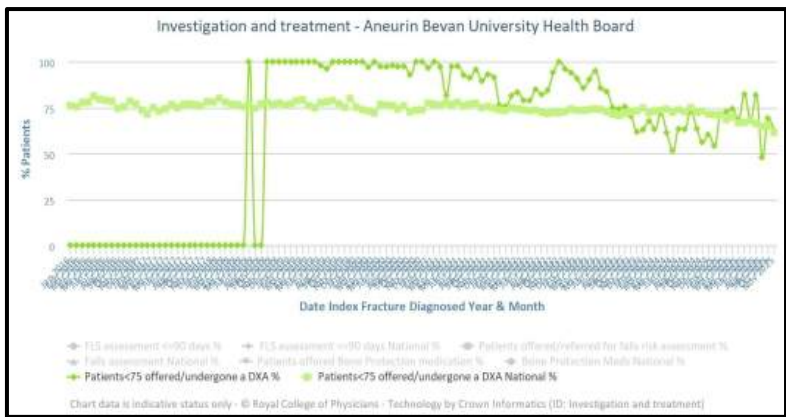
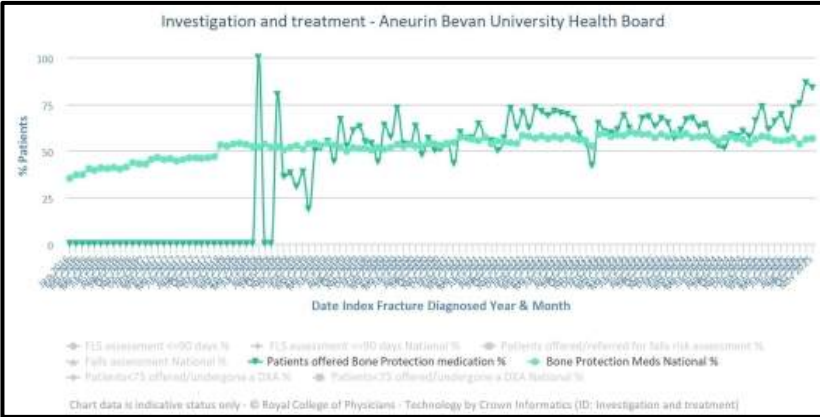
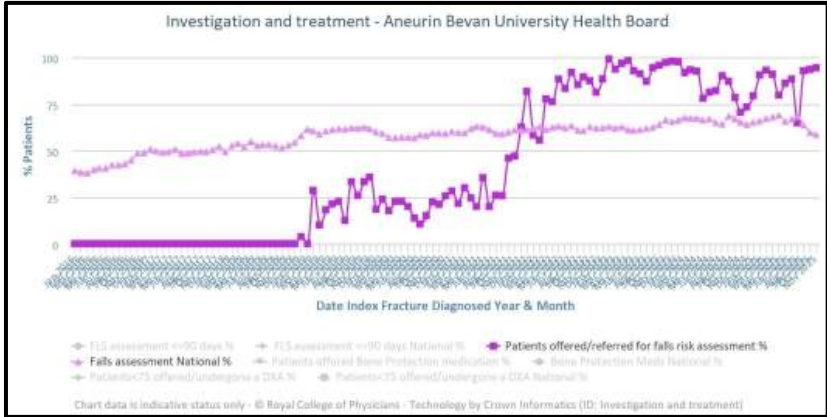
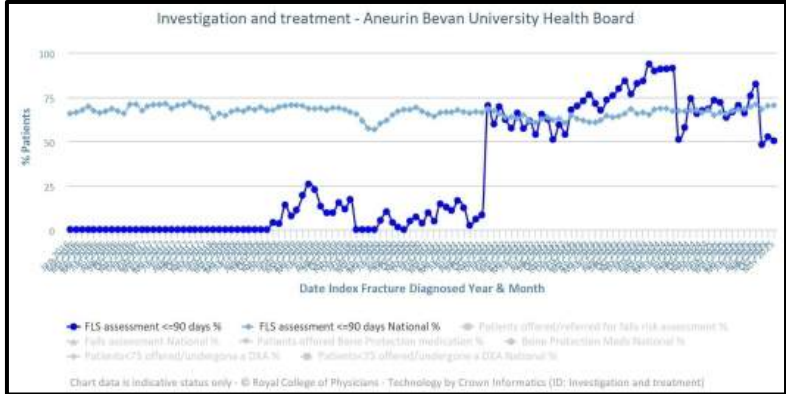
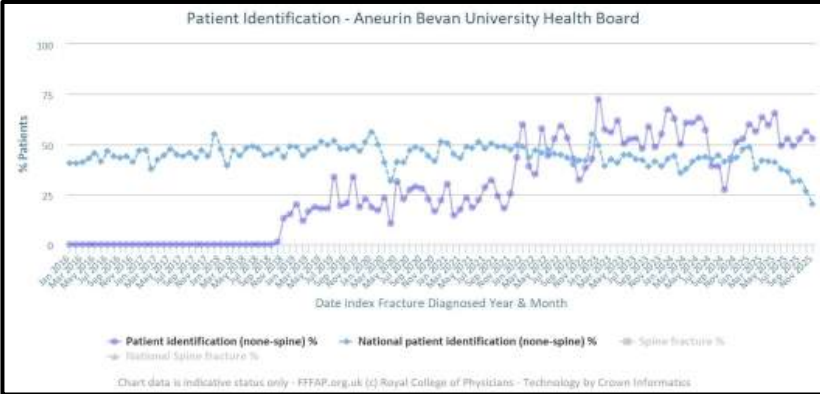
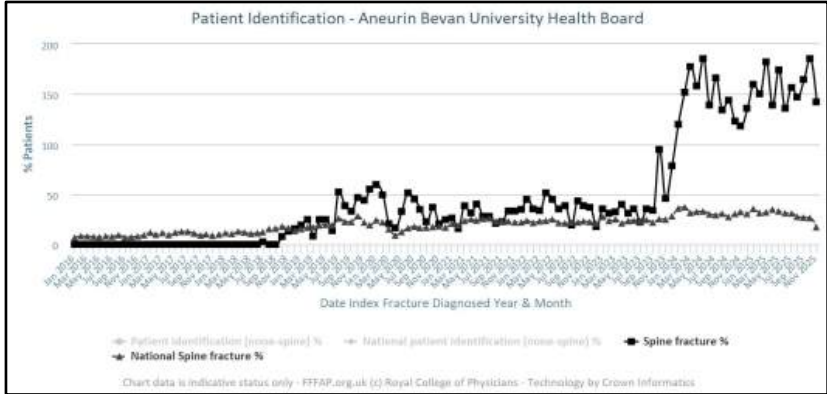
AB - FLS	2020	2021	2022	2023	2024	2025
Estimated fracture patients	3730	3425	3730	4055	3755	3755
Total No of patients Identified – (80%)	725 (24.8%)	875 (25.5%)	1649 (44.2%)	2181 (50.4%)	2639 (70.7%)	2890 (77%)
KPI4 – Assessed with 90 days						
AB-FLS	3.3%	21.3%	60.3%	75%	73.8%	64.3%
Wales	64%	65.1%	77.8%	79.6%	77.2%	67.7%
National	64.2%	66.5%	62.8%	63.8%	69.8%	67.2%
% Recommended Treatment - 50% (cases)	57.3% (415 cases)	57.7% (505 cases)	65.7% (1083 cases)	63.8% (1391 cases)	59.7% (1559 cases)	70.9% (2049 cases)
% Monitored (52 weeks) – 80% (cases)	19.8% (82 cases)	18.4% (92 cases)	16.4% (292 cases)	25.9% (360 cases)	61.3% (956 cases)	? 70%
Patients treated to guidance (80/50/80 ROS standard)	82 (6.9%)	93 (7.8%)	178 (14.8%)	360 (30.2%)	962 (80.1%)	1434
Minimum Expectation	1193	1096	1193	1312	1201	1202
Missed opportunity	1113 (93.1%)	1003 (92.2%)	1015 (85.1%)	832 (69.8%)	239	Zero

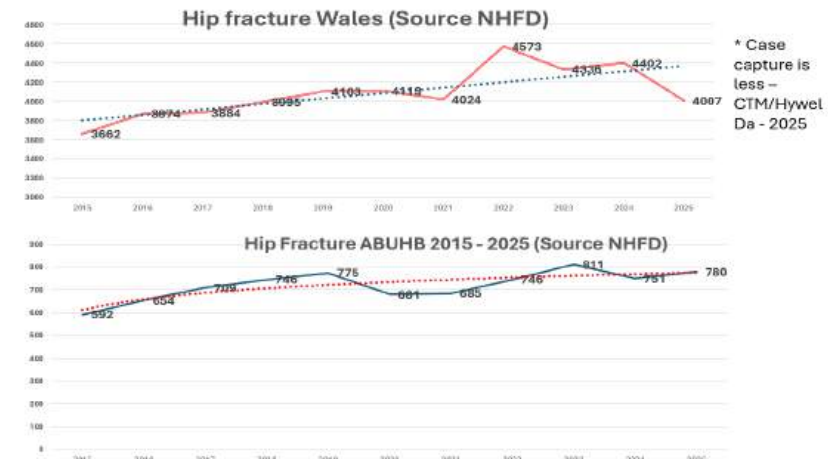
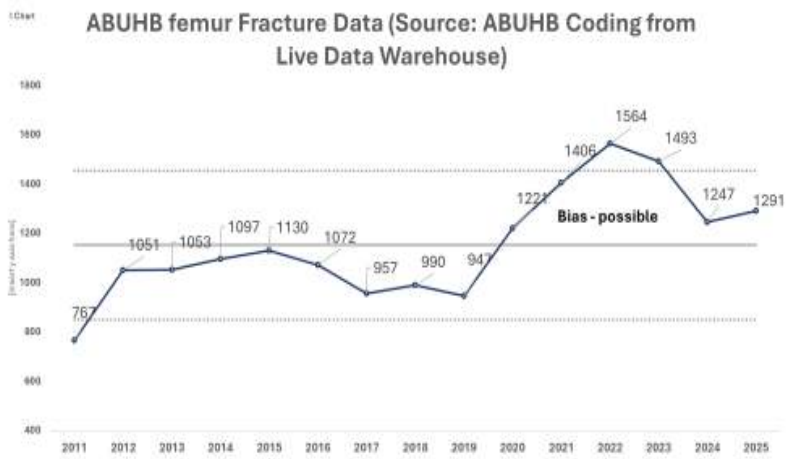
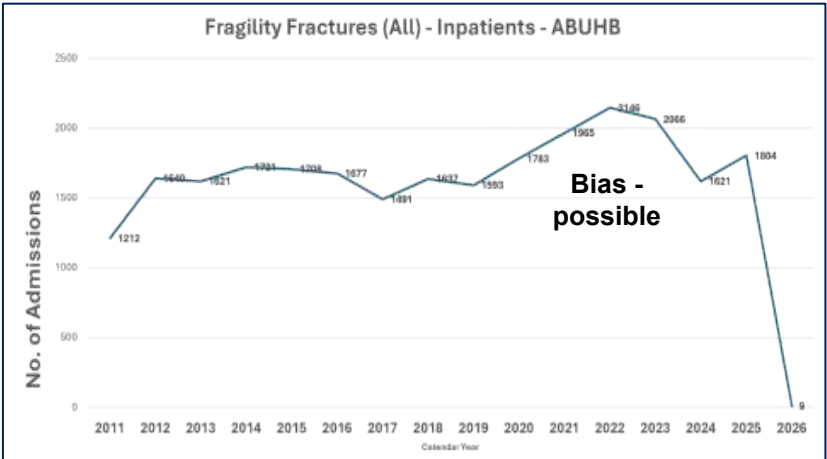
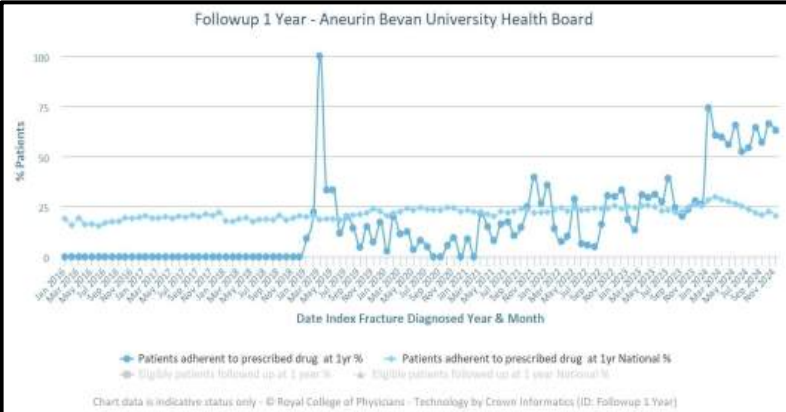
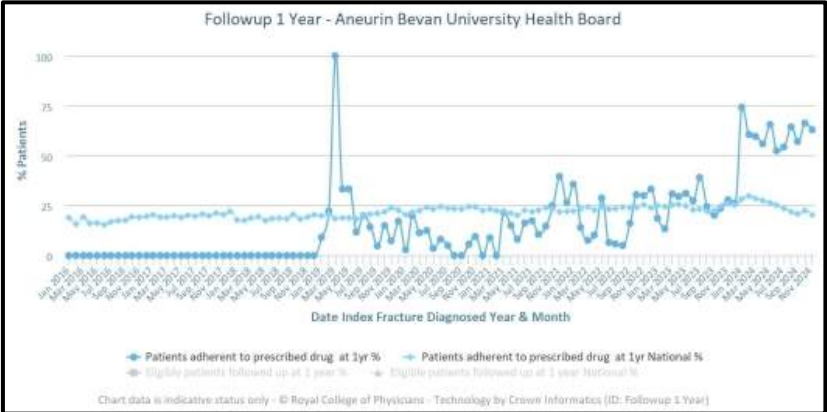
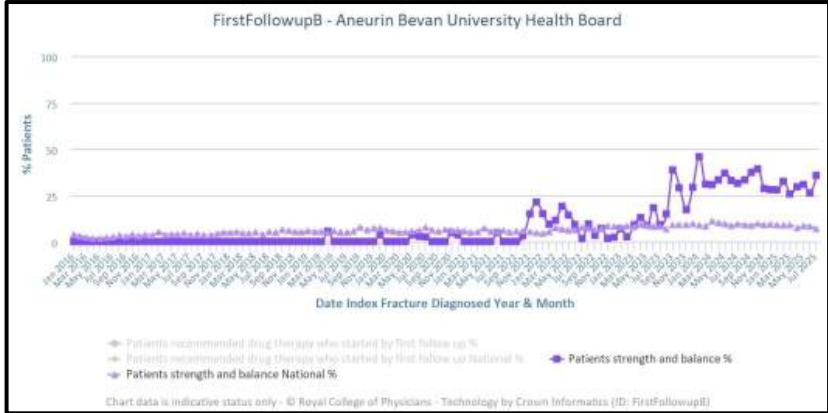
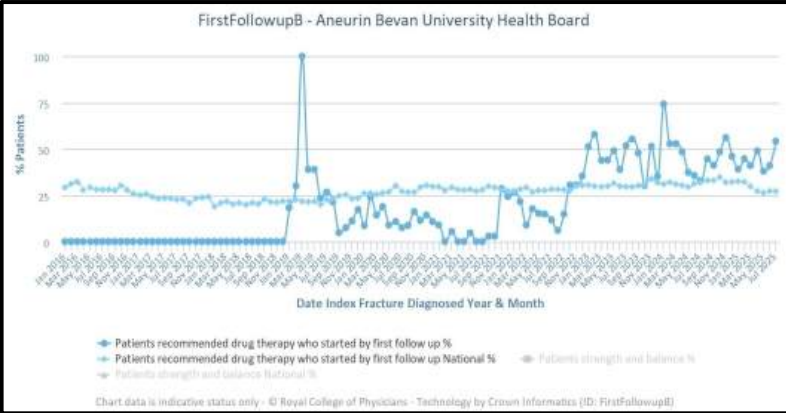
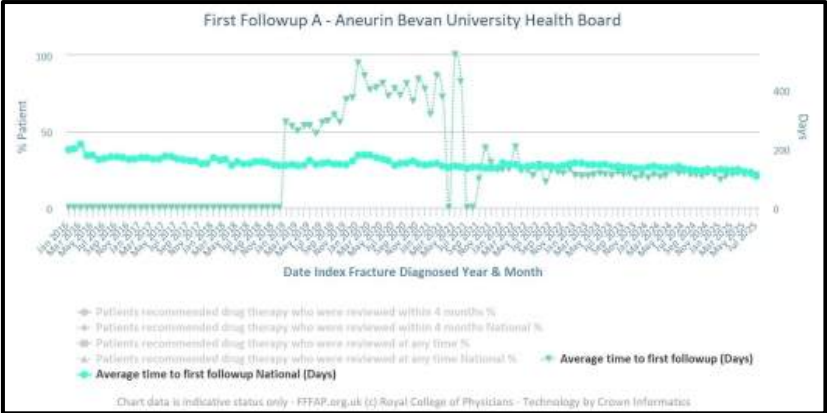


Benchmarking

Year	FLS Service/Unit	Total FLS submitted records	KPI 2 Non-Spine Case identification	KPI 3 Spine fractures	KPI 4 Assessment within 90 days	KPI 5 DXA within 12 Weeks	KPI 6 Falls risk assessment	KPI 7 Bone treatment	KPI 8 Strength & Balance by 16 weeks	KPI 9 16 week follow up	KPI 10 Treatment by 1st followup	KPI 11 1 year drug adherence*
2021	Wales 2021	2031	23.2	11.3	65.1	23.3	61.5	56.8	3.9	13.7	10.2	30.2
2022	Wales 2022	3151	31.9	15.2	77.8	33.7	86.1	62.5	6.1	21.4	16.1	27.4
2023	Wales 2023	3535	17.8	9.3	79.6	23	90.6	63.3	13.3	43.2	36.5	23.4
2024	Wales 2024	5256	20.7	36.5	80.1	14.5	75.9	63.8	19.3	33.2	32.1	33
2025	Wales 2025	8273	35.1	64.8	68.5	16.2	54.8	60.3	9.1	29.6	20	Not available yet
2021	ABUHB 2021	875	24.6	29.5	21.3	24.1	34.5	57.7	4.8	1.4	8.3	18.4
2022	ABUHB 2022	1647	46	36.7	60.3	12.8	79.7	65.6	9.2	19	18.3	16.7
2023	ABUHB 2023	2179	56.4	43	74.9	14.5	94.6	63.8	17.6	58.7	46.1	26
2024	ABUHB 2024	2613	50.5	146.1	78.5	21.9	85	60.1	33.8	48.7	48.3	61.3
2025	ABUHB 2025	2632	56.1	157.9	65.3	41.5	86.1	70.3	29.6	58.1	44	Not available yet

2025 data is incomplete, therefore, is subject to change. However, the currently available data shows an improving picture for 7 KPIs against 2024 data.

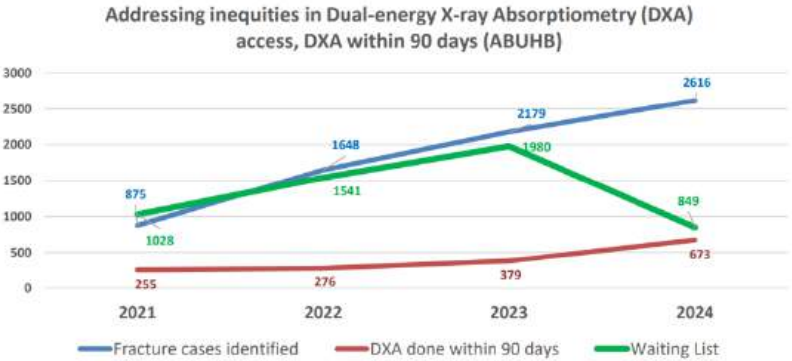




Projected – cost avoidance

- Total FLS investment
 - Staffing cost – Full business case (2025-26) £387,520 plus drugs
- Hip fracture reduction = 2022 = 746; 2023 = 811 (average = 778)
- Hip Fracture 2024 = 751; 2025 – 780 (average = 765)
- Average Hip fracture avoided = 13/year (post FLS two years)
- Cost avoided = 13 x £27000 = £351,000
- More reduction of overall fractures – Femurs (1528 average to 1269)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	DXA scanning	Working with Radiology	I Singh / Non Pugh/ Terissa Williams	December 2026	Amber



Addressing inequities in dual-energy x-ray absorptiometry (DXA) access: a multi-dimensional quality improvement approach | Age and Ageing | Oxford Academic

Assurance and Risk Level

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

Key Success and Concerns

Let The First Fragility Fracture be the Last! - NHS Wales Performance and Improvement

Report Concerns:	
1	DXA within 90 days – needs attention
2	demand will rise- other speciality – Breast, Coeliac
3	Primary Care engagement and FU

National Non-Hodgkin Lymphoma Audit 2025 (NNHLA) An audit of care received by people diagnosed with non-Hodgkin lymphoma between 1 Jan 2022 & 31 Dec 2022 in England and 1 Jan 2023 & Dec 2023 in Wales (version 2 – Sep 2025)		Clinical Lead:	Dr Victoria Williams Consultant Haematologist
		NICE:	NG52 , QS150
Rationale:	The National Non-Hodgkin Lymphoma Audit (NNHLA) evaluates patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales in line with its Quality Improvement Plan. This sets out the scope, care pathway, 5 quality improvement goals and 11 performance indicators that are utilised to measure progress against these goals.		
Objectives:	This year’s report includes people diagnosed with NHL from 1 January 2023 to 31 December 2023 in Wales. It reports on 5 out of the 11 performance indicators for Wales outlined in the NNHLA Quality Improvement Plan (see on slide 3). Although the data presented in this report relates to treatment up to the end of 2023 in Wales, it is being published in September 2025 to allow sufficient follow-up time for the full care pathway to be captured, including definitive treatment and short-term outcomes. This is particularly important in NHL, where treatment pathways can span many months, and sufficient time is needed to ensure that key quality indicators, such as completion of multi-modality treatment and survival outcomes, are accurately recorded and reported.		
Presented at Clinical Standards & Effectiveness Group – 19 March 2026			

Quality Statements – QS150

This quality standard covers diagnostic reporting and the organisation of haematological cancer services for people of all ages (children, adults and young people) and managing haematological cancers in adults and young people (aged 16 and over). It describes high-quality care in priority areas for improvement.

- Statement 1 People with haematological cancer have an integrated report produced by a specialist integrated haematological malignancy diagnostic service (SIHMDS) that is shared with the haemato-oncology multidisciplinary team (MDT).
- Statement 2 Young people and adults with specific subtypes of non-Hodgkin's lymphoma have staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).
- Statement 3 Young people and adults with localised stage IIA follicular lymphoma have local radiotherapy as first-line treatment.
- Statement 4 Young people and adults who have completed their treatment for non-Hodgkin's lymphoma or myeloma have a discussion about their end-of-treatment summary plan.

NNHLA Quality Improvement Plan 2024

The Quality Improvement Plan describes the approach taken across the NATCAN cancer audits to develop improvement goals and performance indicators, ensuring these are measurable, actionable and improvable.

The NNHLA Quality Improvement goals, developed following a thorough scoping exercise in 2023 and in consultation with stakeholders in the Clinical Reference Group (CRG) are as follows:

- Improving timely diagnosis and treatment
- Treatment appropriate to the subtype of NHL
- Improving safety and reducing toxicity of NHL therapy
- Improving overall survival
- Reducing variation in NHL management among NHS providers.

The NNHLA has identified eleven performance indicators, which are mapped to these five quality improvement goals and clinical guidelines. It sets out improvement methods, improvement activities and approaches to evaluation of the Quality Improvement Plan.

Table 1.* Performance indicators (PIs) and accompanying contextual measure included in this report.		
Performance Indicators and contextualising measure (in order of appearance in report)	England^	Wales#
New Contextualising measure ¹ : Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis.	Yes (1/1/2021-31/12/2022)	No. In development.
1. Proportion of people diagnosed with NHL discussed at a multi-disciplinary team (MDT) meeting within 4 weeks of diagnosis.	Yes (1/1/2022-31/12/2022)	No. Data not available for Wales.
2. Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
4. Proportion of people with high-grade lymphoma (Burkitt Lymphoma (BL), Diffuse Large B-Cell Lymphoma (DLBCL) or high-grade T-cell) receiving systemic anti-cancer therapy (SACT), who start SACT within 62 days of referral.	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
5. First-line systemic anti-cancer therapy (SACT) regimens received by people with high-grade lymphoma (BL, DLBCL or high-grade T-cell).	Yes (1/1/2021-31/12/2022)	No. In development.
7. Proportion of people with high-grade lymphoma (BL, DLBCL or high-grade T-cell) who start radiotherapy within 8 weeks of end of first-line systemic anti-cancer therapy (SACT).	Yes (1/1/2022-31/12/2022)	No. Regimen-level SACT data not provided
8. Proportion of people with NHL receiving radiotherapy, reported by subtype.	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
9. Proportion of people diagnosed with NHL who are recorded as having received an episode of care that was delivered as part of a clinical trial, reported by sub-type.	Yes (1/1/2021-31/12/2022)	No. Data not available for Wales
11. Overall 2-year survival of people with high-grade lymphoma (BL, DLBCL, mantle cell or high-grade T-cell).	Yes. 1 and 2-year survival reported by sub-type nationally	Yes. 1-year survival reported by sub-type nationally

4.1 Data Completeness

Key Message: NHS trusts and multi-disciplinary teams should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Particular attention should be given to documentation of staging, MDT records and CNS involvement in both England and Wales.

4.3 Diagnosis and Staging

Key Message: Improved staging should be prioritised as complete staging data will allow risk-adjusted comparisons between groups of people diagnosed with NHL and NHS trusts/ MDTs.

4.2 Characteristics of people diagnosed with non-Hodgkin lymphoma (NHL)

‘CaNISC’ data identified 729 people diagnosed with NHL in Wales in 2023 across 17 Welsh hospitals. In both England and Wales, there was a similar mean age of 69 years at diagnosis, with a diagnosis most likely to be made between the ages of 70 and 79.

Overall, the patient characteristics for England in 2022 and Wales 2023 have not changed compared to last year’s State of the Nation report 2024 (England 2020-2021 and Wales 2022).

4.4 Diagnosis to Treatment Pathway

PI4: Proportion of people with high-grade lymphoma (Burkitt lymphoma (BL), DLBCL (Diffuse Large B-Cell Lymphoma) or high-grade T-cell) receiving SACT, who start SACT within 62 days of referral.

Key Message: 55% of people with high-grade NHL in England receiving SACT (2022) and 48% of people with high-grade NHL in Wales receiving SACT (2023), start SACT within 62 days of referral.

PI 2: Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).

Key Message: Ongoing improvement is needed at NHS trust level regarding record of, and involvement of CNS teams in England to ensure people with NHL receive the appropriate support during treatment.

4.5 Treatment

PI 8: Proportion of people with NHL receiving radiotherapy, reported by subtype.

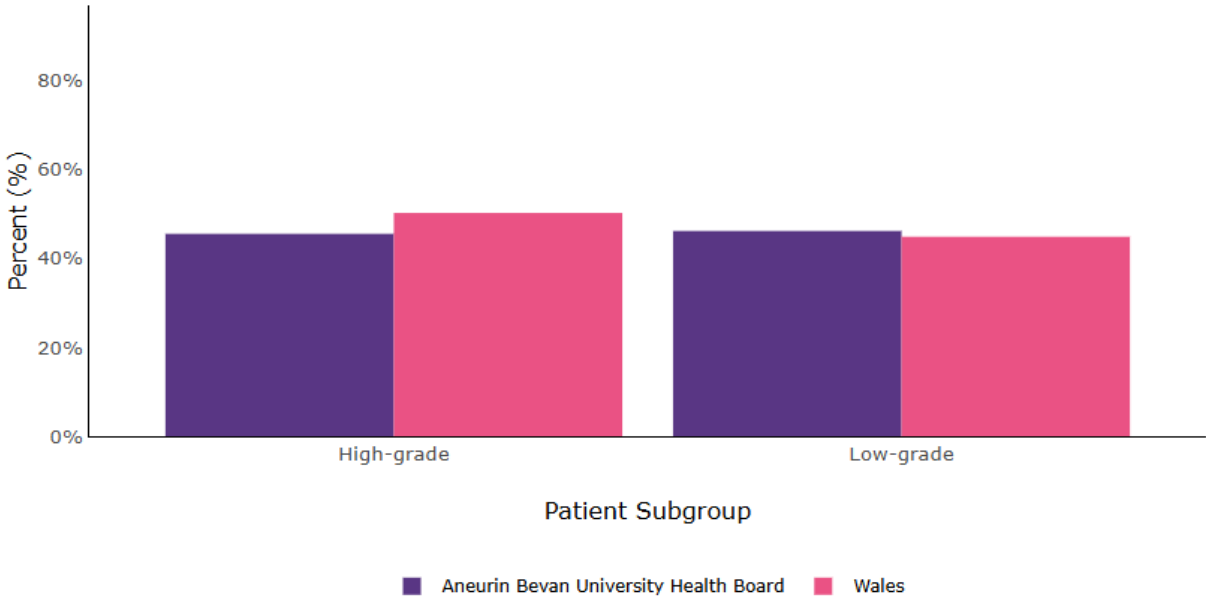
Key Message: Further analysis of variation in care across NHS hospitals is required to understand the use and delivery of radiotherapy for varying sub-types.

4.6 Outcomes

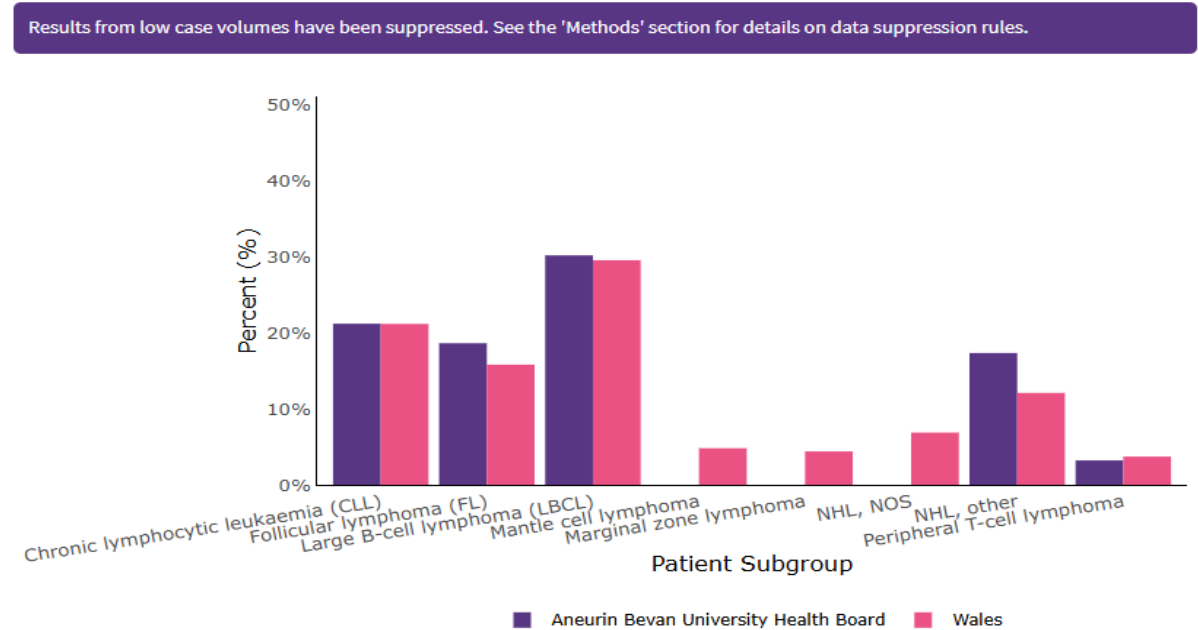
PI 11: Overall 2-year survival of people with high-grade lymphoma (BL, DLBCL, mantle cell or high-grade T-cell).

Key Message: Overall 1-year survival for all NHL cases was approximately 80% in England and Wales; around 70% for high-grade cases and 90% for low-grade cases.

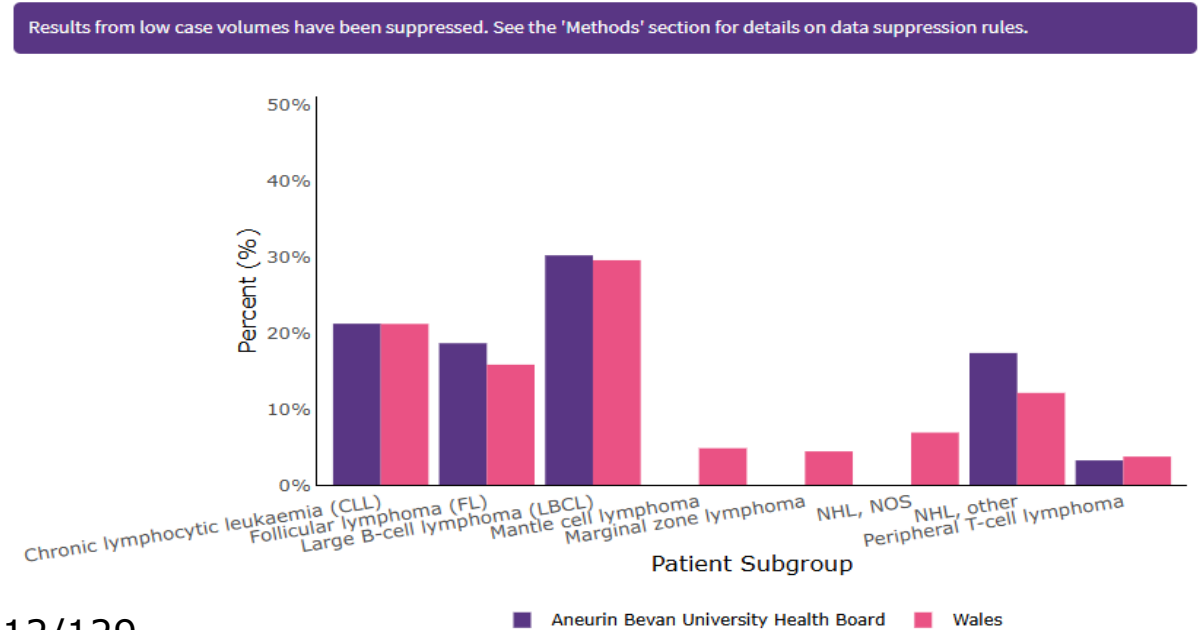
Proportion of people diagnosed with NHL reported by grade



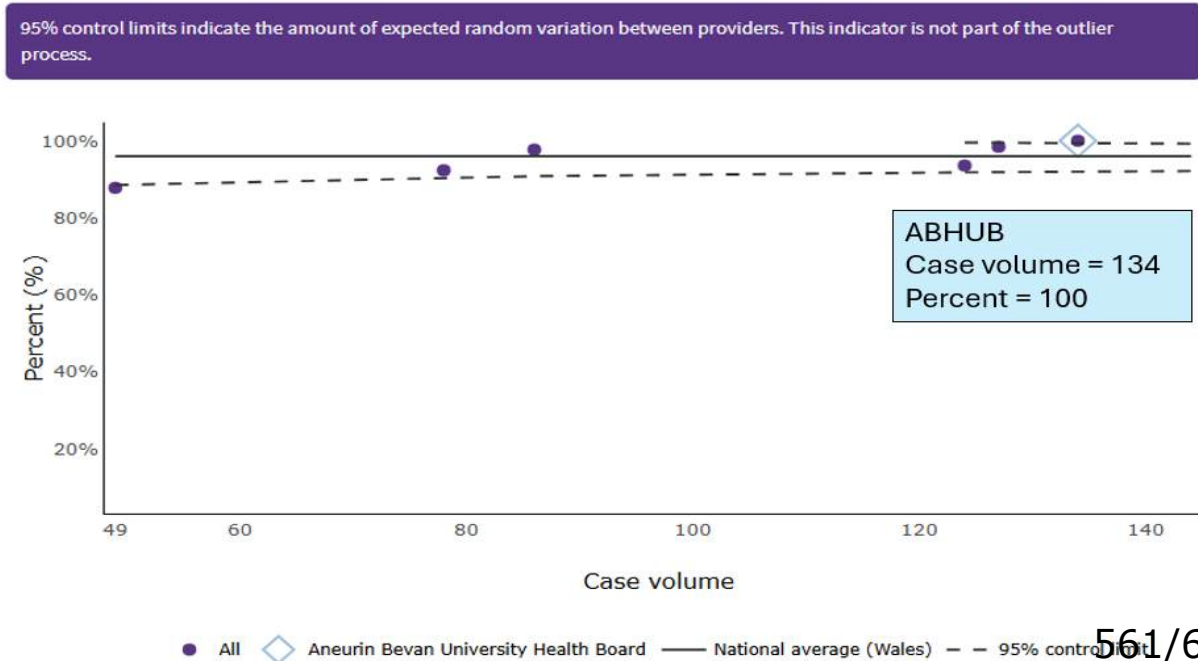
Proportion of people diagnosed with NHL reported by subtype



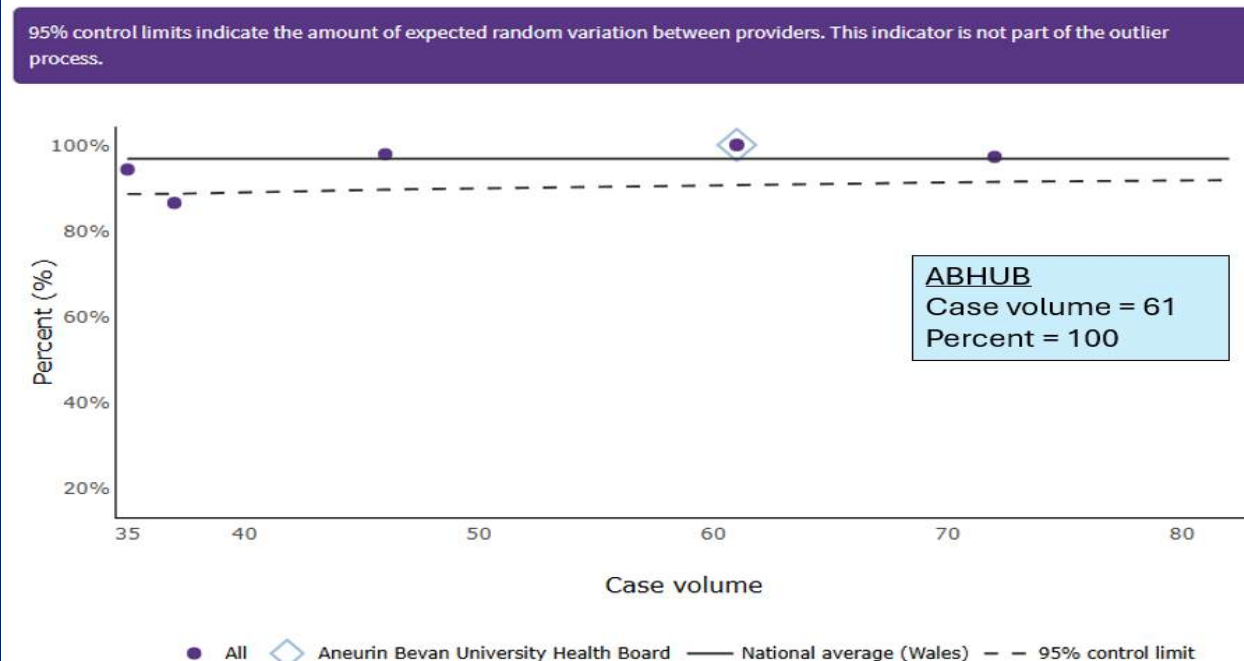
Proportion of people diagnosed with NHL reported by subtype



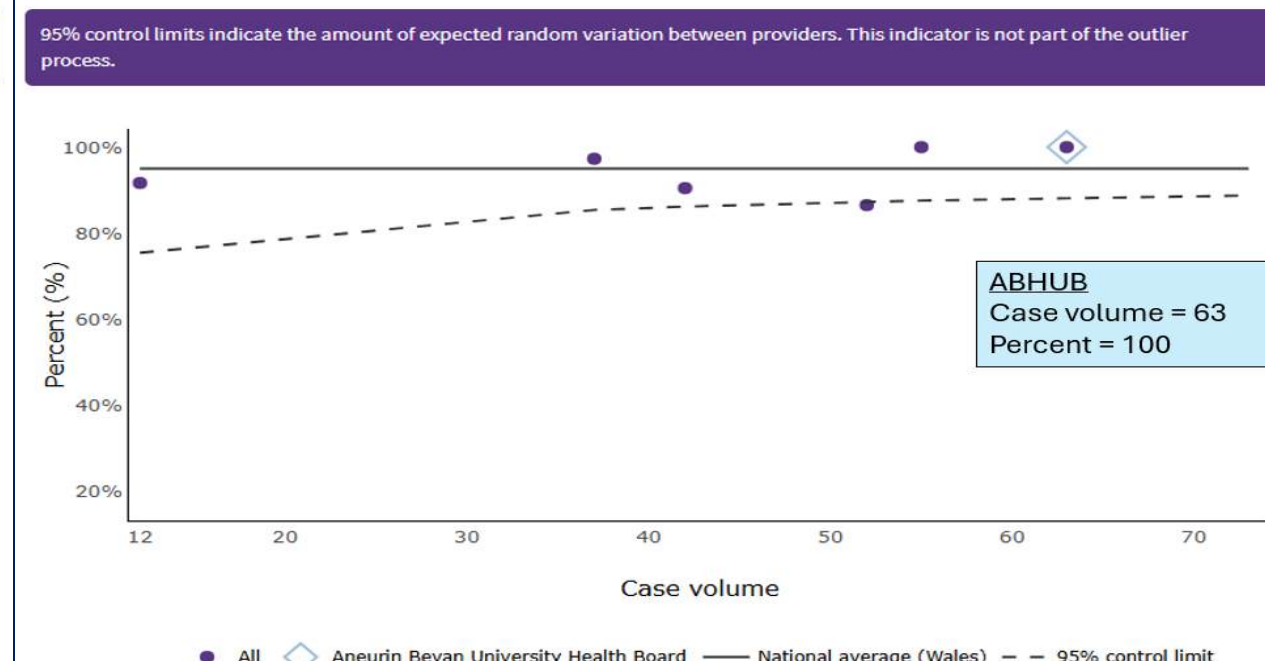
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (all grades)



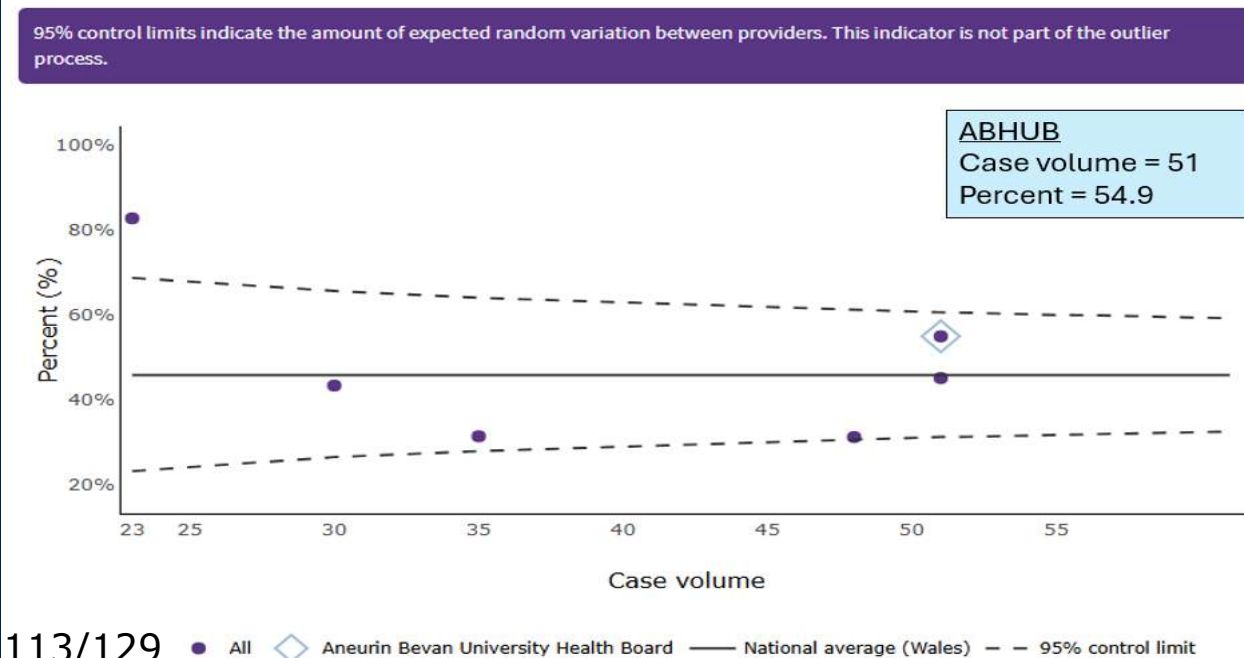
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (high grade)



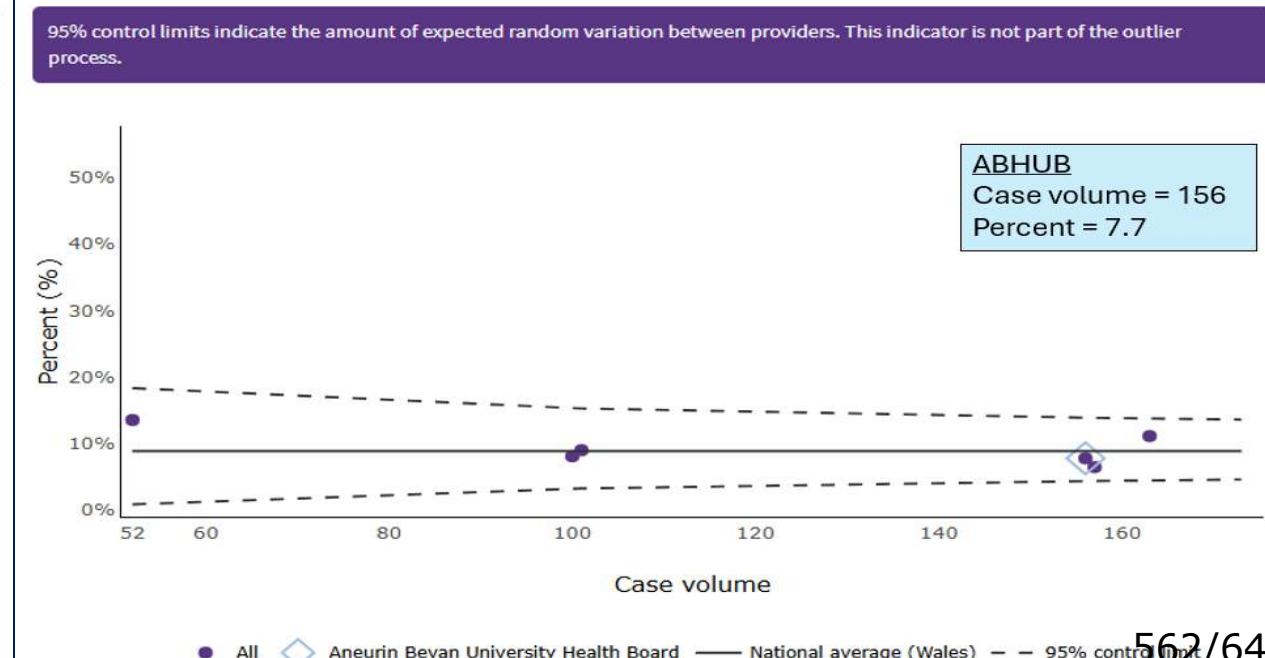
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (low grade)



Proportion of people diagnosed with high-grade lymphoma who start SACT within 62 days of referral

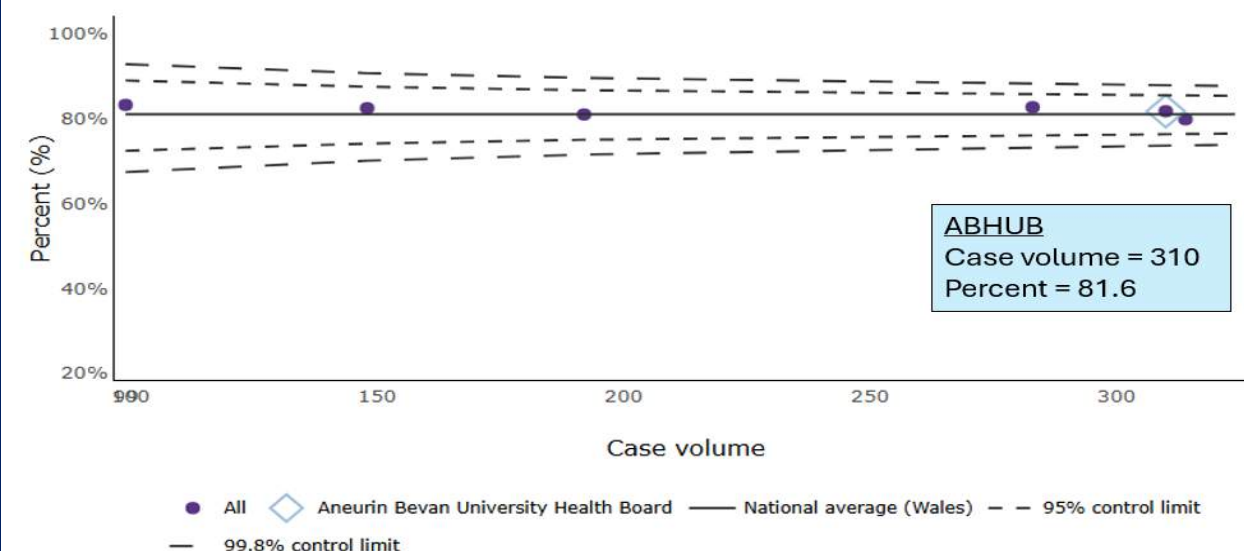


Proportion of people diagnosed with NHL receiving radiotherapy, reported by subtype (all grades)



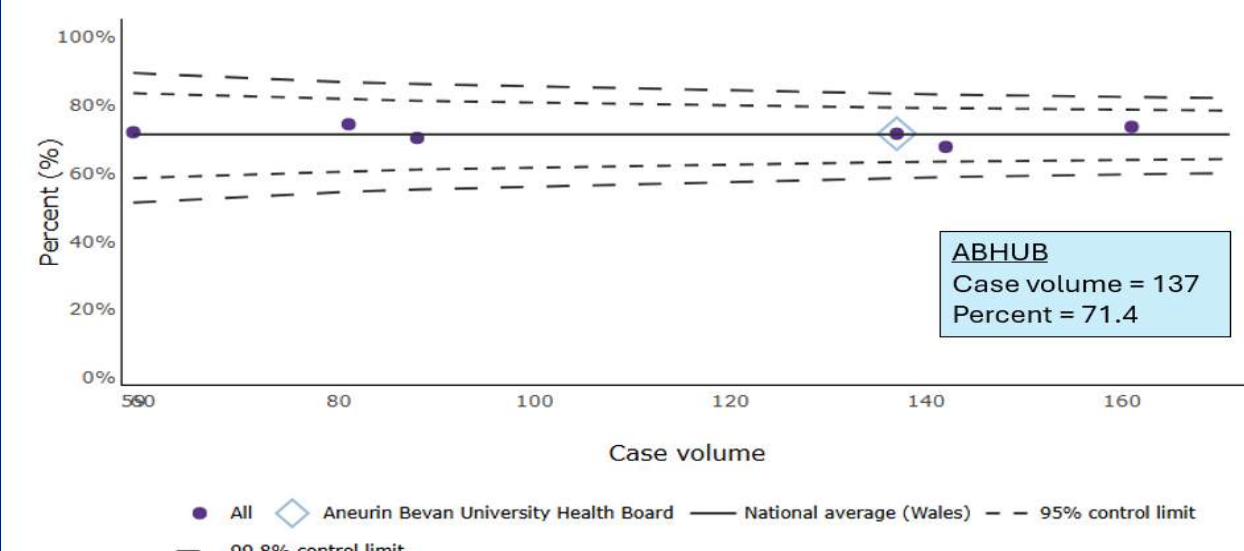
Adjusted 1-year survival of people diagnosed with NHL, reported by grade (all grades)

Multiple imputation with chained equations applied for missing values in risk-adjustment variables. Logistic regression applied for risk-adjustment. .



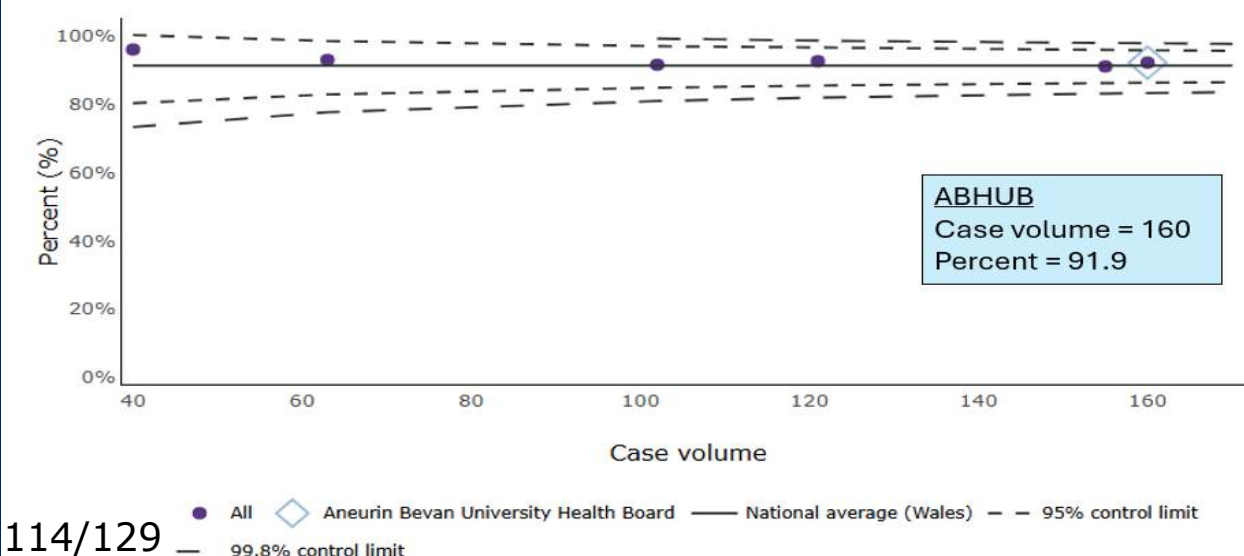
Adjusted 1-year survival of people diagnosed with NHL, reported by grade (high grade)

Multiple imputation with chained equations applied for missing values in risk-adjustment variables. Logistic regression applied for risk-adjustment. .



Adjusted 1-year survival of people diagnosed with NHL, reported by grade (low grade)

Multiple imputation with chained equations applied for missing values in risk-adjustment variables. Logistic regression applied for risk-adjustment. .



Data Completeness - Aneurin Bevan University Health Board (NHL)

Metric	%	Rank in Wales (6 Health Boards)
Data completeness for Ann Arbor Staging	67.5	4
Data completeness for Binet staging	Data completeness for this indicator was zero in ABUHB during the audit period	
Data completed for clinical nurse specialists	85.9	2
Data completed for performance status	70.5	6

Assurance and Risk Levels

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
Has this audit been placed on a Risk Register (N/A if above risk is None)	
NO	
If not on a risk register, why not: The outcomes from the audit tell us our patients have similar 1-year overall survival compared to the rest of England and Wales, these outcomes are also comparable with what studies would suggest overall survival should be. The improvements needed are focussing on improving data collection as opposed to anything that affects patient safety.	

Key Success and Concerns

Report Successes:	
1	Performing above average in terms of CNS review for patients being diagnosed with both low grade and high-grade lymphoma
2	Outcomes at 1 year comparable/in keeping with national average for low grade and high-grade lymphoma
Report Concerns:	
1	Data completeness for performance status and staging
2	Improving data for timely SACT to ensure more people getting chemotherapy within 62 days (it should be noted that there is no single pathway for investigation of possible lymphoma due to the nature of the disease)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress :
1	Local review at NHS trust/health board level is needed to identify diagnostic and treatment pathway delays and reduce inter-provider variation in people with high-grade NHL starting SACT within 62 days of referral. This may include examination of delays along the pathway, chemotherapy unit capacity and staffing, and mode of delivery of SACT, in order to understand system-level delays.	- At a Welsh level, there is a NOP which is out for consultation to describe optimal pathway for diagnosis and treatment of lymphoma. - Local project to be done looking at timeliness of biopsies being sent from ABUHB to AWLP to see if that part of diagnostic process can be improved	- WCN - Dr Williams and haematology team	- Out for consultation hopefully will be live by next audit cycle - June 2026	
2	Ensure there is a designated coordinator or clinician to improve the completeness and quality of data items recorded in the national cancer datasets at each NHS trust/health board (with particular focus on staging in England and Wales and treatment delivery in Wales). This will allow better risk adjustment of outcome variables including survival outcomes for people with non-Hodgkin lymphoma and effectively inform outlier identification. The launch of the Audit's national quality improvement initiative in October 2025 will further support this effort. NHS trusts/health boards encouraged to participate in the initiative to	In place, Dr Trickey has worked with cancer services co-ordinator for 2024 to ensure data completeness. New MDT proformas also in place since 2024 to improve documentation PS and staging	Lymphoma team consultants and cancer co-ordinator	On-going	Has been done for next audit cycle, will be on-going piece of work New MDT proformas for

National Audit of Cardiac Rhythm Management (NACRM)		Clinical Lead:	Jessica Hamer
2 nd edition 1 April 2024 to 31 March 2025		NICE:	TA324 , TA314 , TA88

Rationale:	The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures in the UK through the collection, analysis and dissemination of data relating to centres across the UK. Clinical leadership is provided by the British Heart Rhythm Society (BHRS) .
Objectives:	The objectives of the report are to highlight trends in procedure volumes, assess variation in clinical practice and access to care, introduce new quality indicators, and support service improvement by enabling hospitals and regions to benchmark performance. The report also seeks to inform future planning by identifying areas of emerging technology uptake, monitoring compliance with national guidelines, and promoting timely and accurate data submission to enhance the quality and impact of cardiac rhythm management services.

Presented at Clinical Standards and Effectiveness Group – 19 March 2026

Devices	Ablation
80,818 cardiac implantable electronic device (CIED) procedures performed. 17,856 CIED procedures were for complex implants (ICDs, CRT). 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum recommended volumes. <i>(see slide 3)</i> - There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1:1). <i>(see slide 4)</i> 3.5% one year mortality after ICD implant <i>(see slide 5)</i> 4.4% 1 year re-intervention rates for simple CIED implants, but variable between hospitals. <i>(see slide 6)</i> - There was a 4-fold increase in conduction system pacing. <i>(No data relating to ABUHB)</i> - There was a 37% fall in leadless pacemaker procedures <i>(No data relating to ABUHB)</i>	24,323 total ablation procedures performed. 10,372 AF ablation procedures, increasing 53% since 2015. 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume. <i>(see slide 7)</i> 38% rate of general anaesthetic provision for ablation procedures, varying from 5 to 100% between hospitals. <i>(No data relating to ABUHB)</i> - Re-intervention rate for accessory pathway ablation is 5.9%, 3 x the rate for other standard ablation procedures <i>(No data relating to ABUHB)</i>
Abbreviations: AF= Atrial Fibrillation; BHRS= British Heart Rhythm Society; CIED= Cardiac Implantable Electronic Devices; CRT= Cardiac Resynchronisation Therapy; ICD= Implantable Cardioverter Defibrillator	

Report at a glance: 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum

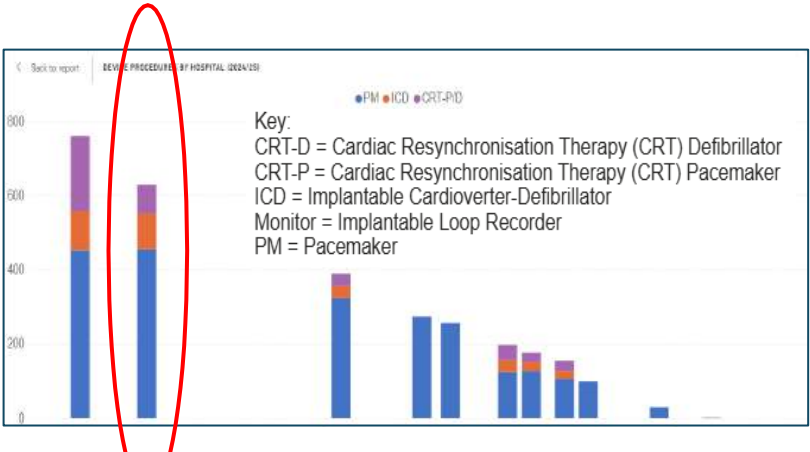
Most hospitals delivered more than the minimum recommended number of CIED procedures

The British Heart Rhythm Society (BHRS) Standards (2024 January revision) recommend that device centres undertake a minimum procedure volume per year:

A minimum of 80 new pacemaker implants per year.

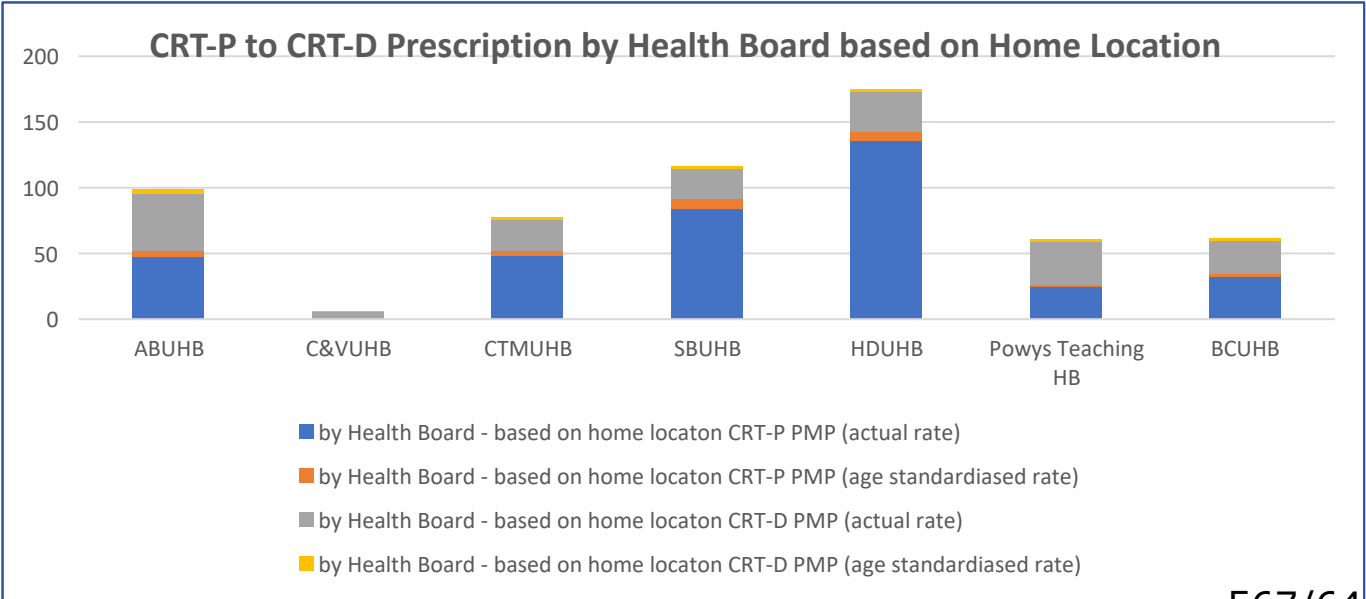
A minimum of 60 new ICD or CRT implants per year

Rank	PM	ICD	CRT-P/D	Total procedures	Hospital
28	452	104	203	759	Morrison Hospital
42	454	97	77	628	Grange University Hospital
83	323	33	32	388	Royal Glamorgan Hospital
100	273	0	0	273	Glan Clwyd Hospital
106	255	0	0	255	Glangwili General Hospital
118	123	33	41	197	Ysbyty Gwynedd
123	126	24	25	175	Princess of Wales Hospital
130	106	20	28	154	Wrexham Maelor Hospital
135	98	0	0	98	Bronglais General Hospital
150	29	0	0	29	Prince Charles Hospital
161	1	0	0	1	University Hospital of Wales



Report at a glance: There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1: 1)

by Health Board - based on home location				
Health Board	CRT-P PMP (actual rate)	CRT-P PMP (age standardised rate)	CRT-D PMP (actual rate)	CRT-D PMP (age standardised rate)
ABUHB	47.8	4	43.6	3.6
C&VUHB	0	0	5.6	0.5
CTMUHB	48.4	4	22.9	1.9
SBUHB	83.5	7.6	23.5	2.2
HDUHB	135.7	7.1	30.2	1.6
Powys Teaching HB	24.7	1.5	32.9	2.1
BCUHB	32	2.6	24.7	2.1

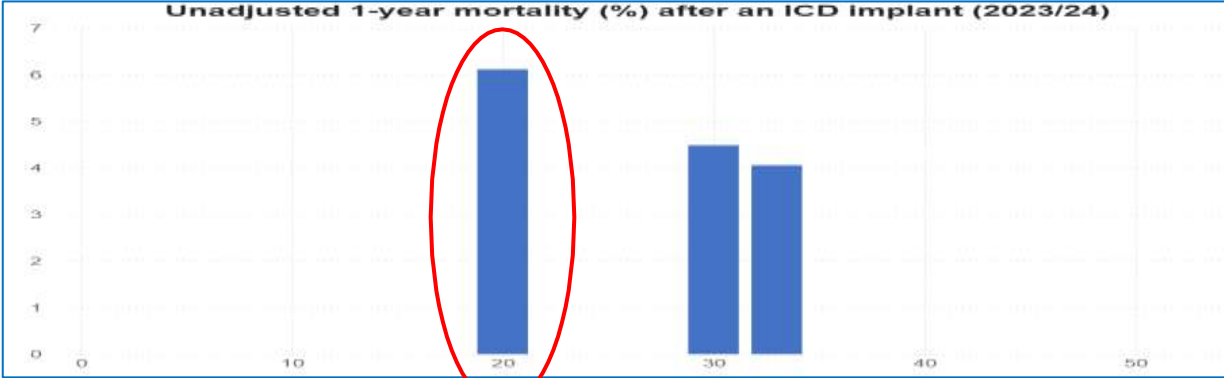


Report at a glance: 3.5% one-year mortality after ICD implant (national average)

One year mortality after defibrillator implantation was 3.5% but varied from 2 to 24% between hospitals

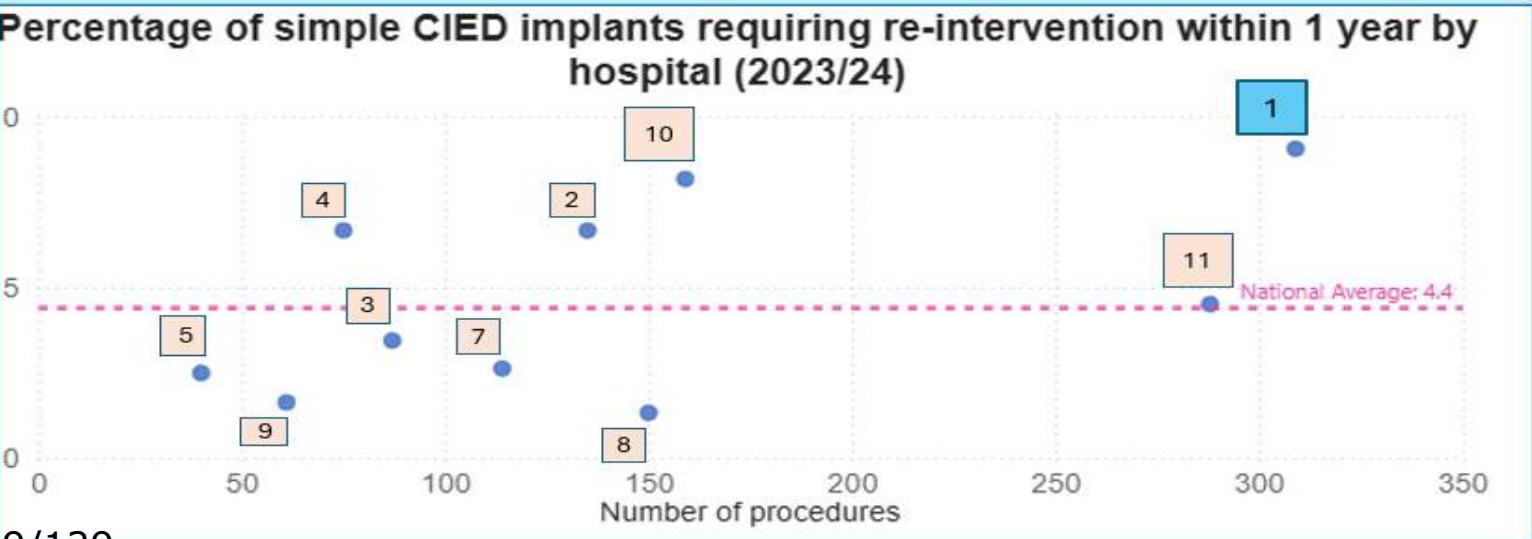


Unadjusted one year mortality after ICD implant 2023/24				
Site	Rank (national)	Mortality (%)	Total Cases	Deaths
GUH	20	6.1	49	3
Ysbyty Gwynedd (YG)	30	4.5	4,988	224
Wrexham Maelor (WMH)	33	4.1	22,284	905



Report at a glance: 4.4% 1 year re-intervention rates for simple CIED implants but variable between hospitals (national average)

The 1-year re-intervention rate after simple CIED implants ranged from near zero to 12% across different hospitals



Key			
Hospital ID No.	Site	PM new implant count	1 year re-intervention (%)
1	GUH	309	9.1
2	Glan Clwyd	135	6.7
3	Wrexham Maelor	87	3.4
4	Ysbyty Gwynedd	75	6.7
5	UHW	40	2.5
6	Prince Charles		
7	Princess of Wales	114	2.6
8	Royal Glamorgan	150	1.3
9	Bronglais	61	1.6
10	Glangwili	159	8.2
11	Morriston	288	4.5

Report at a glance: 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume

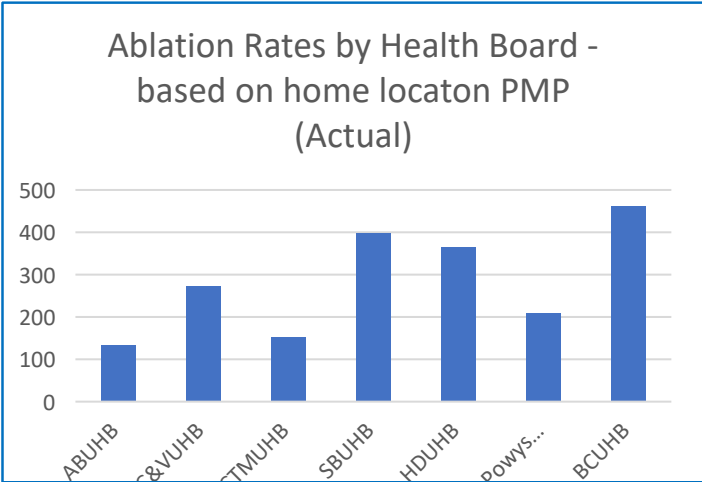
Ablation rates varied 12-fold across ICBs and Health Boards in England and Wales



Ablation Rates per million population (PMP)

Actual rate - all ablation types

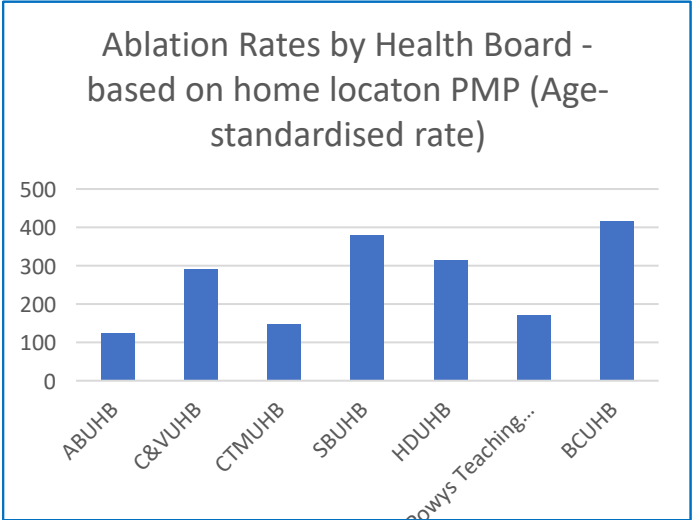
by Health Board - based on home location		by Cardiac Network - based on Hospital location	
Health Board	PMP	Cardiac Network	PMP
ABUHB	133	Wales	247
C&VUHB	272		
CTMUHB	152		
SBUHB	398		
HDUHB	366		
Powys Teaching HB	210		
BCUHB	461		



Ablation Rates per million population (PMP)

Age-standardised rate - all ablation types

by Health Board - based on home location		by Cardiac Network - based on Hospital location	
Health Board	PMP	Cardiac Network	PMP
ABUHB	125	Wales	247
C&VUHB	290		
CTMUHB	147		
SBUHB	379		
HDUHB	315		
Powys Teaching HB	171		
BCUHB	415		



Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	X
Risk level	Description	Select
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	Devices
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	EP
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES ☐
If not on a risk register, why not: Device waiting list has been added to risk register.		

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Complete data entry	1	Discrepancies in numbers
2	Meeting minimum numbers	2	Poor access to EP for ABUHB patients
3	Increase in implant numbers since the opening of Grange University Hospital	3	Poor data entry from tertiary centre making it difficult to benchmark

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Commence CSP programme	CP and operator training. Engage with companies regarding support and proctor.	Cardiology CD	Next financial year	Ongoing
2	Look to complete business case for local EP services	Business case to be completed.	Cardiology CD	Next financial year	Ongoing

Report Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
Clinical Practice:						
1	Device therapy: As pacemaker and ICD implantation rates remain lower than comparable countries, regional services should review waiting lists and local practice against guidelines.	Business case being worked up for third cath lab and additional implanter		Cardiology CD	Next financial year	ongoing
2	AF Ablation: Given variation across regions, local services should review patient selection and re-intervention rates for AF ablation					n/a
3	Re-intervention rates: Hospitals should review accessory pathway ablation practice given relatively high re-intervention rates.					n/a
4	Emerging technologies: Regional services should review appropriate clinical use and access to emerging technologies (suchas leadless pacing, conduction system pacing or pulsed field ablation).	Current implanters have had CSP training – initiation of service delayed due to sickness		Cardiology CD	Next financial year	Ongoing
Data Completion:						
1	Implant Records: There is an increasing obligation to monitor medical implants and all operators should ensure implant identifiers and relevant clinical fields are completed and submitted to the NACRM within agreed timelines (see background for more details on captured fields).	All data entered via electronic pacing system (Solus) – data is pulled and sent to NICOR monthly		IT manager	Ongoing	ongoing
2	Emerging technologies: There is a growth of emerging heart rhythm technologies and all operators should ensure correct submissions are made to facilitate monitoring of procedures and outcomes of changing practice.	Specialist services commissioned by JCC and often that is a barrier to our adoption of them (eg leadless pacing)				

122/129

122571/644

National Vascular Registry – State of the Nation Report 2025 An audit of care received by people who had vascular procedures during 2024 in NHS hospitals in England, Wales, Scotland and Northern Ireland	Clinical Lead:	David McLain - Consultant Vascular Surgeon
	NICE:	NG19 , NG156 QS208 , QS209

Rationale:	The report was developed to evaluate the quality and outcomes of care for adults undergoing major vascular procedures in NHS hospitals. Its primary rationale is to support vascular services in delivering safe, high-quality care by benchmarking performance against national standards, identifying delays and variations, and highlighting areas for improvement. By aligning with NICE guidelines, VSGBI frameworks, and other national standards, the report aims to drive quality improvement initiatives, share best practices, and ensure compliance with evidence-based care pathways.
Objectives:	Its objectives are to benchmark care against national standards, identify delays and variations in treatment, and highlight areas for improvement. The report focuses on key indicators such as short-term postoperative mortality and timeliness of interventions for procedures including lower limb revascularisation, major amputation, abdominal and thoracic aortic repairs, and carotid endarterectomy.

Context
The National Vascular Registry (NVR) audits major vascular procedures across the UK. The 2025 report reviews care delivered in 2024 for lower limb revascularisation, major amputation, aortic repairs (AAA and thoracic), and carotid endarterectomy (CEA). Key indicators include timeliness of treatment, postoperative outcomes, and data completeness.

Please Note: Aneurin Bevan University Health Board (ABUHB) do not undertake major limb amputation, aortic repairs or carotid endarterectomy.

Standards and Guidelines

National guidelines underpin the management of people with vascular conditions, and the NVR evaluates patterns of care against these recommendations. An overall framework for vascular services is described by the “Provision of Services for People with Vascular Disease” published by the Vascular Society of Great Britain & Ireland. Additional standards originate from documents published by the National Institute for Health and Care Excellence (NICE), European Society of Vascular Surgery guidelines, national screening guidance, and government documents. From these, and in consultation with its professional and patient advisory groups, the NVR developed five quality improvement (QI) goals and associated indicators, which are published in the [NVR Healthcare-Improvement-Strategy Aug2023.pdf](#)

National Guidelines and Frameworks that underpin the National Vascular Registry:	
VSGBI 2021	VSGBI 2016
VSGBI 2012	NAAASP 2020
VSGBI 2022	NICE 2012
NICE 2019	

Quality Improvement

The State of the Nation report published in November 2025 sets out five QI goals, developed to address the key concerns identified in the NVR Healthcare Improvement Strategy (August 2023).

One of the concerns raised was regarding the variation in the time taken for patients undergoing a lower limb revascularisation procedure following a non-elective admission for chronic limb threatening ischaemia. As ABUHB do not undertake major limb amputation, aortic repairs or carotid endarterectomy, it was this particular concern and associated action relating to lower limb revascularisation that was relevant and of interest to ABUHB.

Opposite are all five improvement goals, with the goal of relevance to ABUHB highlighted.

QUALITY IMPROVEMENT GOALS



REDUCE DELAYS FOR CLTI REVASCULARISATION
Ensure patients admitted as emergencies receive revascularisation within 5 days



IMPROVE TIMELINESS FOR AAA REPAIR AND CEA
Meet standards for AAA repair within 8 weeks and CEA within 14 days of symptoms



ENSURE TIMELY MAJOR LOWER LIMB AMPUTATION
Perform amputations within 48 hours of decision to operate



STRENGTHEN INTEGRATED CARE FOR DIABETIC PATIENTS
Coordinate management across primary and secondary care

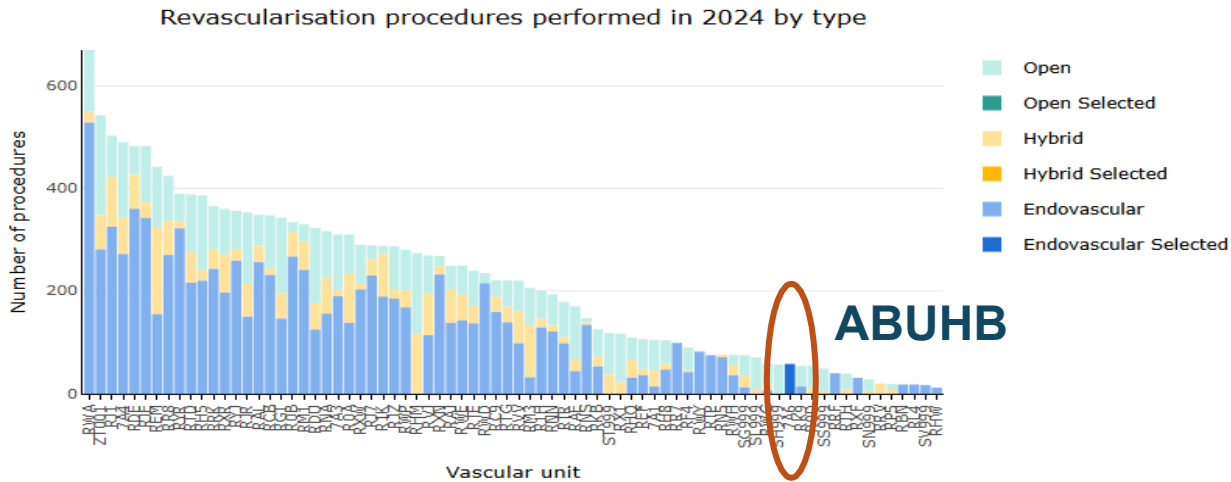


EXPAND ACCESS TO ENDOVASCULAR REPAIR FOR RAAA
Ensure suitable patients have access to EVAR

Lower limb revascularisation

The data tables and graphs shown on slides 4 to 7 report metrics for patients who had a lower limb revascularisation procedure between January and December 2024, performed using open surgery (bypass), endovascular techniques or a combination of both (hybrid). The analysis focuses on the first procedure undergone by a patient during an admission; subsequent procedures are re-operations. The waiting time plots include NHS vascular units with at least 10 non-elective chronic limb-threatening ischaemia (CLTI) cases in 2024.

	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	963	16,618
Open surgical	<5	317	4,529
Hybrid	<5	112	2,453
Endovascular	58	534	9,636
Emergency CLTI cases (2024)	<5	502	5,182
Median time (IQR) from assessment to procedure (days)		6 (4 - 10)	6 (3 - 9)
CLTI treated within 5 days		43%	49%



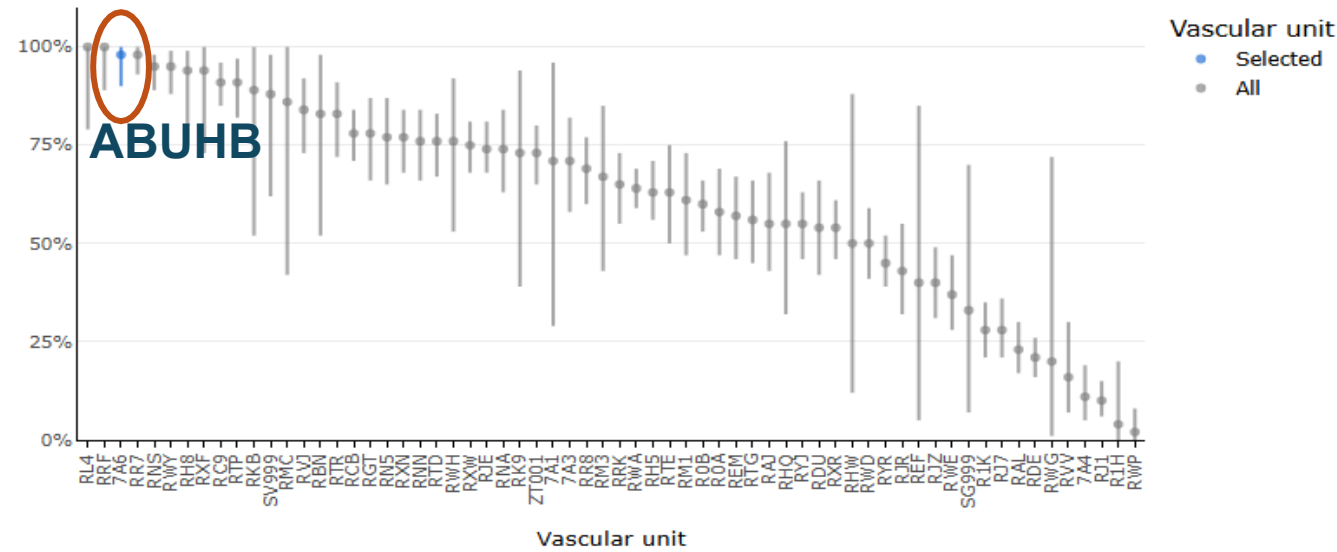
Patient characteristic	Time period	NVR cases	Vascular unit	UK	Lowest	Highest
Age over 75 years (%)	2024	58	33%	33%	18%	48%
Men (%)	2024	58	72%	71%	56%	88%
Current smokers (%)	2024	58	36%	29%	16%	54%
Diabetes (%)	2024	58	47%	51%	18%	73%
Chronic heart disease (%)	2024	58	22%	29%	0%	56%
Chronic lung disease (%)	2024	58	16%	21%	0%	48%
Chronic kidney disease (%)	2024	58	3%	17%	0%	69%
Indication: Rest pain / tissue loss (%)	2024	58	70%	76%	16%	98%

	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	534	9,636
Case ascertainment	>85%	100%	58%
Day cases (2024)	98%	52%	60%
NVR cases (2022-2024)	168	1,387	28,140
Adjusted in-hospital mortality (2022-2024)	1.6%	1.8%	1.6%
Readmitted within 30 days (2024)	14%	21%	14%

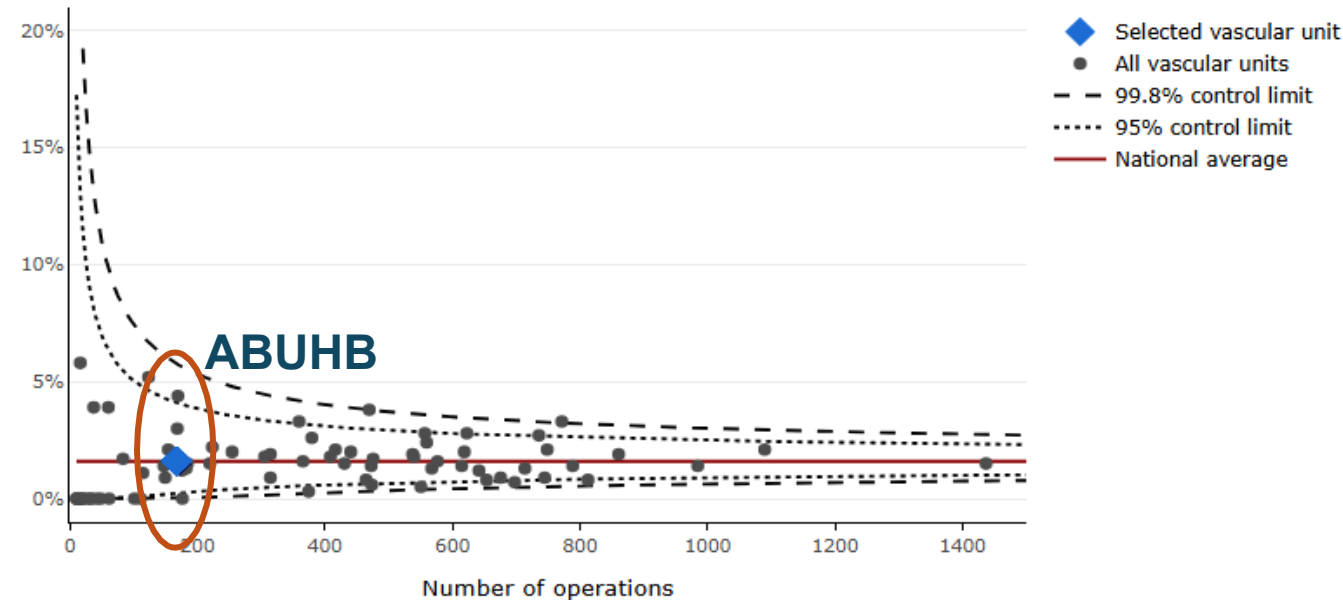
Lower limb angioplasty/stenting

The data/graphs on slides 8 to10 report on lower limb endovascular revascularisation procedures, such as angioplasty and stenting. The analysis focuses on the first procedure undergone by a patient during an admission. Most metrics are relevant to procedures performed from January to December 2024, while the mortality funnel plot is based on data from NHS vascular units that submitted at least 10 procedures in the NVR from January 2022 to December 2024. The day case plot is displayed for NHS vascular units with at least 5 elective angioplasty cases in 2024.

Elective endovascular procedures performed as day cases in 2024



Risk-adjusted in-hospital mortality in 2022-2024



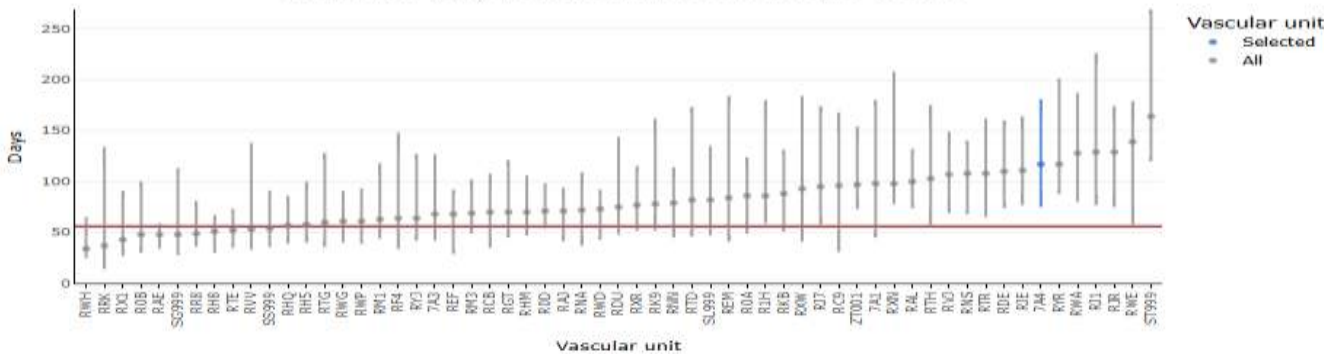
Elective infrarenal abdominal aortic aneurysm repair

This section presents process metrics and outcomes for elective infrarenal AAA repairs, including revision procedures but excluding complex repairs. Most metrics are presented for procedures performed between January and December 2024, apart from in-hospital mortality which is reported for the period from January 2022 to December 2024 to give robust outcome estimates. Vascular units with fewer than 10 procedures submitted in the reporting period are not shown in the graphs.

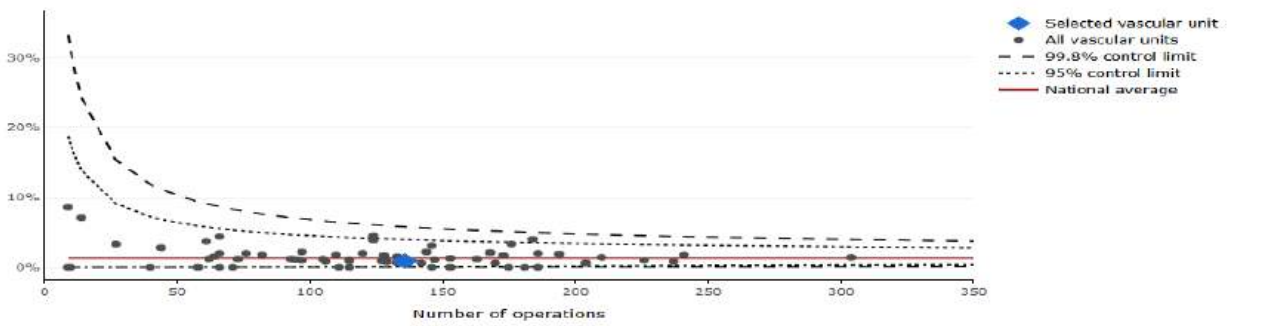
	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	46	138	2,511
Case ascertainment	>85%	100%	91%
No. of EVAR	26	76	1,556
Median time (IQR) from assessment to procedure (days)	117 (75 - 181)	90 (50 - 148)	81 (46 - 138)
Had surgery within 8 weeks of assessment	13%	30%	33%
Discussed at MDT	98%	96%	86%
Had anaesthetic review	100%	100%	97%
Median (IQR) length of stay for EVAR (days)	2 (2 - 3)	2 (2 - 3)	2 (1 - 3)
Median (IQR) length of stay for open repairs (days)	10 (8 - 12)	8 (7 - 10)	7 (6 - 10)
NVR cases (2022-2024)	136	406	8,203
Risk-adjusted in-hospital mortality (2022-2024)	0.9%	1.1%	1.3%

	Cardiff and Vale University Health Board 7A4	Wales	UK
EVAR	28	69	1,211
Case ascertainment	>85%	100%	94%
No. of EVAR	11	11	515
Median (IQR) length of stay (days)	6 (3 - 14)	6 (3 - 15)	9 (4 - 18)
Risk-adjusted in-hospital mortality (2022-2024)	50.4%	56.9%	34.8%

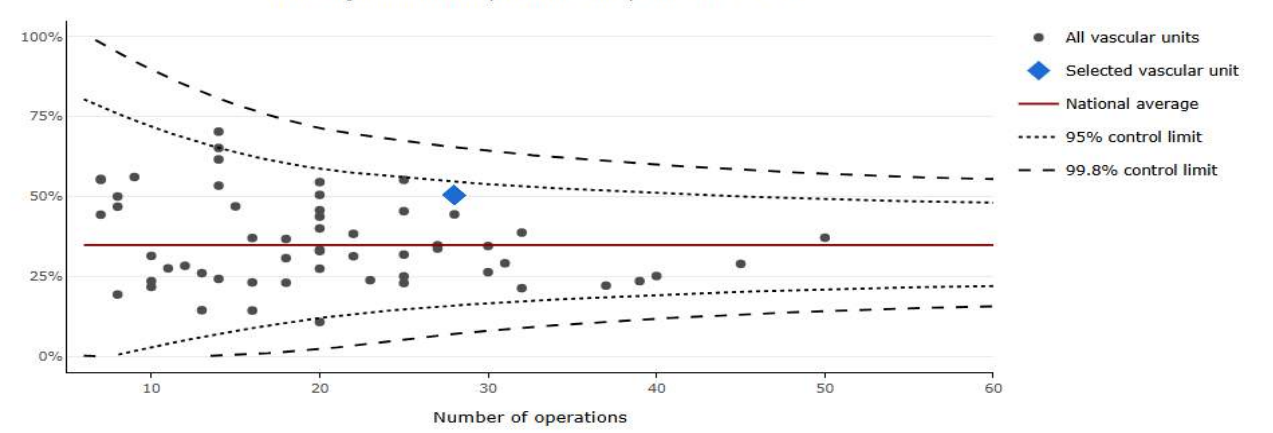
Median time (IQR) from assessment to AAA repair in 2024



Risk-adjusted in-hospital mortality in 2022-2024



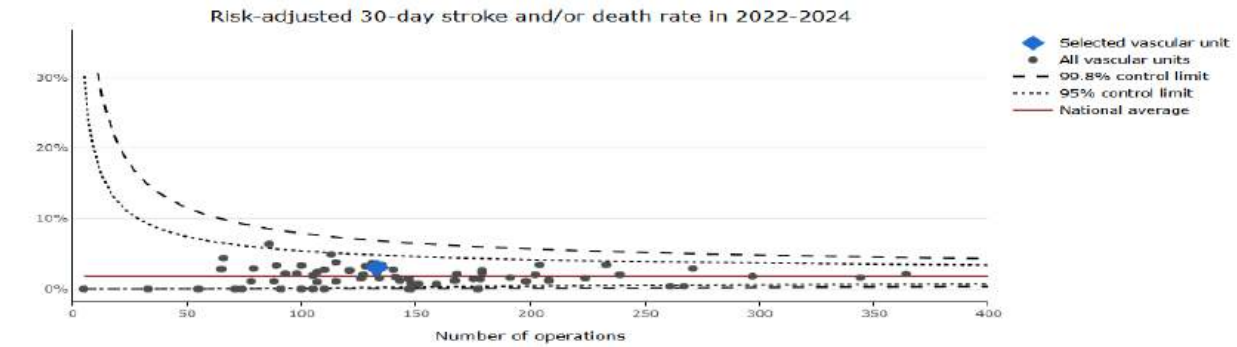
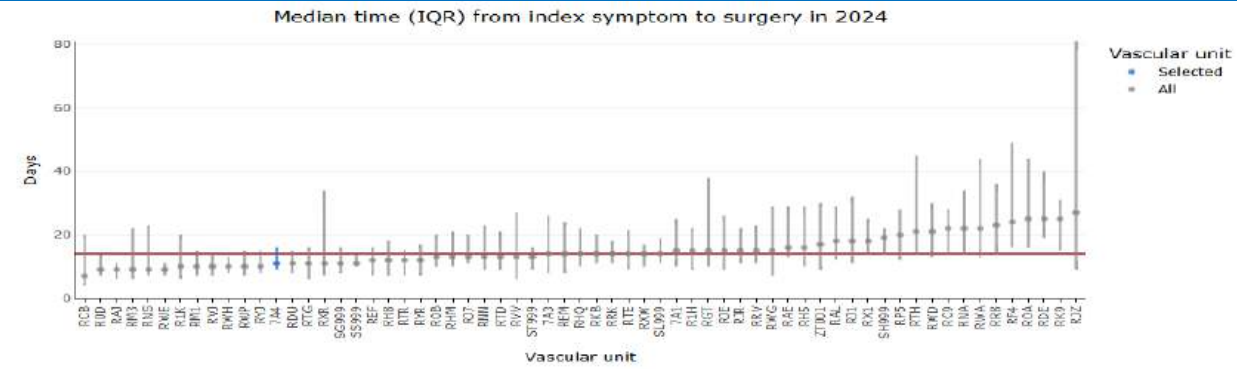
Risk-adjusted in-hospital mortality in 2022-2024





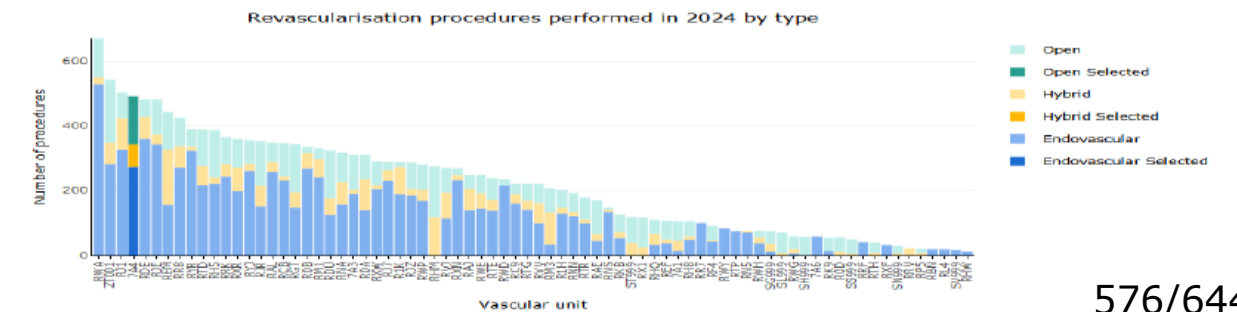
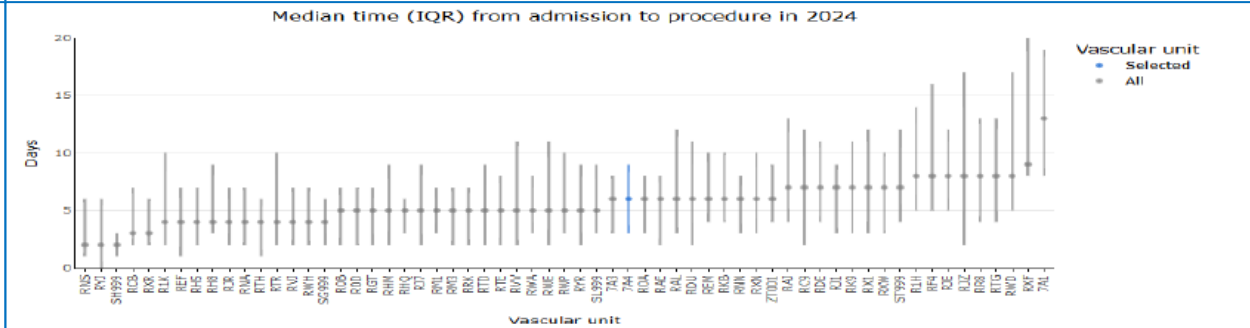
Carotid Endarterectomy

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	43	129	2,877
Case ascertainment	>85%	100%	87%
Symptomatic cases	42	128	2,719
Referred within 7 days of symptom	68%	61%	70%
Had surgery within 7 days of referral	63%	62%	43%
Had surgery within 14 days of symptom	64%	57%	53%
Median delay (IQR) from symptom to surgery (days)	11 (9 - 16)	13 (9 - 24)	14 (9 - 24)
Median (IQR) length of stay (days)	3 (2 - 5)	4 (3 - 6)	2 (1 - 4)
NVR cases (2022-2024)	133	414	9,603
Adjusted Stroke and/or death rate (2022-2024)	3%	2.3%	1.8%



Lower Limb Revascularisation

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	490	963	16,618
Open surgical	148	317	4,529
Hybrid	70	112	2,453
Endovascular	272	534	9,636
Emergency CLTI cases (2024)	255	502	5,182
Median time (IQR) from assessment to procedure (days)	6 (3 - 9)	6 (4 - 10)	6 (3 - 9)
CLTI treated within 5 days	47%	43%	49%



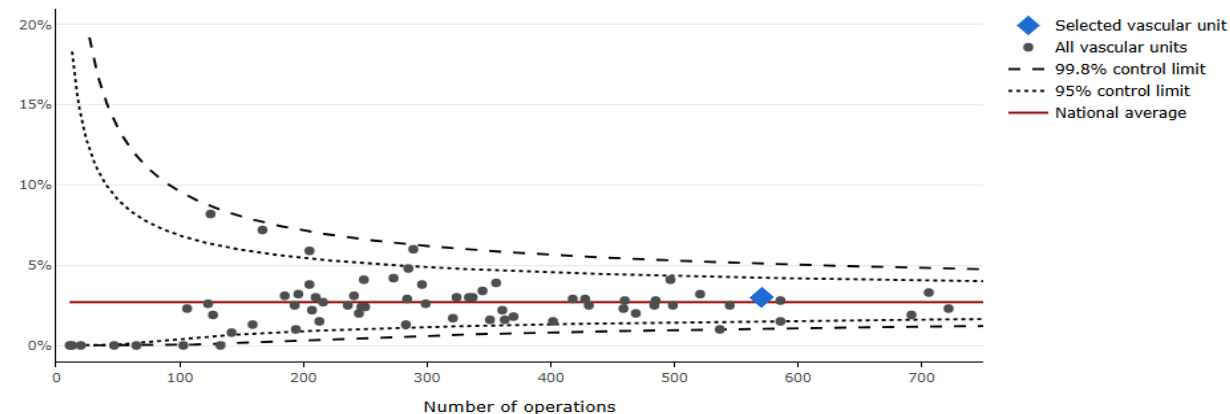
Bypass

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	218	429	6,982
Case ascertainment	>85%	100%	89%
Median (IQR) length of stay (days)(2024)	10 (6 - 17)	11 (6 - 20)	8 (4 - 16)
NVR cases (2022-2024)	571	1,301	20,865
Adjusted in-hospital mortality (2022-2024)	3%	3%	2.7%
Readmitted within 30 days (2024)	9%	13%	13%

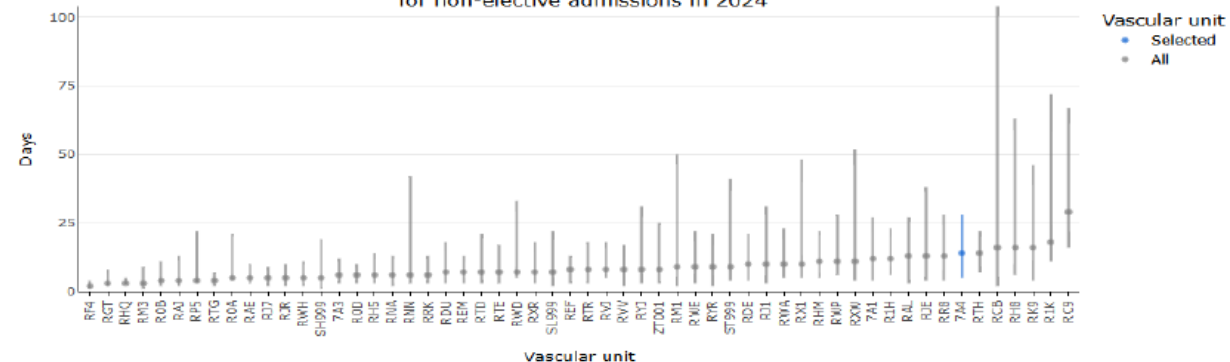
Amputation

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	136	321	3,877
Case ascertainment	>85%	100%	84%
Median (IQR) time from assessment to amputation for non-elective admissions (days)	14 (5 - 28)	8 (4 - 23)	7 (3 - 20)
AKA to BKA ratio	0.8	1.1	0.9
Received prophylactic antibiotics	80%	91%	92%
Consultant vascular surgeon present in theatre	94%	80%	76%
Median (IQR) length of stay (days)	25 (16 - 36)	23 (15 - 38)	22 (14 - 36)
NVR cases (2022-2024)	442	1,045	12,387
Adjusted 30-day in-hospital mortality (2022-2024)	9.1%	7.1%	5.9%

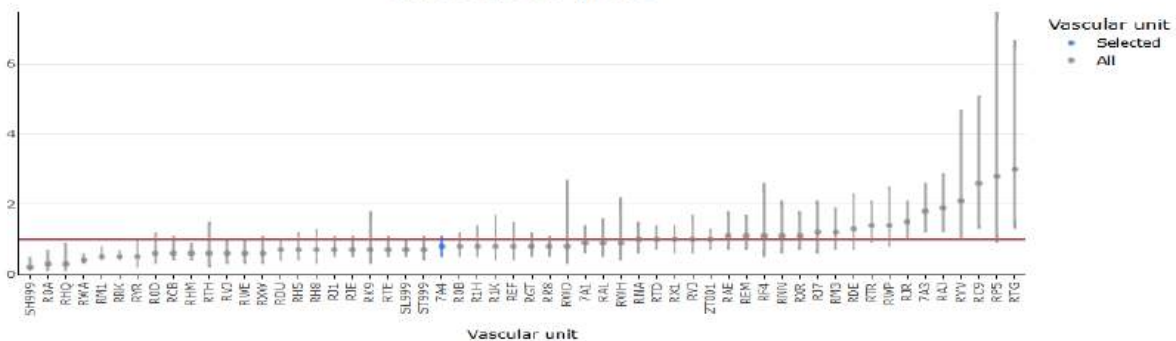
Risk-adjusted in-hospital mortality in 2022-2024



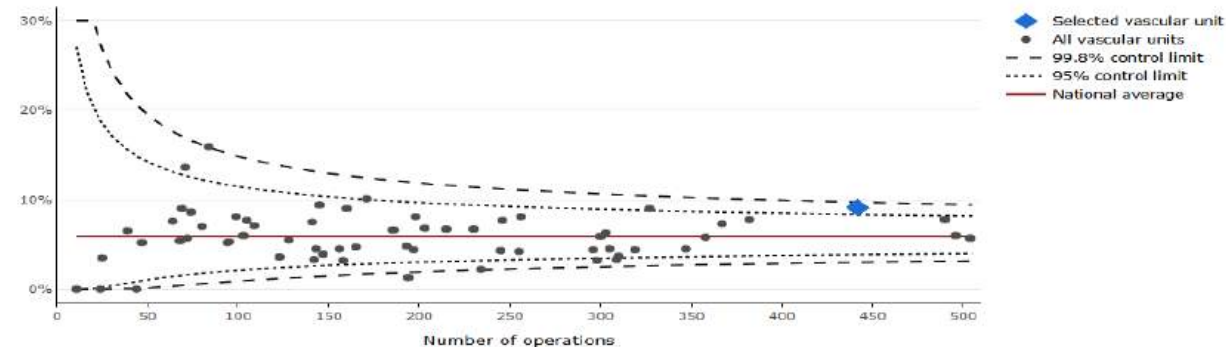
Median time (IQR) from vascular assessment to amputation for non-elective admissions in 2024



AKA to BKA ratio in 2024



Risk-adjusted in-hospital mortality in 2022-2024



Assurance and Risk

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	X
Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	X

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Good quality service from the ABUHB IR department.	1	SEWVN Major Lower Limb Amputation mortality – a) post op care, b) consider palliation
2	Good and timely carotid service.	2	SEWVN delay for AAA repair – continue to monitor
3	Good and timely lower limb revascularisation service		

Report Recommendations (relevant to ABUHB):		S.M.A.R.T Actions: Responsible: Due Date: Progress:	
1	Evaluate strategies for reducing long delays to revascularisation for people with chronic limb threatening ischaemia (CLTI), to address lack of improvement in meeting timelines recommended in VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease. <i>(Extended from 2024 SotN recommendations)</i>		Continued awareness and monitoring

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Continue to monitor MLLA and AAA delivery				



National Clinical Audit Plan for 2026/2027

Medical Director's Quality & Patient Safety

June 2026

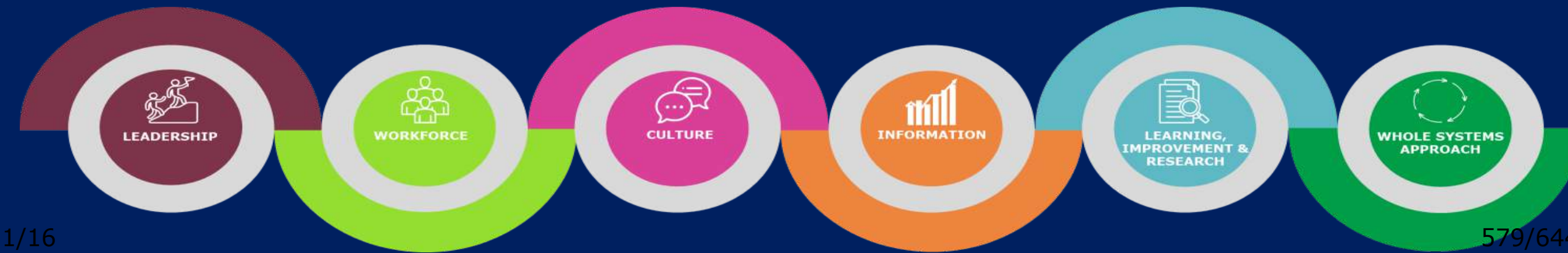


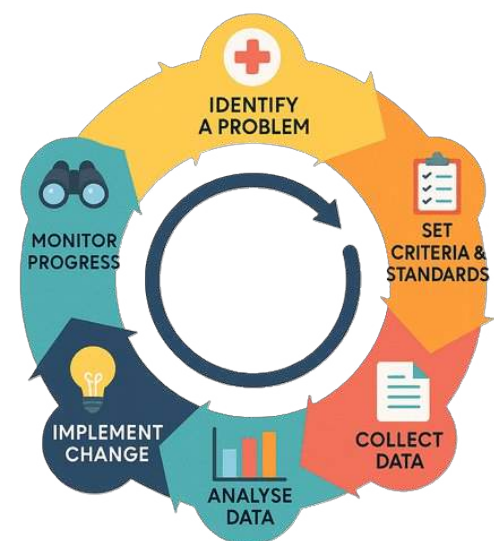
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8	Clinical Audit Awareness Week	

- Aneurin Bevan University Health Board is committed to delivering safe, effective, and high-quality care for the population of Gwent.

Clinical audit is a core component of the Quality Strategy and a key delivery mechanism for Pillar Three of the six pillars of quality – clinical effectiveness, providing a structured, evidence-based approach to assessing care against local and national standards and reducing unwarranted variation in practice.

- Audit findings are used to drive improvement, support re-audit, and provide assurance on the effectiveness and outcomes of care.
- All audit activity is managed through the Audit Management and Tracking (AMaT) system, enabling consistent governance, real-time action tracking, and organisational oversight.
- In line with Welsh Government requirements, audit outputs are aligned with **Healthcare Quality Improvement Partnership** and **National Clinical Audit and Patient Outcomes Programme**, which operates on a published nine-month rolling audit cycle.
- Clinical audit is reported through the Quality Management System and Quality Outcomes Framework, ensuring clear accountability, learning, and Board-level assurance via Quality Management Group (QMG) and the Patient Quality, Safety and Outcomes Committee (PQSOC).

What is Clinical Audit?



Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit evidence-based standards.

Where practice does not meet agreed standards, changes are implemented and monitored, and re-audited to confirm improvement.

Clinical audit supports:

- Safe, effective, and patient-centred care
- Reduction of unwarranted variation
- Assurance on compliance with national and local standards
- Continuous learning and service improvement

Key Features of Clinical Audit

- Measures current practice against agreed standards (e.g. NICE, national guidelines)
- Identifies gaps, risks, and areas for improvement
- Drives action and improvement
- Includes re-audit to demonstrate sustained change
- Provides assurance to clinical teams, management, and the Board

Clinical Audit Registration

The Health Board registers all audits using AMaT, which improves:

- Collaboration
- Compliance
- Engagement
- Accountability
- Assurance
- Learning
- Transparency

AGREE
STANDARDS



MEASURE
PRACTICE



IDENTIFY GAPS



IMPLEMENT
CHANGE



RE-AUDIT &
ASSURE
IMPROVEMENT

Six Domains of Quality

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:



PERSON CENTRED

PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.



SAFE

SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm.



TIMELY

TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.



EFFECTIVE

EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes.



EFFICIENT

EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.



EQUITABLE

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.



LEADERSHIP

Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.



WORKFORCE

Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable



CULTURE

Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.



INFORMATION

Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.



LEARNING, IMPROVEMENT RESEARCH

Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.



WHOLE SYSTEM APPROACH

Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

Patient and Staff Experience, Complaints, Concerns, and Compliments:	Clinical audit places strong emphasis on patient and staff experience, supporting person-centred care and a positive working environment. By providing a structured way to measure, understand, and improve compassionate and effective care, audit enables feedback from patients, families, and staff to directly inform learning and improvement. This approach helps identify areas for change, supports the spread of effective practice, and strengthens trust and accountability by demonstrating that experience is actively listened to, acted upon, and embedded within service improvement.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Clinical Effectiveness:	Clinical audit is a core element of clinical effectiveness, providing assurance that care is delivered in line with evidence-based standards and best practice. By systematically reviewing performance and driving improvement, audit helps identify variation, mitigate risk, and sustain high-quality, safe care. Embedded within the wider improvement cycle, clinical audit enables organisations to demonstrate measurable impact, effective governance, and ongoing assurance of clinical effectiveness across services.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.

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



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Health Board National Clinical Audit Priorities

Aneurin Bevan University Health Board has four key clinical audit priorities:

1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of improvement plans
 2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
 3. Trainees are supported to participate in audits that support clinical governance
 4. Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available
- Clinical audit provides a critical mechanism through which the Six Pillars of Quality and the Health and Care Quality Standards are embedded into day-to-day practice.
 - Through the delivery of the National Clinical Audit Plan, statutory requirements for participation, reporting, and compliance are met, while maintaining a clear focus on learning and improvement rather than compliance alone.
 - Audit activity enables the Health Boards to test whether care is safe, effective, timely, person-centred, equitable, and efficient, and to identify variation, risk, and opportunities for improvement.
 - By translating national standards and quality expectations into local review, action planning, and re-audit, clinical audit ensures that learning is systematically captured, shared, and acted upon.
 - This approach not only fulfils statutory obligations but also strengthens continuous improvement, ensuring that quality standards are meaningfully applied and that evidence-based learning leads to sustained improvement in patient outcomes, experience, and safety.

Principles of the Annual National Clinical Audit Plan

In developing the Aneurin Bevan University Health Board National Clinical Audit Plan the following approach has been followed:

Purpose of National Clinical Audits:

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

Participation and Compliance:

- Directorates must participate and engage in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), National Confidential Enquiries (NCEPOD), and relevant service reviews.
- Include non-NCAPOP national audits in the Health Board's Quality Plan (e.g., Falls).
- Implement and audit National Institute of Clinical Excellence (NICE) guidance and Health Technology Wales (HTW) adoption, subject to external review.
- Service evaluation and re-audit should be conducted following changes in practice.

Audit Management:

- Register all clinical audit activities within Directorates.
- Collaborate with clinicians, managers, and audit staff to meet all requirements. This includes all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Enable healthcare professionals to participate in audits for revalidation and professional development.

Support and Review:

- Ensure resources, governance, and structures support audit engagement.
- Establish a formal process for reviewing performance and improvements.
- Escalate issues to the Executive Board when necessary.
- Clear process for risk identification following audit.

Clinical Standards and Effectiveness Group - Processes

Healthcare Quality Improvement Partnership (HQIP) Reporting, Assurance and Scheduling Process

The Medical Director's Clinical Audit Quality and Patient Safety (QPS) team provides regular horizon-scanning updates on anticipated HQIP report publication dates to support forward planning and assurance, recognising that schedules may change. Any amendments are communicated promptly to the relevant Clinical Lead and Divisional Triumvirate. Based on the national audit timetable and local priorities, QPS coordinates and schedules the presentation of clinical audits at appropriately timed Clinical Standards and Effectiveness Group (CSEG) meetings, ensuring aligned, timely, and risk-informed consideration of findings.

Following report publication, QPS incorporates Health Board data into a standardised PowerPoint template and undertakes a structured validation process with the nominated presenter to confirm data accuracy, narrative consistency, and alignment with AMaT records. Audit findings, assurance considerations, and agreed actions are formally reviewed at CSEG, enabling clinical scrutiny, triangulation, and organisational learning. Meeting outputs are captured through concise summary logs setting out decisions, actions, and review timeframes, with supporting audit presentations retained for detailed reference. All documentation, including summary logs and presentation materials, is accessible to staff via the Quality and Patient Safety (QPS) intranet page.

Action Planning and Governance

Prior to each CSEG meeting, QPS work collaboratively with the Clinical Lead and Divisional or Directorate Management to ensure that proposed actions are clearly aligned with report recommendations and Health Board priorities. Actions are agreed using the S.M.A.R.T. framework and assigned a six-month review date to support ongoing monitoring, follow-up, and assurance through established governance routes.

New Procedure Applications

Applications for new procedures are considered through the CSEG governance process to ensure appropriate clinical oversight, assurance, and alignment with standards. To date, five applications have been approved. Prior to being submitted to CSEG, the applications will have gone through the Business Development Innovation & Value. The head of this team will also support the applicants present to the CSEG.



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Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) Team coordinates delivery of the Clinical Audit Plan with clinical leads, ensuring compliance with NCAPOP and the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP).
- Divisions are supported to deliver audits, with participation, findings, and actions consistently documented and tracked.
- The Clinical Standards and Effectiveness Group (CSEG) provides multidisciplinary operational oversight of clinical audit findings, including the identification of risks and opportunities for improvement.
- Key themes and risks are escalated to the Quality Management Group (QMG), ensuring learning from audit informs the wider Quality Management System.
- Board-level assurance is provided through the Patient Quality, Safety, and Outcomes Committee (PQSOC).
- The Audit, Risk, and Assurance Committee (ARAC) oversees the robustness of audit governance arrangements.
- Together, these routes ensure a clear line of sight from front-line audit activity to corporate risk and Board assurance.



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National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

Cancer Audits

HQIPO Ref.		Name of publication	Publication date	CSEG
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG May 2026
634	NATCAN	National Pancreatic Cancer Audit (NPaCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG May 2026
633	NATCAN	National Ovarian Cancer Audit (NOCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG July 2026
640	NATCAN	National Lung Cancer Audit (NLCA) – State of the Nation Report (England & Wales)	12/02/2026	CSEG May 2026
719	NATCAN	National Ovarian Cancer Audit (NOCA) – State of the Nation Report (Eng & Wal)	11/06/2026	CSEG July 2026
751	NATCAN	National Primary Breast Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
752	NATCAN	National Metastatic Breast Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
753	NATCAN	National Pancreatic Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
754	NATCAN	National Non-Hodgkin Lymphoma Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
755	NATCAN	National Kidney Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
756	NATCAN	National Oesophagogastric Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
757	NATCAN	National Bowel Cancer Audit – State of the Nation Report (England & Wales)	08/10/2026	CSEG Mar 2027
758	NATCAN	National Prostate Cancer Audit – State of the Nation Report (England & Wales)	08/10/2026	CSEG Mar 2027

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
618	NCEPOD	Blood sodium Report	11/09/2025	TBC for a later date
650	SSNAP	Sentinel Stroke National Audit Programme – State of the Nation Report	13/11/2025	Stroke Board
NICOR	NICOR 2024/25 (2nd Ed)	National Audit of Cardiac Rhythm Management (NACRM)	11/12/2025	CSEG Mar 2026
NICOR	NICOR 2024/25 (2nd Ed)	Myocardial Ischaemia National Audit Project (MINAP)	11/12/2025	CSEG Feb 2027
NICOR	NICOR 2024/25 (2nd Ed)	National Audit of Percutaneous Coronary Interventions (NAPCI)	11/12/2025	CSEG Feb 2027
NICOR	NICOR 2024/25 (2nd Ed)	National Heart Failure Audit (NHFA)	11/12/2025	CSEG Jul 2026
617	NCEPOD	Emergency paediatric surgery	11/12/2025	TBC for a later date
701	NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health – State of the Nations Report	12/02/2026	CSEG Jul 2026
702	NMPA	National Maternity and Perinatal Audit – Multiple Births Report	12/03/2026	CSEG Sep 2026
659	NPDA	National Paediatric Diabetes Audit – Annual Core State of the Nation Report 2026	12/03/2026	CSEG May 2026
730	NAD	National Audit of Dementia – Service Mapping Exercise for Memory Assessment Services	14/05/2026	CSEG Jul 2026
715	NELA	National Emergency Laparotomy Audit – First Annual No Laparotomy State of the Nation Report	14/05/2026	CSEG Jul 2026

The reports listed above were published in 2025/26; however, due to scheduling and availability, these will be considered at CSEG meetings during 590/644

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
651	NRAP	Asthma and COPD – National Respiratory Audit Programme (NRAP) – Primary Care Report	14/05/2026	CSEG Jul 2026
720	NCEPOD	Acute illness in patients with a learning disability	11/06/2026	CSEG Sep 2026
705	MNI	Perinatal Mortality Surveillance 2026 Report (2024 births)	11/06/2026	CSEG Sep 2026
691	NRAP	National Respiratory Audit Programme (NRAP) – State of the Nation Report 2026	11/06/2026	CSEG Sep 2026
711	Epilepsy12	Epilepsy12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People – State of the Nation Report 2026	09/07/2026	CSEG Sep 2026
734	NMPA	National Maternity and Perinatal Audit (NMPA) – State of the Nation Report 2026	13/08/2026	CSEG Sep 2026
712	NACEL	National Audit of Care at the End of Life (NACEL) – State of the Nation Report 2026	13/08/2026	CSEG Oct 2026
718	FFFAP	National Hip Fracture Database (NHFD) – State of the Nation Report 2026	10/09/2026	CSEG Nov 2026
706	MNI	Maternal Mortality and Morbidity Surveillance and Confidential Enquiry 2026 Report	10/09/2026	CSEG Nov 2026
731	NEIAA	National Early Inflammatory Arthritis Audit (NEIAA) – State of the Nation Report 2026	08/10/2026	CSEG Dec 2026
722	NNAP	National Neonatal Audit Programme (NNAP) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
717	NCAP	National Clinical Audit of Psychosis (NCAP) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
716	NELA	Eleventh Annual Emergency Laparotomy (NELA) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
714	FFFAP	National Audit of Inpatient Falls (NAIF) – State of the Nation Report 2026	08/10/2026	IP Falls Group
733	SSNAP	Sentinel Stroke National Audit Programme (SSNAP) – State of the Nation Report 2026 Stroke Board with update to CSEG	12/11/2026	CSEG Feb 2027
728	NVR	National Vascular Registry (NVR) – State of the Nation Report 2026	12/11/2026	CSEG Feb 2027
723	NPDA	National Paediatric Diabetes Audit (NPDA) – Workforce Spotlight Audit Report 2026	12/11/2026	CSEG Feb 2027
721	NCEPOD	Pleural Procedures	12/11/2026	CSEG Nov 2027
696	NCEPOD	Stabilisation of the Critically Ill Child	10/12/2026	CSEG Nov 2027
736	FFFAP	Fracture Liaison Service Database (FLSDB) – State of the Nation Report	14/01/2027	CSEG Feb 2027

The reports listed above were published in 2025/26; however, due to scheduling and availability, these will be considered at CSEG meetings during 2026/27.



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Conclusion

- The success of the delivery of clinical audit plan is driven by strong partnership working between the Quality and Patient Safety Clinical Audit Team and clinical leads across services.
- AMaT plays a central role in enabling effective clinical audit oversight; AMaT has become a critical enabler of assurance and oversight for clinical audit activity. It provides a consistent, central system through which the Health Board can plan, track, and monitor delivery of the National Clinical Audit Plan on a year-on-year basis, ensuring visibility of audit activity, progress against priorities, and completion of the full audit cycle.
- The Clinical Audit Team collaborates with clinical leads to coordinate, track, and support audit activity, ensuring that audits are completed, findings are clearly documented, and SMART action plans are developed and monitored. Crucially, this collaborative approach ensures that learning from audit is owned clinically and fed back into Directorates, where it informs local improvement and decision-making.
- Through structured reporting, action tracking, and re-audit, the Health Board now has a clear line of sight between audit findings, improvement activity, and assurance, enabling the Health Board to understand where care is improving, where risks remain, and where further support or escalation is required.
- Work will continue to support this model that strengthens both learning and accountability, embedding clinical audit as a meaningful driver of improvement while providing robust assurance to governance forums and the Board.



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University Health Board

Clinical Audit Awareness Week

Clinical Audit Awareness Week 2026, led nationally by the Healthcare Quality Improvement Partnership (HQIP), will take place from 22–26 June 2026. The week will focus on promoting the value of clinical audit in improving patient care, supporting patient safety, reducing health inequalities and enabling data-driven improvement, reinforcing the role of audit within effective clinical governance and continuous quality improvement.

Book your session [here](#)

- ❖ **Monday 22 June** – Turning Strategy into Reality: Clinical Audit as a Strategic Enabler of the NHS Three Shifts
- ❖ **Tuesday 23 June** – Patient Involvement and Care Equity: Improved Outcomes for All
- ❖ **Wednesday 24 June** – Shaping the Future Together: Innovation and Transformation
- ❖ **Thursday 25 June** – Patient Safety: Using Data and Audit to Reduce Harm
- ❖ **Friday 26 June** – Data-Informed Improvement: From Insight to Impact



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Aneurin Bevan
University Health Board

Internal Audit Progress Report

Audit, Risk and Assurance Committee

June 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services



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Partnership
Audit and Assurance Services



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



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1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2025/26 Internal Audit Plan;
- confirm the status of the audit work for the 2026/27 Internal Audit Plan;
- confirm the final position for the 2025/26 Head of Internal Audit Opinion; and
- note briefs issued in the period for information.

2. Progress against the 2025/26 and 2026/27 Internal Audit Plans

As we have concluded the 2025/26 Internal Audit Plan (summarised in Appendix A), we have now commenced delivery of the 2026/27 Internal Audit Plan. The current progress is summarised below, with further detail within Appendix B.

Audit Status	Number
Final reports	0
Draft reports	0
Work in progress	2
Planning	4
Pre-planning	22
Total number of audits planned	28

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 19th May 2026:

AUDIT ASSIGNMENT	ASSURANCE RATING
Overseas Recruitment	Reasonable
Cancer Referral Rates	Reasonable

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

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 reports issued since 19th May 2026.

Overseas Recruitment (reasonable)

We completed a review of the processes for ensuring visas for overseas recruitment are robust. However, we identified significant data quality and record-keeping weaknesses, including inconsistencies between ESR and the visa tracker (a variance of 319 staff), inaccurate or incomplete visa records, and errors such as duplicate entries and outdated information, largely due to insufficient reconciliation processes. However, overall, we did not identify any missing / incorrect visas.

Cancer Referral Rates (reasonable)

This focussed audit found that the overall arrangements for managing suspected cancer referrals broadly align with national guidance and expectations, with GP referral conversion rates (7.8%) consistent with the all-Wales average. However, the report highlights areas for improvement, including the absence of formal Health Board procedures incorporating referral guidance, limited training for administrative staff, and a lack of consistent recording and analysis of referrals rejected during screening.

4. 2025/26 Head of Internal Audit Opinion

The 2025/26 Final Head of Internal Audit Opinion is presented to this Audit, Risk and Assurance Committee and remains as previously indicated, at **reasonable** assurance.

5. Summary of Audit Briefs Recently issued

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

6. Recommendation

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

Appendix A: Progress against 2025/26 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Draft Report
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)	Reasonable	Draft Report
6. Business Continuity Plan	Reasonable	Final Report
7. Capital Projects: Service Readiness	Reasonable	Final Report
8. Falls Management	Reasonable	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	N/A	Deferred
13. Public Health	Advisory	Final Report
14. Six Goals Programme	N/A	Deferred
15. Discharge Planning	Substantial	Final Report
16. Safeguarding	Reasonable	Final Report
17. Cancer Referral Rates	Reasonable	Final Report
18. Occupational Health	Reasonable	Final Report
19. Overseas Recruitment	Reasonable	Final Report
20. Speaking up Safely	Limited	Final Report
21. Follow-up of High Priority Recommendations	Advisory	Final Report
22. Cyber Security (Including cyber incident response)	Reasonable	Final Report
23. Shadow IT		Work in Progress
24. Welsh Intensive Care Information System	Substantial	Final Report
25. RGH Central Decontamination Unit (capital systems from 2024/25)	Reasonable	Final Report
26. Estates Assurance – Space Utilisation	Advisory	Final 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)	Reasonable	Draft Report

Appendix B: Progress against 2026/27 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Policy Management		Pre-planning
2. Governance of Escalation Level		Pre-planning
3. Sustainable Funding		Pre-planning
4. Charitable Funds		Work in progress
5. Stakeholder Engagement		Pre-planning
6. Duty of Quality		Pre-planning
7. Value and Sustainability		Pre-planning
8. Welsh Risk Pool Lessons		Pre-planning
9. Hospital Sterilisation and Disinfection Unit (HSDU)		Planning
10. Patient Experience		Pre-planning
11. Dementia Care		Pre-planning
12. Mental Capacity Act - Deprivation of Liberty Safeguards		Pre-planning
13. Cancer Referrals		Pre-planning
14. Discharge Planning		Pre-planning
15. Primary Care and Community Services Divisional Review		Pre-planning
16. Clinical Audit		Pre-planning
17. Job Planning		Planning
18. Rostering & Operational Workforce Management		Pre-planning
19. Vaccination Programme		Planning
20. Job Evaluation		Work in progress
21. Follow-up of Agreed Actions		Pre-planning
22. Electronic Prescribing and Medicines Administration		Pre-planning
23. Project Management Office		Pre-planning
24. Procurement of Digital Services		Pre-planning
25. Networks		Pre-planning
26. Capital Systems		Pre-planning
27. Estates Assurance		Pre-planning
28. Ophthalmology Review (2025/26)		Planning

Appendix C: 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 D: Audit / Review Briefs Issued

Audit Title	Status	Outline Scope
Job Evaluation	Brief issued	To ensure the requirements of the NHS Job Evaluation Handbook are being applied in a fair, consistent and equitable manner by the Health Board.
Charitable Funds	Brief issued	To assesses the adequacy and effectiveness of key controls over donations, restricted funds, financial reporting, and decision-making by the Charitable Funds Committee.
Job Planning	Draft brief issued	The audit will provide assurance that arrangements are in place and operating effectively for consultant job planning.
Vaccination Programme	Draft brief issued	Evaluate the processes in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.

Overseas Recruitment

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference

ABU-2526-19

Fieldwork

February – March 2026

Executive Sign Off

June 2026

Audit, Risk and Assurance Committee

23 June 2026

Executive Lead

Sarah Simmonds, Director of Workforce & Development

Audit Team

Stephen Chaney, Head of Internal Audit
Eifion Jones, Deputy Head of Internal Audit
Rhian Gard, Audit Manager



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Executive Summary

Purpose

To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff.

Overview

Aneurin Bevan University Health Board (the 'Health Board') employs overseas staff to assist with staff shortages, in turn they must maintain valid and current visa documentation as a condition of employment.

This audit was undertaken to assess whether the Health Board has effective and timely processes to monitor visa requirements, respond to changes in immigration regulations, and maintain compliance with Home Office sponsorship obligations. The review evaluated the adequacy of existing controls, the robustness of monitoring arrangements, and the organisation's ability to act promptly when visa updates or renewals are required.

Overall, we did not identify any issues with non-compliant visa requirements (e.g. expired visas) within our sample tested. However, we have raised key findings over the completeness and robustness of records maintained by the Health Board. Whilst we have concluded **reasonable** assurance, a review should be completed of each ESR record to ensure visa requirements remain compliant. Details of the key findings are provided below:

- On ESR, 329 more staff are documented as requiring visas than noted in the Overseas Recruitment team's Visa Tracker (the 'Tracker') – of those 171 visas had been incorrectly recorded as expired at the time of fieldwork, the oldest being 2016. However, sample testing of 20 individuals confirmed that they were classed as Indefinite Leave to Remain (ILR) and thus, not requiring a visa. Assurances should be sought on the remaining individuals.
- Various inconsistencies were found within ESR records, including incorrect dates, incomplete expiry dates and staff included as requiring visas despite subsequently being provided Indefinite Leave to Remain.
- Inaccuracies were also identified in the Tracker. For example, employees that had been terminated remained on the Tracker, duplicate entries, differing expiry dates for the same employee and visa expiry dates not reconciling with ESR.

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	To ensure the Health Board is adhering to and updating visa requirements within sufficient timeframes for overseas staff:		
	a) Control Framework	-	Substantial
	b) Visa tracking process	1,3	Limited
	c) DHCW Centralised Management Platform	2	Reasonable
	d) Certificate of Sponsorship (CoS)	4	Reasonable

Management Actions



High Priority



Medium Priority

Themes



■ Information, Data
Quality & Data
Accuracy

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Overseas Recruitment - At a Glance

Background

The Health Board sponsors international professionals to fill recognised shortages in skilled roles.

A skilled worker visa allows a foreign national to live and work legally in the UK for a specific role and duration, and requires a confirmed job offer, evidence of skills, and employer sponsorship. Immigration rules, sponsorship duties, and Home Office requirements change, and non-compliance can result in financial penalties, reputational harm, and restrictions on the Health Board’s ability to sponsor future employees.

As part of the sponsorship process, a Certificate of Sponsorship (CoS) is issued by the licensed employer. For the Health Board, this involves assigning the CoS through the Home Office’s online sponsorship system. The Overseas Recruitment team’s responsibilities include ensuring compliance and safeguarding the organisation and the employee from immigration breaches. This is achieved by outlining the visa application steps, providing timelines and guidance, co-ordinating start dates, supporting relocation arrangements, and monitoring visa expiry dates to ensure timely renewals.

Within the sample tested we did not identify any expired visas, but confirmed discrepancies between ESR and the Tracker. These are summarised within the table below.

Key Observations from Data Validation

	ESR Extract Report*	Health Board’s Visa Tracker
Total Staff Identified as Requiring a Visa	1,327	998 (adjusted to remove duplicates)
Duplicate Records	0	10
Incorrect Visa Status Recorded (Sample 20 of 329 additional records within ESR)	20	0
Incorrect Expiration Dates Recorded (Sample testing of 11 of the largest variances)	2	9
Terminated Staff not Removed	0	5
ESR Current Records Incorrect	4	N/A

* The extract report contains all current staff recorded on ESR as requiring a visa

Findings & Agreed Action Plan

Objective 1: Adhering to and updating visa requirements within sufficient timeframes for overseas staff

a) Control Framework

Substantial

The Health Board’s Overseas Recruitment team has established internal standard operating procedures (SOPs) and process flow diagrams to support the accurate management and monitoring of visa requirements for sponsored staff. These procedures are aligned with Home Office requirements to promote consistency, standardisation, and compliance with national expectations.

We were advised that the team is notified by NHS Wales Shared Services Partnerships (NWSSP) and / or contact is made with the Home Office to advise of any changes to legislation. The team that are responsible for internationally educated nurses (IENs) and medics (doctors) work closely together with NWSSP and regularly share information to ensure requirements are adhered to correctly.

We sample tested 20 overseas employees, comprising of IENs (10) and medics (10) to ensure Certificate of Sponsorships, visa details including renewal status, ESR records and Monday.com were reviewed.

b) Visa Tracking Process

Limited

The Overseas Recruitment team maintain a Visa Tracker (the ‘Tracker’) to ESR, which is used to monitor visas and expiry dates for IENs and medics. Visa records are reviewed weekly, with a focus on employees whose visas are due to expire within the next twelve weeks. Line managers are notified when a visa is approaching expiry so that renewal actions can be initiated. Where required actions are not taken, an established escalation route is followed. We were informed that the tracking of IEN visas will initially be transferred to Microsoft Lists – with medics to follow if successful. Where a visa application has been submitted but the Home Office’s decision is delayed, an “In-Service” Employer Check Service (ECS) request can be made. This provides assurance of the individual’s right to work for up to six months. If no action is taken to renew a visa and / or a right-to-work cannot be evidenced, the individual must be removed from duty and their employment terminated, as overseas employees cannot legally work for the Health Board without valid immigration status. We sought to determine and test the performance of this process, but we were unable to as the dates are overwritten to reflect the latest position. Therefore, we have not provided assurance over the effectiveness of this process.

We sought to reconcile the Tracker to ESR records. However, as detailed in **finding 1**, instances were identified where both ESR and the Tracker were incorrect, but significantly, there was a variance of 329 employees between both sets of records. Further sample testing of 20 individuals, as detailed below, identified that these individuals now had Indefinite Leave to Remain status.

Given the variances identified, management should undertake a regular reconciliation – see **finding 3**.

c) DHCW Centralised Management Platform

Reasonable

Monday.com is the system used by NWSSP to manage and track the recruitment of overseas employees. It has been in place since 2023. Prior to its introduction, recruitment agencies liaising with overseas candidates worked directly with individual recruitment teams, who completed the visa process locally. Certificate of Sponsorship arrangements and Right to Work checks were also managed independently by each health board under local agreements.

Since 2023, all international candidates recruited across NHS Wales should be recorded and monitored through Monday.com, and this information is reported to Welsh Government. The intention of the system is to strengthen governance by co-ordinating the approach within one system, standardising processes, improving oversight, and enhancing the completeness and consistency of data across health boards.

Health boards are responsible for updating Monday.com regularly, while NWSSP undertakes a data quality review every three months to identify and resolve any outstanding gaps. For the audit sample of 20 staff, only one issue was identified with Monday.com, where an individual had been terminated on ESR and the Tracker but had not been updated as terminated on Monday.com. This is detailed in **finding 2**.

d) Certificate of Sponsorship (CoS)

Reasonable

For CoS processing, the completed documentation is submitted to NWSSP for verification and assignment through the Home Office’s online sponsorship system. NWSSP notifies the Health Board once the CoS has been approved. Following approval, the individual must apply for their visa and provide a share code, which is checked via the GOV.UK online right-to-work service. All documentation is stored in the employee’s electronic recruitment file, and visa details are recorded on the individual’s ESR record. Once a CoS has been issued, any subsequent changes to the employee’s contract or salary including periods of long-term sickness exceeding four weeks must be reported to the Home Office using the CoS change notification process.

As part of the audit twenty overseas employees were checked and it was confirmed that all CoS and Right to Work checks were completed correctly. However, we found one instance where the passport retained on file for one medic had expired. A record of the new passport was recovered from elsewhere and placed within the employee record - see **finding 4**.

Key Findings		Risk & Impact	Agreed Management Action
1	Discrepancies in Information In reconciling an ESR extract report against the Health Board’s visa tracker for January 2026, several inconsistencies were identified. A summary of the key observations is detailed below ESR / Tracker Testing: • Within the ESR extract report, there were 1,327 employees identified as requiring a visa, however the tracker contained only 998 employees (a difference of 329). • 171 of the 329 visas had been incorrectly recorded as expired at the time of fieldwork, one having not been updated since October 2016. • A sample of twenty employees recorded as requiring visas (from the 329) concluded that nineteen of those had obtained Indefinite Leave to Remain, whilst the other was a bank worker with no substantive employment within the Health Board.	Failure to comply with Home Office visa and sponsorship requirements, leading to fines, sanctions, or loss of sponsorship	Agreed Action: A full review of all overseas worker records held on ESR and the Visa Tracker will be completed to verify visa status, expiry dates and employment status. Any discrepancies identified will be corrected. In addition, a quarterly reconciliation process will be implemented between ESR and the Visa Tracker, supported by a quarterly termination report review to ensure leavers are removed promptly. The Overseas Recruitment Team will also work with Recruitment Services and NWSSP to review the TRAC-to-ESR interface and agree any corrective actions required to improve data integrity. Expected Evidence of Implementation: • An initial review has been completed and no immediate cause for concern was identified. This will be validated by the completed reconciliation report. • Action log of discrepancies corrected. • Quarterly reconciliation schedule. • Agreed actions from TRAC/ESR review.

	42 variances were identified in visa expiration dates between the tracker and ESR. From a sample of the 11 largest variances, two of these were confirmed by management as incorrectly recorded at ESR. - A total of nine employees appeared on the Tracker but did not appear in the ESR extract report. Of these, four were attributed to errors in ESR – two had not been inputted correctly on to ESR by Recruitment Services at the point of appointment, whilst the remaining two should have been identified within the extract report process. Tracker Testing: - Nine employees appeared on the Tracker but not at the ESR report. Five of these were incorrectly included at the Tracker having been terminated - and should be removed from the main list. - A total of ten duplicate entries were identified on the Tracker, whilst recognising that eight included the same dates for visa expiration, two did have differing dates for the same employee. 42 variances were identified in visa expiration dates between the Tracker and ESR. From a sample of the eleven largest variances, management confirmed that the tracker dates were incorrect in nine instances.		
	Theme: Information, Data Quality & Data Accuracy	High Priority	Officer: Deputy Director of Workforce and Head of Recruitment Target Implementation Date: Completed
2	DHCW Centralised Management Platform Since 2023, DHCW has utilised a cloud-based platform to manage overseas recruitment (Monday.com). From our sample of twenty overseas employees, one medic employee had been terminated but was showing as live on Monday.com.	Incomplete records resulting in gaps and incorrect reporting. Illegal working Reputational risk	Agreed Action: A review of current processes will be undertaken to ensure employee status changes are reflected consistently across Monday.com and local records. Responsibility for updating termination status will be clarified and included within the team's operating procedure.
		Medium Priority	Expected Evidence of Implementation: - Updated SOP. - Evidence of review of current records. Officer: Head of Recruitment Target Implementation Date: 31 October 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

3	Data Quality Management outlined that ESR and the tracker were previously regularly reconciled but that this had ceased. A periodic reconciliation should be reintroduced.	Data records do not reconcile and provide conflicting conclusions.	Agreed Action: The effectiveness of the revised monitoring arrangements, including ESR notifications and new starter reports, will be reviewed over a six-month period. A sample reconciliation between ESR and the Visa Tracker will be undertaken quarterly during this period to provide assurance that the revised process is operating effectively
			Expected Evidence of Implementation: - Quarterly reconciliation results. - Six-month review report.
		Medium Priority	Officer: Head of Recruitment Target Implementation Date: 31 October 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
4	Medics Records testing Health Board electronic records are retained in set file structures for each employee, however the minimum supporting data required to be retained has not been defined – accordingly the folders varied in content. From our sample of twenty overseas employees, the passport retained on file had expired for one medic. The Overseas Recruitment team were able to locate a copy of the new passport from emails, and this was placed in the electronic folder.	Incomplete records resulting in gaps and incorrect reporting. Illegal working Reputational risk	Agreed Action: A minimum document checklist for overseas recruitment files will be developed and implemented. A quality assurance review of a sample of overseas recruitment files will be undertaken quarterly to ensure required documentation is present and current.
			Expected Evidence of Implementation: - Document checklist. - QA records. - Sample review results.
		Medium Priority	Officer: Head of Recruitment Target Implementation Date: 31 October 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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



Cancer Referral Rates

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

ABU-2526-17

April - May 2026

Leanne Watkins, Chief Operating Officer

June 2026

Leanne Watkins, Chief Operating Officer

Stephen Chaney, Head of Internal Audit

Eifion Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

The purpose of the audit was to seek to determine if there are controls in place to monitor the referral of patients for cancer treatment in a timely and appropriate manner and identify any data anomalies, whilst adhering to NICE guidance.

Overview

We have concluded reasonable assurance on this area. In Wales, some 80% of cancer referrals are made by GPs with an all-Wales level conversion rate (i.e. cases that result in a positive cancer diagnosis) of 8%. At 7.8%, the Health Board’s GP referral conversion rate is close to this all-Wales average.

However, NICE guideline *NG12: Suspected cancer: recognition and referral* NG12 is designed to identify patients at a cancer risk of $\geq 3\%$, and against this, the relatively high conversion rate seen nationally and at health board level may indicate conservative application of referral thresholds. This audit did not include further analysis to ensure that eligible lower-risk patients are not being inappropriately excluded from the pathway, e.g. through a review of emergency presentations, stage at diagnosis, and tumour-site-level variation.

The matters found in this review requiring management attention include:

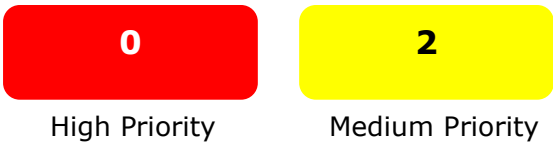
- an absence of Health Board procedure documents for staff involved in cancer care that incorporates cancer referral guidance.
- lack of formalised consistent recording, analysis or reporting of the GP referred cases rejected by secondary care.

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

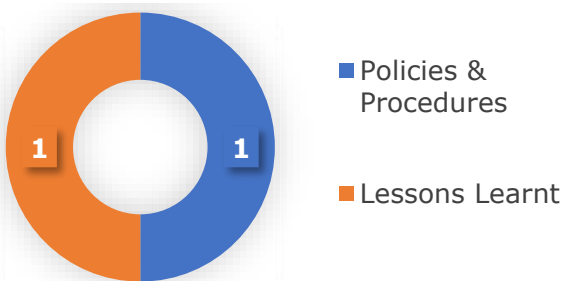
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	the Health Board follows the national suspected cancer pathway model used across NHS Wales for identifying and treating cancer cases	1	Substantial
2	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.	2	Reasonable

Management Actions



Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: the Health Board follows the national suspected cancer pathway model used across NHS Wales for identifying and treating cancer cases	Substantial

Overview / Summary of Observations

In England and Wales, healthcare professionals are provided clear, nationally agreed guidance on when to refer patients for suspected cancer, primarily through the NICE guideline *NG12: Suspected cancer: recognition and referral*. This guidance is aimed mainly at GPs and primary care clinicians but is relevant to all clinicians involved in early cancer detection.

It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian. However, when exercising their judgement, professionals and practitioners are expected to take this guideline fully into account.

Standard Operating Procedures (SOP) and Health Board Training Materials

We were informed that the NG12 guidance is widely known in the GP and Primary Care community and is included in GPs structured three year training programmes (this and other related clinical training was not in the scope of this audit), we noted an absence of health board specific procedure documents for staff involved in cancer care that incorporate cancer referral guidance (**Finding 1**). Whilst included as a medium priority finding, the action focuses on strengthening the internal procedures, which is separate to the audit objective, but should still support the overall process.

We noted too that currently there are no formal Health Board training materials or programmes being delivered to clinical administrative staff covering cancer referral protocols. However, we were advised that this is to be addressed in the 'Cancer Operational and Accountability Framework' (the 'Framework'). The Framework, currently being developed by Cancer Services, will apply to all clinical administrative staff and services relating to urgent suspected cancer across the Health Board. It will also set out the principles and guiding rules for managing patients through their pathway and staff training arrangements.

SCP Performance

Welsh Government '*Guidelines for Managing Patients on the Suspected Cancer Pathway (WHC (2024) 07)*' provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the different cancer waiting time targets that it defines. We noted the Health Board operates case-by-case progress tracking, with oversight, reporting and monitoring at both a local and an all-Wales level. Primarily a performance guideline, we reviewed the materials evidencing this activity but did not perform any substantive testing in this area.

Key Findings		Risk & Impact	Agreed Management Action
1	Standard Operating Procedures (SOP) We noted an absence of Health Board procedure documents incorporating cancer referral guidance for staff involved in cancer care. Additionally, appropriate training should be provided to relevant staff – which is currently planned for roll-out as part of the 'Cancer Operational and Accountability Framework'.	Risk of inconsistent referral practices.	Agreed Action: 1. Cancer Operation and Accountability Framework currently in development where training programme will form an important element of the document. 2. Materials for clinical administration staff (all levels) will be developed alongside the training programme.
			Expected Evidence of Implementation: • Document exists and is approved • Staff have been trained • Materials are accessible and used • Practice has actually changed / is being monitored
		Medium Priority	
Theme: Policies & Procedures		Control Design	Officer: Cancer Services Manager Target Implementation Date: 31 October 2026

Objective 2: 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.

Reasonable

Overview / Summary of Observations

NICE guidance NG12 *Suspected cancer: recognition and referral* details cancer referral thresholds in the context of 'conversion' rates, this being the percentage of suspected cancer referrals that result in a confirmed cancer diagnosis. The clinical referral threshold of 3% it sets refers to the probability that a patient presenting with certain symptoms or signs has cancer. Where these are present, patients should be urgently referred or investigated. The premise is that where patient assessment protocols set out in NG12 are applied as intended, this will result in a referral conversion rate of 3%.

The 3% risk comes from research evidence on symptom combinations, age, sex and risk factors and NICE embeds these thresholds into specific symptom-based referral criteria throughout the NG12 guidance document.

Regarding the potential influences of population size, age profile, deprivation levels, environment category etc., we noted there are no operational or population-based modifiers to the 3% threshold included in the guidance. Whilst it implicitly acknowledges variations of age and sex by embedding these factors into the risk evidence behind its symptom-based recommendations, deprivation, population size, and environment categories are not incorporated in this way and therefore may impact consequent conversion rates.

Referral Activity Outcomes

There is a lack of published referral conversion rate statistics for the health boards of Wales, but we note that for GP referrals, the Health Board's own records evidence a referral conversion rate of 7.8% (2025 data), which is consistent with the all-Wales value of c.8% referenced within the report, Cancer Services in Wales Jan 2025, Audit Wales.

Referral conversion rate monitoring

We noted that within the Health Board, referral conversion rates are not reported against targets and are not generally otherwise challenged. Oversight groups/ activities in operation in the Health Board include the following:

- monthly meetings of the Health Board's Cancer Board;
- fortnightly cancer assurance meetings with the different Health Board services involved with the provision of cancer care; and
- monthly submission by the Health Board of a cancer update to Welsh Government.

Additionally, all the health boards of Wales submit their cancer services data centrally and NHS Performance and Improvement (P&I) Cancer Resources contain a number of useful resources and links to support oversight and improvement of the Suspected Cancer Pathway (SCP).

We noted that oversight monitoring through these bodies/ activities focusses mainly on SCP performance (e.g. case progress against SCP waiting targets) and that referral conversion rates are not a standing agenda item in any of these, only examined by exception, if at all. In response to our enquiries in this area, we are advised that NHS P&I are preparing to produce all-Wales referral conversion statistics by mid-2026/27.

Referral screening/ vetting process

We noted that a process of screening/ vetting of GP referrals is operated within the Health Board. Referral 'vetting' is conducted by consultants and more recently by their support 'interface GPs'. Through this process, cases can be upgraded or downgraded, or if referral criteria are not met, are rejected and returned to the referring GP (rejected cases are appropriately removed from the referral count to avoid skewing the

conversion rate metrics). Regarding the latter, we were advised that whilst this is an area where change in practices could provide benefits, there is no formalised consistent recording, analysis or reporting of the rejected cases (**Finding 2**).

Key Findings		Risk & Impact	Agreed Management Action
2	Analysis and reporting of rejected referrals We noted that there is no formalised consistent recording, analysis or reporting of the GP referred cases rejected through the screening/ vetting process operated by the Health Board and this may mean opportunities to make improvements to the related workflows are missed.	Risk of ongoing excessive referral of cases that do not meet the referral criteria.	Agreed Action: 1. Establish current practices when rejecting referrals. 2. To identify an appropriate and robust method of recording rejected primary care referred cases. 3. Provide guidance to clinicians when rejecting referrals. 4. Aim to provide regular reporting of rejected referral rates/reasons.
			Expected Evidence of Implementation: • Documented process / SOP showing how rejected referrals are handled (including identified current practice and agreed standard approach) • Clinician guidance (published document or templates) setting out clear rejection criteria and standard wording • Regular reports or dashboards showing: ○ number/percentage of rejected referrals ○ reasons for rejection ○ trends over time
	Theme: Lessons Learnt	Medium Priority Control Operation	Officer: Cancer Services Manager 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, 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 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.



Aneurin Bevan University Health Board – Audit Committee Update

Date issued: June 2026



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Performance audit update	6
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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 April 2026.

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 began 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

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:** Report in clearance
- **Expected committee date:** September 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:** drafting report
- **Expected committee date:** September 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations.
- **Status:** Planning
- **Expected committee date:** November 2026

Review of the management and prevention of diabetes

- **Executive Lead:** Medical Director
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but 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.
- **Status:** Planning
- **Expected committee date:** March 2027

Local work – Operating Theatre efficiency and effectiveness

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work will focus on the management of operating theatres and the extent that arrangements support efficient, effective and good quality services.
- **Status:** Planning
- **Expected committee date:** March 2027

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>NHS planned care – fit for the future?</u>	June 2026

Since the last committee update, Audit Wales has not published any new corporate documents.

<u>Strategic Equality Plan 2026-2030</u>	April 2026

There are no relevant Audit Wales consultations currently underway

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



[Data tools](#) to help you better understand public spending trends.



Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.



Our [newsletter](#) which provides you with regular updates on our public service audit work, good practice, and events.



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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.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	23 June 2026
CYFARFOD O: MEETING OF:	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit, Risk and Assurance Committee - Review of Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Audit, Risk and Assurance Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2026/27 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

Across the 2026/27 financial year, the Committee has received all items as scheduled in its Forward Work Plan.

Asesiad / Assessment

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work plan have been included.

Between May 2026 and June 2026 there have been two amendment made to the forward work programme – inclusion of item - **Management actions and implementation dates within the GUH Extension report be updated to enable effective tracking.** To be actioned by Head of Internal Audit

And inclusion of item – **Report Process for Managing and Approving Extensions.** To be actioned by the Director of Corporate Governance

Argymhelliad / Recommendation

The Committee is requested to

- **NOTE** the updated Committee forward work plan as provided in **Appendix 1.**

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	Not Applicable Choose an item. Choose an item. Choose an item.

**Gwybodaeth Ychwanegol:
Further Information:**

Ar sail tystiolaeth:
Evidence Base:

N/A

Rhestr Termau:
Glossary of Terms:

N/A

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

N/A

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

Resource Assessment:

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

• **Workforce**

Not Applicable

• **Service Activity & Performance**

Not Applicable

• **Financial**

Not Applicable

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

No does not meet requirements

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

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

Not Applicable
Choose an item.

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

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		✓D		✓	✓	
Review of Standing Orders, Standing Financial Instructions, and Scheme of Delegation	An	DofCG						✓
Audit Recommendations Tracking Report (April-June, July-September, October-December, January-March.)	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	✓		✓	✓	✓	
Report Process for Managing and Approving Extensions	An	DofCG				✓		

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
Financial Governance and Control								
Report of the use of Single Tender Action	SI	DofF&P	√			√	√	
Report of Losses and Special Payments <i>(May report will be included in the Accounts)</i>	BI	DofF&P	√	√			√	
To Approve Reviewed and Updated Financial Control Procedures	Ad hoc	DofF&P	√		√	√	√	
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	An	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			√	√		√

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
Post Payment Verification								
Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26	An	PPV Manager			√			
Receive a Mid-Year update in respect of Post-Payment Verification Activity	An	PPV Manager					√	
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	√					
Input clear numerical implementation dates against recommendations in the Capital Projects Report.	SI	HofIA			√			
Management actions and implementation dates within the GUH Extension report be updated to enable effective tracking ensuring clarity around actions taken or to be taken	SI	HofIA			√			
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	√	√	√	√	√	√

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
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								
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	21	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

Charitable Funds

Final Internal Audit Brief

Aneurin Bevan University Health Board



GIG
CYMRU
NHS
WALES

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

Charitable Funds is the term given to money that is donated to the Health Board and which is administered through a registered charity, Aneurin Bevan University Health Board Charitable Fund and Other Related Charities. The Health Board is the Corporate Trustee of the Charity and has appointed the Charitable Funds Committee to oversee the management of its funds. The Committee ensures proper stewardship, investment management, and compliance with charity law. Its purpose is to manage money donated, bequeathed, or raised for the benefit of patients, staff, and services across the Health Board.

The Health Board has worked with Churches, Charities and Local Authorities Investment Management (CCLA) since 2018. CCLA are appointed to manage investments in accordance with the Health Board’s ethical, environmental and investment objectives and ensure that they are not in contravention of the aims of the Charity.

The total income for the year 2024/25 confirmed in the audited accounts submitted to the Charity Commission was £795,000 which comprised of donations and legacies (£413,000), charitable activities (£193,000) and investment income (£189,000). For the same period, the movement in funds was £820k with closing funds of £4.944m.

Scope, Risks & Approach

Scope	To assesses the adequacy and effectiveness of key controls over donations, restricted funds, financial reporting, and decision-making by the Charitable Funds Committee. Objectives of the area under review: 1. Confirm whether decisions in respect of charitable funds are transparent, well governed, evidence based, and compliant with key charitable funds policies. 2. Assess whether controls ensure donations are received, recorded, safeguarded, and designated in line with donor intent. 3. Charitable funds expenditure is appropriate, properly authorised and accurately recorded. 4. Evaluate whether restricted and delegated funds are correctly defined, monitored, and committed in accordance with donor intent and charitable objectives.
Associated risks	• Decisions made without sufficient evidence leading to poor value for money or misaligned spending donor restrictions not captured, resulting in funds being used for unintended purposes. • Unapproved or inappropriate expenditure breaches donor restrictions. • Failure to maximise charitable income opportunities. • Reputational damage, regulatory breach, or loss of public trust.
Limitations to scope	The audit will not review the financial treatment/ reporting of charitable funds.
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
	Efficient	Information Leadership

Contacts & Timings

Client contacts	Robert Holcombe	Director of Finance & Procurement
	Rob Jones	Assistant Director of Finance – Financial Systems
	Gareth Lewis	Head of Financial Services & Accounting
	Alison Griffiths	Charitable Funds Manager
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Rhian Gard	Audit Manager
Indicative timings	Fieldwork	July 2026
	Debrief meeting	August 2026
	Audit Committee	T.B.C
Brief agreement	Robert Holcombe, Director of Finance, Procurement & Value 02.06.26	



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.

Job Evaluation

Final Internal Audit Brief

Aneurin Bevan University Health Board



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Gwasanaethau Archwilio a Sicrwydd
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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Introduction

Within the NHS, Job Evaluation (JE) is a fundamental component of the Agenda for Change pay system, which applies to more than one million staff covered by the *NHS Terms and Conditions of Service Handbook*.

The NHS Job Evaluation Scheme ensures that all posts are allocated to the appropriate pay band through a consistent and transparent job matching and evaluation process. This approach promotes fairness, consistency, and equality across the workforce. Aneurin Bevan University Health Board (the 'Health Board') is required to adhere to the standards and procedures set out in the *NHS Job Evaluation Handbook*.

Scope, Risks & Approach

Scope	To ensure the requirements of the NHS Job Evaluation Handbook are being applied in a fair, consistent and equitable manner by the Health Board. Objectives of the area under review: 1. The Health Board has appropriate policies and procedures in place, which set out the job evaluation process, roles and responsibilities, and promote fairness, consistency and equality for all members of staff. 2. Systems and processes for co-ordinating, monitoring and managing the evaluation of new posts, re-evaluations of changed posts and outcome review requests are compliant with policy. 3. Identified Job Matchers have received suitable training and support in relation to job matching, analysis, evaluation and outcome review requests. 4. Local consistency-checking arrangements are in place and align with the requirements of the NHS Job Evaluation Handbook,
Associated risks	• Lack of clarity regarding the process, resulting in the poor co-ordination of service provision and incorrect outcome decisions, potentially resulting in equal pay concerns; • Staff resources and skills are insufficient to operate the process correctly; and • The job evaluation process is not robust which undermines the integrity of the function leading to disputes and challenges over outcomes.
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
	Equitable Person Centred	Workforce Culture Leadership

Contacts & Timings

Client contacts	Sarah Simmonds Shelley Williams Cathy Brooks	Director of Workforce & Organisational Development Assistant Director of Workforce & OD Head of Workforce Planning
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	June 2026 July 2026 T.B.C
Brief agreement	Sarah Simmonds, Director of Workforce & Organisational Development 02.06.2026	



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