Audit, Risk and Assurance Committee
Main Meeting

Tuesday 15 September 2026, 09:30 - 12:00

Microsoft Teams

Agenda

1. Preliminary Matters

ARAC 20260915 Agenda Approved.pdf (3 pages)

1.1. Welcome and Introductions

Information *Chair*

1.2. Apologies for Absence

Information *Chair*

1.3. Declarations of Interest

Information *Chair*

1.4. Draft Minutes of the last Meeting held on 23rd June 2026

Decision *Chair*

ARAC 20260915 1.4 20260623 Minutes.pdf (16 pages)

1.5. Committee Action Log and Matters Arising

Decision *Chair*

ARAC 20260915 1.5 Action Log.pdf (3 pages)

2. Items for Approval/Ratification/Decision

Information

2.1. To Approve Reviewed and Updated Financial Control Procedures

Decision *Director of Finance and Procurement*

ARAC 20260915 2.1 Finance Governance Report - 15.09.26.pdf (8 pages)

2.2. To Receive Q1 Audit Recommendation Tracking Report

Decision *Director of Corporate Governance*

ARAC 20260915 2.2 Internal_External Audit Recommendations Cover Report.pdf (8 pages)
ARAC_20260915 2.2a _Appendix A_Deep Dive Report Extended Implememtation Dates.pdf (15 pages)
ARAC 20260915 2.2b Appendix B Completed.pdf (8 pages)
ARAC 20260915 2.2c Appendix C Revised Deadlines.pdf (6 pages)

2.2.1. To Receive Report for Managing and Approving Extensions

Decision *Director of Corporate Governance*

ARAC 20260915 2.2.1 ARAC_Review and Approval of Revised Audit Recommendations Procedure.pdf (6 pages)
ARAC 20260915 2.2.1a _Appendix A_V2 DRAFT Audit Recommendation Tracking Procedure September 26.pdf (20

pages)

3. Items for Discussion

3.1. To Receive and Discuss the Full Suite of Risk Management Documents:

Discussion *Director of Corporate Governance*

- Risk Management Framework
- Risk Management Procedure
- Risk Management Guidance Handbook
- Risk Appetite Statement

ARAC 20260915 3.1 _Review of the Health Board Risk Management Framework Documentation Prior to Board Approval.pdf (5 pages)
ARAC 20260915 3.1a Appendix A_DRAFT Risk Management and Assurance Framework July 26 v3.pdf (18 pages)
ARAC 20260915 3.1b Appendix B_DRAFT Risk Management Procedure July 26 v3.pdf (22 pages)
ARAC 20260915 3.1c Appendix C_DRAFT Updated Risk Assessment and Scoring Handbook July 26.pdf (14 pages)
ARAC 20260915 3.1d Appendix D_DRAFT Risk Appetite Statement_July 26 v2.pdf (12 pages)

3.2. To Receive Committee Risk and Assurance Report

Discussion *Director of Corporate Governance*

ARAC 20260915 3.2 _Strategic Risk Report_September 2026.pdf (8 pages)
ARAC 20260915 3.2a Appendix A_Strategic Risk and Assurance Dashboard 14.08.26.pdf (3 pages)
ARAC 20260915 3.2b _Appendix B_Revised Strategic Risk Descriptions For Endorsement.pdf (2 pages)

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

Discussion *Director of Finance and Procurement*

ARAC 20260915 3.3 - Single Tender Action Report - 01.04.2026 - 31.08 (1).pdf (6 pages)

3.4. To Receive a Progress Report on Counter Fraud Activity

Discussion *Head of Counter Fraud*

ARAC 20260915 3.4 Counter Fraud Mid Year Report September 2026 Final .pdf (9 pages)
ARAC 20260915 3.4a - Appendix 1 - Counter Fraud Mid Year Report.pdf (3 pages)
ARAC 20260915 3.4b - Appendix 2 - Counter Fraud Mid Year Report.pdf (2 pages)
ARAC 20260915 3.4c Appendix 3- Dr Extra Duties LPE Final Report.pdf (39 pages)
ARAC 20260915 3.4d - Appendix 4 - LPE agency nurse Final.pdf (7 pages)
ARAC 20260915 3.4e Appendix 5 - Fraud Action Plan - Impersonating a Nursing Professional.pdf (4 pages)

3.5. To Receive Internal Audit Progress Report

Discussion *Head of Internal Audit*

ARAC 20260915 3.5 ABUHB September 2026 Internal Audit Progress Report issued.pdf (7 pages)

3.6. To Receive Internal Audit Review Reports

Discussion *Head of Internal Audit*

- Falls Management Audit Report (reasonable)
- Satellite Radiotherapy – NHH (reasonable)

ARAC 20260915 3.6a ABUHB 2526-08 Final Falls Management IA Report .pdf (13 pages)
ARAC 20260915 3.6b FINAL Report SRU ABU-SSU-2526-28 .pdf (17 pages)

3.7. To Receive External Audit Progress Report 2025-26

Discussion *Audit Wales*

ARAC 20260915 3.7 ABUHB Audit Committee Update September 2026.pdf (10 pages)

3.8. To Receive External Audit Review Reports

Discussion *Audit Wales*

- Cancer Services

ARAC 20260915 3.8 Cancer Services.pdf (47 pages)

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4. Items for Information

Information

4.1. Update on Financial Grip and Control

Information *Director of Finance and Procurement*

ARAC 20260915 4.1 Grip Control ARAC Report 17.09.26.pdf (6 pages)
ARAC 20260915 4.1a Appendix 1 Financial_Grip_and_Control_Assurance_Report.pdf (17 pages)

4.2. Structured Assessment 2026 Audit Brief

Information *Audit Wales*

ARAC 20260915 4.2 Audit Brief - Structured Assessment 2026 (FINAL).pdf (19 pages)

4.3. Internal Audit Briefs:

Information *Head of Internal Audit*

- Vaccination Programme audit brief
- Policy Management audit brief
- Value and Sustainability audit brief
- Patient Experience audit brief

ARAC 20260915 4.3a ABUHB2627 19 Final IA Brief Vaccination Programme.pdf (4 pages)
ARAC 20260915 4.3b ABUHB 2627 01 Final Policy Management Audit Brief.pdf (4 pages)
ARAC 20260915 4.3c ABU-2627-07 Final IA Brief Value & Sustainability.pdf (3 pages)
ARAC 20260915 4.3d ABU-2627-10 Final Internal Audit Brief - Patient Experience.pdf (3 pages)

4.4. Review of Committee Programme of Business 2026/27

Information *Director of Corporate Governance*

ARAC 20260915 4.4 Committee Programme of Business.pdf (3 pages)
ARAC 20260915 4.4 Committee Programme of Business Appendix A.pdf (7 pages)

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5. Other Matters

Information *Chair*

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

Decision *Chair*

5.2. Any Other Urgent Business

Discussion *Chair*

5.3. Date of the Next Meeting: Tuesday 24th November 09.30-12.00

Information

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

AUDIT, RISK & ASSURANCE COMMITTEE MAIN MEETING AGENDA	
Date and Time	**Tuesday 15th September 09.30-12.00**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on 23rd June 2026	Attached	Chair
1.5	Committee Action Log and Matters Arising	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	To Approve Reviewed and Updated Financial Control Procedures	Attached	Director of Finance & Procurement
2.2	To Receive Q1 Audit Recommendation Tracking Report	Attached	Director of Corporate Governance
2.2.1	To Receive Report for Managing and Approving Extensions	Attached	Director of Corporate Governance
3	**ITEMS FOR DISCUSSION**		
3.1	To Receive and Discuss the Full Suite of Risk Management Documents: • Risk Management Framework • Risk Management Procedure • Risk Management Guidance Handbook • Risk Appetite Statement	Attached	Director of Corporate Governance

3.2	To Receive Committee Risk and Assurance Report	Attached	Director of Corporate Governance
3.3	To Receive Report on the use of Single Tender Action	Attached	Director of Finance and Procurement
3.4	To Receive a Progress Report on Counter Fraud Activity	Attached	Head of Counter Fraud
3.5	To Receive Internal Audit Progress Report	Attached	Head of Internal Audit
3.6	To Receive Internal Audit Review Reports • Falls Management Audit Report (reasonable) • Satellite Radiotherapy – NHH (reasonable)	Attached	Head of Internal Audit
3.7	To Receive External Audit Progress Report 2025-26	Attached	Audit Wales
3.8	To Receive External Audit Review Reports • Cancer Services	Attached	Audit Wales
4	**ITEMS FOR INFORMATION**		
4.1	Update on Financial Grip and Control	Attached	Director of Finance and Procurement
4.2	Structured Assessment 2026 Audit Brief	Attached	Audit Wales
4.3	Internal Audit Briefs: • Vaccination Programme audit brief • Policy Management audit brief • Value and Sustainability audit brief • Patient Experience audit brief	Attached	Head of Internal Audit
4.4	Review of Committee Programme of Business 2026/27	Attached	Director of Corporate Governance
5	**OTHER MATTERS**		

5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: **Tuesday 24th November 09.30-12.00**		

Motion to Exclude Members of the Public and the Press

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

BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MINUTES OF THE AUDIT, RISK AND ASSURANCE COMMITTEE

DATE OF MEETING	23rd June 2026 09.30-12.00
VENUE	Microsoft Teams

PRESENT	Iwan Jones, Chair
	Dafydd Vaughan, Vice Chair
	Neil Patrick, Independent Member
	Helen Cunningham, Independent Member
	Helen Sweetland, Independent Member
IN ATTENDANCE	Rani Dash, Director of Corporate Governance Rob Holcombe, Director of Finance and Procurement Robert Jones, Assistant Director of Finance Gareth Lewis, Head of Financial Services and Accounting 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 Lucy Windsor, Head of Corporate Risk and Assurance Amanda Legge, All Wales Post Payment Verification Manager Sara Jeremiah, Post Payment Verification Location Manager Leeanne Lewis, Assistant Director for Quality and Patient Safety Seema Srivastava, Medical Director Harry Morris, Committee Secretariat
APOLOGIES	None

Preliminary Matters	
ARAC 0623/01	**Welcome and Introductions** Iwan Jones (IW), Chair, welcomed everyone to the Committee.
ARAC 0623/02	**Apologies for Absence** Iwan Jones (IW), Chair, **NOTED** that there were no apologies received.
ARAC 0623/03	**Declarations of Interest** There were no Declarations of Interest to record.
ARAC 0623/04	**Minutes of the previous meeting** The minutes of the meeting held on the 19th May 2026 were agreed as a true and accurate record.
ARAC 0623/05	**Committee Action Log** The Committee reviewed the action log, noting actions completed, actions in progress, and actions not yet due.
ARAC 0623/06	**To Receive Clear Numerical Implementation Dates Against Recommendations in the Capital Projects Report** Stephen Chaney (SC), Head of Internal Audit, presented an update on previously reported audit recommendations relating to the Capital Projects and Grange University Hospital (GUH) Extension reviews. SC advised that, following further discussion between Internal Audit and management, the implementation dates associated with the outstanding recommendations had been revised to provide greater clarity and specificity, addressing concerns previously raised by the Committee regarding the lack of defined completion timescales. SC confirmed that updated timelines had been agreed with management and reflected within the audit tracker. The

	Committee was advised that one recommendation had required a revised completion date to align with the implementation of an updated policy, with the extension considered appropriate in the circumstances. SC further confirmed that Internal Audit had reviewed the revised timescales and considered them to be realistic, achievable and reflective of the work required to fully implement the recommendations. During discussion, the Committee sought assurance that the revised implementation dates had been set at an appropriately realistic level to minimise the need for further extensions whilst maintaining momentum in the delivery of the agreed actions. SC confirmed that the dates had been agreed following engagement with management and represented the best assessment of when implementation could reasonably be completed. The Committee **NOTED** the update and the inclusion of defined implementation dates and **ACCEPTED** the revised timelines associated with the audit actions.
ARAC 0623/07	**Management actions and implementation dates within the GUH Extension report be updated to enable effective tracking** Stephen Chaney (SC), Head of Internal Audit, provided an update on management actions and implementation dates relating to the Grange University Hospital (GUH) Extension report. SC advised that, in line with the discussion on the previous item, the outstanding audit actions had been reviewed and updated to include clearer and more specific implementation dates to support effective monitoring and reporting. SC reported that the revised timelines had been agreed with management and aligned, where appropriate, to key programme milestones and policy developments. The updated implementation dates had subsequently been incorporated into the audit tracker to provide greater transparency regarding progress against the recommendations. The Committee sought assurance that the revised timescales were realistic and achievable and would provide a robust basis for

	future monitoring. SC confirmed that the implementation dates had been agreed following engagement with management and reflected a realistic assessment of the work required to complete the actions. The Committee **NOTED** the update in respect of management actions and implementation dates within the GUH Extension report.
ITEMS FOR APPROVAL / RATIFICATION / DECISION	
ARAC 0623/08	**To Approve Reviewed and Updated Financial Control Procedures** Robert Jones (RJ), Assistant Director of Finance, presented the updated Financial Control Procedures. RJ advised that there were no significant policy changes to report and no items exceeding the threshold for escalation. It was noted that the updates primarily reflected minor technical amendments, including changes issued by Welsh Government, which had already been incorporated into the document. RJ outlined that an additional minor amendment relating to a change in contact details (email address) within the procedures had been identified shortly before the meeting. It was explained that, under normal governance arrangements, such changes would require full reapproval; however, given the administrative nature of the amendment, a more proportionate approach was proposed. The Committee considered the proposal and agreed that minor administrative updates, such as contact detail changes, did not alter the substance of the procedures and could be approved without requiring full resubmission through the governance process. It was noted that a revised approach to managing such updates would be explored. The Committee **APPROVED** the updated Financial Control Procedures, including the minor amendments discussed.
ITEMS FOR DISCUSSION	

ARAC 0623/09	**To Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)** Rani Dash (RD), Director of Corporate Governance, presented the updated Annual Report (Overview and Performance Section). RD advised that the report had been updated following feedback from the previous Committee meeting, as well as comments received from Welsh Government and Audit Wales. It was noted that feedback from Welsh Government had been minimal and had been incorporated into the revised version. RD confirmed that a slightly amended version of the report had been circulated to members shortly before the meeting, with changes limited to the inclusion of comparative end of year performance data and minor narrative updates within the Chief Executive's overview. RD provided assurance that these amendments were not material and did not alter the overall substance of the report. The Committee considered the updated report and noted that it had not significantly changed from the version previously reviewed. Assurance was provided that the performance data presented remained consistent and appropriately validated. The Committee did not raise any substantive comments on the report and accepted the assurance provided in respect of the minor amendments. The Committee **NOTED** the Annual Report (Overview and Performance Section) and **SUPPORTED** its progression as part of the overall Annual Report for Board consideration.
ARAC 0623/10	**To Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)** Rani Dash (RD), Director of Corporate Governance, presented the updated Accountability Report, including the Annual Governance Statement. RD advised that the report had been updated following feedback from the previous Committee meeting, as well as comments from Welsh Government and Audit Wales. It was

	noted that feedback received had been limited and no material issues had been identified. RD confirmed that the updated version reflected the required disclosures and remained consistent with the wider Annual Report. Assurance was provided that the amendments made were minor and did not alter the substance of the report. The Committee considered the report and did not raise any further comments. It was noted that the document aligned with expectations and reflected the organisation's governance arrangements appropriately. The Committee **NOTED** the updated Accountability Report, including the Annual Governance Statement, and **SUPPORTED** its progression as part of the overall Annual Report for Board consideration.
ARAC 0623/11	**To Review Draft/Final Annual Accounts and Financial Statements (Part 3)** Rob Holcombe (RH), Director of Finance and Procurement, introduced the item and invited Robert Jones (RJ), Assistant Director of Finance, to present the Annual Accounts and Financial Statements. RJ advised that the overall financial position remained unchanged from the draft version previously presented to the Committee. It was noted that a small number of minor adjustments had been made, largely relating to updates received after the initial submission and technical classification changes. RJ confirmed that the accounts represented a clean position, with no control issues identified and only minor, non-material amendments required. It was also confirmed that the accounts would be presented to the Board alongside a management representation letter confirming that no material changes had occurred since completion of the audit fieldwork. RH reflected positively on the process, noting effective collaboration with Audit Wales and a strong overall outcome for the year.

	The Committee considered the report and did not raise any questions. It was noted that the accounts were in a robust position and ready to be progressed to the Board for approval. The Committee **NOTED** the Annual Accounts and **SUPPORTED** their progression to the Board.
ARAC 0623/12	**Receive the Annual Head of Internal Audit Opinion (including Specialised)** Stephen Chaney (SC), Head of Internal Audit, presented the Annual Head of Internal Audit Opinion for 2025–26. SC confirmed that, following completion of the audit programme, an overall opinion of reasonable assurance had been provided in respect of the adequacy and effectiveness of the Health Board's governance, risk management and control arrangements. SC explained that the opinion was based on the full range of audit work undertaken during the year, together with wider organisational knowledge and insight from other assurance providers. It was noted that the opinion reflected both the findings of individual audits and the broader maturity of systems and controls across the organisation. SC highlighted that the opinion had been prepared in line with updated audit standards and contributed to the overall assurance framework supporting the Accountable Officer and the Board in assessing the effectiveness of internal controls. The Committee noted the conclusion of reasonable assurance and acknowledged the breadth of work undertaken to support this position. Appreciation was expressed for the engagement and cooperation across services in enabling completion of the audit programme. The Committee **NOTED** the Annual Head of Internal Audit Opinion.
ARAC 0623/13	**To Review Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation**

	Julie Rees (JR), Audit Wales, presented the Audit of Accounts report (ISA260), outlining the findings of the external audit undertaken for 2025–26. JR advised that the audit was substantially complete, with only final standard checks remaining, including confirmation of final signed versions, post-balance sheet review and completion of internal quality assurance processes. JR confirmed that Audit Wales intended to issue an unqualified "true and fair" opinion on the financial statements, alongside a qualified regularity opinion, consistent with previous years. It was noted that the qualification related to the Health Board's failure to meet its statutory financial duties, including the requirement to break even over a three-year period and the absence of an approved three-year Integrated Medium-Term Plan. JR reported that no significant issues had arisen from the audit and that there were no uncorrected misstatements. Any identified adjustments were minor and had been addressed appropriately. The report also set out the proposed management representation letter, which would be signed prior to Board approval, confirming that there had been no material changes since the completion of audit fieldwork. The Committee considered the findings and noted the overall positive audit outcome, recognising the limited level of adjustments required and the constructive engagement between the Health Board and Audit Wales. The Committee **NOTED** the Audit of Accounts report and the proposed audit opinions.
ARAC 0623/14	**Agree a recommendation to the Board in respect of the audited annual report and accounts** Iwan Jones (IJ), Chair, invited the Committee to consider whether it was content to recommend the audited Annual Report and Accounts to the Board for approval. The Committee noted the positive audit outcome, including the confirmation of an unqualified "true and fair" opinion on the

	financial statements, with only minor adjustments required. It was also noted that the overall process had been well managed, with effective collaboration between teams and Audit Wales throughout the audit period. The Committee acknowledged the significant work undertaken across the organisation to produce the Annual Report and Accounts and recognised the level of assurance provided through both internal and external audit processes. The Committee confirmed that it was content to proceed and **AGREED** to recommend the audited Annual Report and Accounts to the Board for approval.
ARAC 0623/15	**Annual Review of Risk Management Framework** Lucy Windsor (LW), Head of Corporate Risk and Assurance, presented the annual review of the Risk Management Framework. LW advised that the proposed revisions represented a significant step forward in the maturity of the Health Board's approach to risk management and assurance, with a stronger focus on evidencing the effectiveness of controls and associated assurances. LW outlined key developments within the updated framework, including the introduction of a revised risk assessment template to improve clarity between controls and assurances, and the inclusion of a risk maturity model to support consistent improvement across the organisation. It was also noted that a Risk Assessor's Handbook had been developed to support more robust and consistent risk assessments. The Committee welcomed the progress made and recognised the strengthening of the framework. Discussion focused on the need to ensure clearer linkage between risks, controls, assurances and resulting actions, and to improve visibility of how risks are actively managed and reduced. The Committee emphasised the importance of ensuring that the framework supported practical application within services and was not viewed as a static reporting tool.

	The Committee also highlighted the need to strengthen the integration between risk management, strategic planning and operational delivery, ensuring that actions within wider organisational plans were clearly aligned to mitigating identified risks. LW confirmed she would circulate the updated Risk Management Framework and supporting documents to Committee members ahead of submission to the Board. The Committee **NOTED** the Annual Review of the Risk Management Framework and **SUPPORTED** the proposed enhancements ahead of further refinement and Board approval.
ARAC 0623/16	**To Receive the Post Payment Verification Annual Report, including, the Annual Workplan for 2025-26** Amanda Legge (AL), Post Payment Verification Manager, presented the Post Payment Verification (PPV) Annual Report and outlined the planned programme of work. AL advised that routine verification visits had been completed during 2025–26, with activity reflecting both scheduled reviews and additional visits undertaken in response to service changes, including mergers and closures. AL reported that a significant number of visits had been undertaken across Wales, with a proportion relating to the Health Board. It was noted that some larger recoveries had been identified, primarily associated with claims data, and that training and support had been provided to practices where issues had arisen. AL highlighted that system changes had led to an increase in duplicate claims in certain areas, particularly in relation to vaccination payments. It was confirmed that actions had been taken to mitigate this risk, including system development and additional validation checks, alongside ongoing internal controls to prevent recurrence.

	The Committee discussed trends in claim activity and sought assurance that emerging risks were being identified and addressed. AL confirmed that trends were monitored across Wales and that targeted training and engagement activity, including roadshows where necessary, were undertaken where recurring issues are identified. The Committee noted the level of assurance provided and the ongoing work to strengthen controls and processes. The Committee **NOTED** the Post Payment Verification Annual Report and Annual Workplan.
ARAC 0623/17	**To Receive the Clinical Audit Activity Annual Report 2024 – 2025 and Agree the Clinical Audit Plan 2026 - 2027** Seema Srivastava (SS), Medical Director, introduced the item and invited Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, to present the Clinical Audit Annual Report and proposed Clinical Audit Plan. SS advised that the report outlined delivery of the clinical audit programme and highlighted ongoing work to strengthen governance and oversight arrangements. LL reported that clinical audit was aligned to national programmes, with an increasing focus on local priorities and a more risk-based approach to audit selection. It was noted that improvements had been made to governance processes, including clearer reporting routes and enhanced tracking of audit activity, action plans and re-audit processes. The Committee acknowledged the progress made; however, a detailed discussion took place regarding the effectiveness of scrutiny arrangements. The Committee raised concerns that there was no evidence of audit findings being sufficiently challenged or progressed, and that there was no evidence of the completeness of prior year actions. The Committee emphasised that this indicated a need for stronger accountability and more robust follow-through of actions.

	The Committee also discussed the balance between nationally mandated audits and locally determined audit activity. No local audit plan was included within the plan. It was emphasised that, while compliance with national requirements was essential, sufficient focus must be given to local risks to ensure that audit activity delivers meaningful improvement. The Chair expressed concern that as raised during previous updates, the current arrangements risked audit becoming a reporting exercise rather than a driver for improvement. The Committee highlighted the importance of ensuring that audit outputs result in tangible change, supported by clear ownership of actions and effective escalation where progress is not made. Further discussion highlighted the need to strengthen executive oversight of clinical audit, with greater visibility and challenge at Executive level to ensure that issues are prioritised and addressed in a timely manner. The Committee **NOTED** the Clinical Audit Annual Report and **APPROVED** the National Clinical Audit Plan for 2026–2027 but expressed concern that again there was no local audit plan or log of outstanding audit actions. SS to undertake a review of outstanding clinical audit actions, including those from previous years, and ensure a clear plan is in place for progression and closure through appropriate governance structures. **ACTION: Medical Director** It was agreed that concerns regarding clinical audit scrutiny, including the management of longstanding audit actions, would be escalated to Executive Committee and PQSOC, with a further update provided to the Committee on how executive-level and committee oversight will be strengthened.
ARAC 0623/18	**To Receive Internal Audit Progress Report** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit Progress Report, providing an update on delivery of

	the 2026–27 internal audit programme. SC advised that work was progressing in line with the agreed plan, with audits being completed as scheduled and no significant issues arising that would impact delivery of the overall programme. SC highlighted that the audit plan continued to be delivered using a risk-based approach, retaining sufficient flexibility to respond to emerging risks and organisational priorities. It was noted that engagement with services remained positive, supporting timely completion of audit work and progression of recommendations. The Committee considered the report and noted the progress made to date. Assurance was provided that the internal audit programme remained on track and continued to align with key organisational risks. The Committee **NOTED** the Internal Audit Progress Report.
ARAC 0623/19	**To Receive Internal Audit Reports** Stephen Chaney (SC), Head of Internal Audit, presented the Internal Audit reports, including Overseas Recruitment and Cancer Referral Rates. **Overseas Recruitment** SC outlined the findings of the Overseas Recruitment review, noting that the audit provided assurance over arrangements supporting international recruitment activity. While overall processes were found to be in place, a number of improvement areas were identified, including strengthening consistency of documentation, governance oversight and financial tracking. The Committee discussed the scale and strategic importance of overseas recruitment and emphasised the need for robust governance arrangements to ensure transparency, consistency and effective oversight. The Committee sought assurance that identified improvements would be addressed in a timely manner and embedded within existing processes.

	The Committee **NOTED** the Overseas Recruitment Internal Audit report. **Cancer Referral Rates** SC presented the Cancer Referral Rates audit, outlining findings relating to referral processes and data quality. It was noted that improvements were required to strengthen the accuracy and consistency of data recording and to support more effective monitoring of referral activity. The Committee discussed the importance of reliable data in understanding demand, performance and patient pathways. It was emphasised that strengthening data quality and oversight would support improved decision-making and service planning. The Committee sought assurance that the identified issues would be addressed through clear actions and ongoing monitoring. The Committee **NOTED** the Cancer Referral Rates Internal Audit report.
ARAC 0623/20	**Receive External Audit Progress Report 2025-26** Sara Utley (SU), Audit Wales, presented the External Audit Progress Report, providing an update on the programme of external audit work for 2025–26. SU advised that the report set out the status of current and planned audit work, including both financial and performance audit activity. SU informed the Committee that the audit of the annual accounts had progressed as planned and was nearing completion, with a positive outcome reported under earlier agenda items. It was also noted that a number of performance audit reviews were ongoing, with further reports expected to be presented to the Committee in due course. The Committee considered the report and noted the breadth of audit work being undertaken by Audit Wales. Assurance was provided that work was progressing in line with agreed plans and

	timescales, and that no new significant issues had been identified. The Committee acknowledged the ongoing work programme and the assurance provided through external audit activity. The Committee **NOTED** the External Audit Progress Report.
ITEMS FOR INFORMATION	
ARAC 0623/21	**Review of 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 0623/22	**Internal Audit Brief** The Committee received the Internal Audit Brief for information. The Committee **NOTED** the Internal Audit Brief.
OTHER MATTERS	
ARAC 0623/23	**Items to be Brought to the Attention of the Board and Other Committees** The Committee considered whether any items required escalation. The Committee **NOTED** that concerns regarding clinical audit scrutiny would be escalated through existing governance arrangements (PQSOC).
ARAC 0623/24	**Any Other Urgent Business** There were no further items raised for discussion.
ARAC 0623/25	**Date of the Next Meeting:** 15th September 2026 09:30

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

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

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	**COMPLETED** Included on the September 2026 Agenda.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**ARAC 0623/17**	**Undertake a review of outstanding clinical audit actions, including those from previous years** Complete a comprehensive review of all open clinical audit actions, with particular focus on longstanding actions. Confirm ownership, progress and relevance of each action, and develop clear plans for completion or closure where appropriate.	Medical Director	November 2026	**In Progress** Deferred to November's Meeting as it needs to go through the Quality Governance structure before being presented to ARAC
June 2026	**Email from Lucy 31/07**	**To develop and share with the Committee a Local (Corporate) Clinical Audit Plan for Approval**	Medical Director	November 2026	**In Progress** Deferred to November's Meeting as it needs to go through the Quality Governance structure before being presented to ARAC

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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 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	Scheduled for Nov 26
Patients' Travel Costs Policy	26/27	Y	Nov-23	28-Nov-26	Scheduled for Nov 26
Cash and Bank	26/27	Y	Nov-23	28-Nov-26	Scheduled for 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	
FMS General Ledger	29/30	Y	Apr-26	28-Apr-29	
Commissioning Non NHS Clinical Services	29/30	Y	Apr-23	18-Apr-26	

2. Technical Accounting Issues

Technical updates

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

Update Note 1 for 2026/27 covered additional information for the Right of Use (RoU) revaluation as part of the quinquennial revaluation exercise which is to be applied from the 2027/28 Financial Year. the following area:

- **Transitional Arrangements**

The new valuation regime requires Property, Plant & Equipment is revalued every 5 years. The transitional requirements bring forward previous revaluations and note the maximum period between revaluations must not exceed 5 years.

- **Impact of Quinquennial on RoU Assets – Peppercorn and Market Value Leases**

Peppercorn RoU Assets will form part of the quinquennial revaluation exercise.

In practice, in most cases, the cost measurement model in IFRS 16 will be an appropriate proxy for current value in existing use or fair value for market value RoU assets.

However, for some right-of-use assets, the cost model in IFRS 16 will not be an appropriate proxy for current value in existing use or fair value. This is likely when the following conditions are met:

- A longer-term lease has no terms that require lease payments to be updated for market conditions, or if there is a significant period of time between updates (such as rent reviews); and
- The fair value or current value in existing use of the underlying asset is likely to fluctuate significantly due to changes in market prices.

The assessment of whether cost is an appropriate proxy for current value in existing use or fair value needs to be performed on an asset-by-asset basis, and the Health Board must keep a record of this exercise for future information purposes.

- **RoU Asset Valuation Treatment between Quinquennials**

For all RoU assets valued at current value in existing use, as part of the quinquennial exercise (peppercorn and market value), organisations need to follow the HMT recommended approach and undertake a desktop revaluation at year 3 of the 5-year revaluation cycle in 2028-29, and therefore not index in between revaluations.

3. Public Sector Payment Policy (PSPP)

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

Category	Invoices	In Mth %	YTD %
NHS	Value	99.8	99.6
	Number	97.1	96.2
Non-NHS	Value	96.8	96.6
	Number	98.1	97.3

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 July and cumulatively for the 2026/27 financial year.

Historical Late Payment Claims

Despite strong performance against the PSPP target during the current financial year, the Health Board has recently received claims relating to historical invoice payments that fell outside the required payment period.

Specifically, the Health Board received claims from two separate suppliers seeking payment of statutory interest and compensation in respect of historical invoices that had been paid outside the 30-day payment period required under PSPP payment terms. Both suppliers were represented by the same specialist organisation, Nobu Statutory Ltd, acting on their behalf in pursuing recovery of late payment charges.

Following receipt of the claims, the Finance Team undertook a detailed validation exercise to verify the invoices concerned, payment histories and the calculation of the associated interest and compensation.

The table below summarises the volume and value of the two late payment claims received by the Health Board and subsequently settled following review by the Finance Team.

Supplier	No. of Invoices Included in Claim	Total Interest & Compensation Claimed (£)	No. of Invoices Validated as Paid Late	Total Claim Agreed (£)	Total Settlement Paid (£)
Altrix Technology Ltd	2,144	89,897	1,376	56,143	50,000
Vyaire Ltd	16	881	16	881	881

Under the Late Payment of Commercial Debts legislation, suppliers are entitled to claim statutory interest at 8% above the Bank of England base rate, together with fixed compensation of £40, £70 or £100 per invoice, depending on the invoice value. The validated claims comprised both statutory interest and compensation charges, with the latter reflecting the number of invoices included within the claims.

Claimant 1 – Altrix Technology Ltd

Altrix Technology Ltd, a Nurse Agency supplier, claimed 2,144 invoices had been paid late between May 2021 and June 2023. Interest and Compensation claimed on these invoices totalled £89,897.

As part of the Finance team review of these invoices, it was identified that a significant number (768) had in fact been paid in time, based on the 30 day payment terms, and therefore this amount was disputed. Whilst all other invoices were validated as paid late, the Health Board were able to negotiate with Nobu to reduce the settlement amount to be paid to £50,000.

Adding further context to this claim, a large volume of these invoices (571) related to payments a single day late, with payments processed for BACS before their due date, but actually being received by the claimant one day after. Therefore a significant portion of the settlement relates to the compensation element in preference to the interest.

	Volume	Interest	Compensation	Value
Initial Claim	2,144	4,046	85,850	89,897
Less				
Not late	768	3,053	30,700	33,753
Remaining claim				
1 Day Late	571	89	22,900	22,989
2+ days late	197	904	32,250	33,154
Total claim lodged by the claimant				**56,143**
Settlement agreed mutually				**50,000**

Claimant 2 – Vuaire Ltd

Vyaire Ltd, a Medical Equipment products supplier, claimed 16 invoices had been paid late between November 2020 and September 2023. Interest and Compensation claimed on these invoices totalled £881. The review of theses invoices confirmed the claims to be valid.

Following agreement of the settlement amounts to be paid the resulting payments have been processed by the Health Board namely:

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Supplier	Total Settlement Paid (£)
Altrix Technology Ltd	50,000
Vyaire Ltd	881

The financial impact of the total settlement paid has been recognised within the Health Board's current year financial position.

Whilst no further liability is currently anticipated in relation to these validated claims, there remains a risk that additional claims may be received in the future, particularly if the specialist organisation has engaged with other suppliers and undertakes similar reviews of historical payment records.

To mitigate this risk, it is recommended that the Health Board continues to strengthen compliance with PSPP payment performance targets, maintains regular monitoring and reporting of payment timeliness, and undertakes a review of historical payment data to assess any potential exposure to further claims. The Health Board will continue to monitor this risk and assess any future claims as they arise.

4. Payments in Excess of £100K

There were no exceptional issues to report.

5. Standing Financial Instructions

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

Argymhelliad / Recommendation

The Audit, Risk and Assurance Committee is asked to note the settlement of the validated claims and the associated financial impact, and to support the continued monitoring of payment performance and assessment of potential exposure to future claims arising from historical late payments.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.5 Record Keeping Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	FCP – Financial Control Procedure ROU – Right of Use PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment: • **Workforce** • **Service Activity & Performance** • **Financial**	**Is EIA Required and included with this paper?** A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Not Applicable Yes, outlined within the paper Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements**

	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker Q1 Position
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance Risk and Assurance Officer

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit, Risk and Assurance Committee with an overview of the status of all internal and external audit recommendations as at the end of Quarter 1 2026/27 (1 April 2026 to 30 June 2026).

Updates were requested against 66 recommendations. This comprised 30 recommendations that had reached their original implementation date during the reporting period and 36 recommendations that had exceeded either their original or a previously revised implementation date.

In addition to obtaining a routine progress update against all 66 recommendations, a more in-depth review was undertaken of the 36 recommendations with overdue or extended implementation dates.

The in-depth review of the 36 recommendations were tested against a consistent framework covering continued relevance, achievement of the intended outcome, documentary or operating evidence, sustainability, residual risk and proportionality. The review distinguished completion of a finite audit action from wider service improvement, strategic delivery or residual risk that should continue to be managed through established governance arrangements.

Appendix A was shared with Internal Audit colleagues to sense-check the methodology, the proposed outcome and the action determined for each recommendation. Internal Audit considered the approach to be sensible and supported the outcome of all 36 recommendations.

Cefndir / Background

The previous report to the Committee (April 2026) covered the position to the end of Quarter **4** 2025/26. At that meeting:

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

This resulted in the Tracker containing **80** Live recommendations.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking

Since the report to the Committee in April, a further **33** recommendations have been added to the Tracker from Audit reports received at June's meeting.

The Tracker currently holds **113** live recommendations. Updates were requested against **66** recommendations:

- **30** that had reached their original implementation date by 30 June 2026; and,
- **36** that had exceeded their original or a previously revised implementation date.

Appendix A provides the in-depth analysis of the 36 overdue or extended recommendations. Appendices B and C provide the position against all 66 recommendations for which updates were requested.

Appendix B contains the recommendations proposed as completed, and Appendix C contains the recommendations for which revised implementation dates are proposed. Table 1 below summarises the overall position.

Table 1

Lead Director	Completed	Revised Deadline	Total Updates
Chief Operating Officer	13	2	**15**
Director of Digital	11	14	**25**
Director of Finance & Procurement	2	0	**2**
Director of Nursing	4	2	**6**
Director of Workforce and OD	2	1	**3**
Director of Allied Health Professions & Health Science	1	1	**2**
Director of Corporate Governance	3	2	**5**

Director of Planning, Strategy and Partnerships	2	4	**6**
Director of Public Health	1	0	**1**
Medical Director	0	1	**1**
Total updates this period	**39**	**27**	**66**

Table 2: Provides a summary of the 39 recommendations proposed as complete. Full details of these recommendations are set out in Appendix B.

Table 2

Completed Recommendations		
Audit Title	**Assurance Rating**	**Number by Priority Rating**
2020 IM&T Control & Risk Assessment	Not Rated	**2**
2021 IT Systems Controls (WRIS)	Reasonable	**4**
2021 Audit of Accounts Addendum	Not Rated	**1**
2023 Estates Condition	Limited	**1**
2024 Structured Assessment	Not Rated	**2**
2024 Mental Health and LD	Reasonable	1
2025 Quality Governance Follow Up	Not Rated	**1**
2025 Structured Assessment	Not Rated	**3**
2025 GMS Contract Challenges	Not Rated	**2**
2025 Digital Transformation	Not Rated	**5**
2025 Declarations of Interest	Substantial	**1**
2025 Newport East Health and Wellbeing Centre	Reasonable	**1**
2025 Subject Access Requests	Limited	**1**
2025 Directorate Review CAHMS	Reasonable	**2** **1**
2025 Occupational Health	Reasonable	**1**
2025 Cyber Security	Reasonable	**1** **2**
2025 Health and Safety	Limited	**1**
2025 Eye Care Review	Not Rated	2
2025 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	2

2026 Safeguarding	Reasonable	1			
2026 RGH Central Decontamination Unit	Reasonable	1			
TOTAL		**3**	**12**	**4**	**20**
		39			

Table 3: Provides a summary of the 27 recommendations for which revised implementation dates are proposed. Full details of these recommendations are set out in Appendix C.

Table 3

Recommendations with Revised Deadlines			
Audit Year and Title	**Assurance Rating**	**Number by Priority Rating**	
2023 IT Infrastructure	Reasonable	1	1
2024 Structured Assessment	Not Rated	1	
2024 Records Management	Limited	2	1
2024 Job Planning	Limited	1	
2024 Declarations of Interest	Substantial	1	
2024 Intelligence Led Organisation	Reasonable	1	1
2024 Medical Equipment and Devices	Reasonable	1	
2025 Eye Care Review	Not Rated	1	
2025 Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	1	
2025 Urgent and Emergency Care: Flow out of Hospital	Not Rated	1	
2025 GUH ED Extension	Limited	1	
2025 Business Continuity Planning	Reasonable	2	1
2025 Quality Governance Follow up	Not Rated	1	
2025 End of Life Care	Reasonable	1	
2025 Records Management	Limited	**1**	
2025 Technical Continuity	Reasonable	**1**	**1**
2025 EDRMS	Reasonable	**1**	**2**
2026 Subject Access Requests	Limited	**1**	
TOTAL		**10**	**11**	**1**	**5**
		27			

Extended Recommendations

In line with the updated approach set out in Item 2.2.1, Audit Recommendation Tracking Procedure, a specific review has been undertaken of recommendations that have received three or more extensions. Only five of the 74 recommendations fall within this category, representing significant progress in reducing the number subject to repeated extension requests.

These comprise three Records Management recommendations and two IT Infrastructure recommendations. The repeated extensions principally reflect capacity constraints, dependencies on wider organisational programmes, outstanding funding or governance decisions, and the time required to demonstrate that new controls and improvement arrangements are operating effectively and sustainably.

Substantive progress has been made against the Records Management recommendations, including enhanced induction and awareness training, ward engagement visits, the establishment of a Health Records Support Network, strengthened contingency arrangements and improved audit activity. Further work is required to formalise some elements, resolve dependencies relating to mandatory training and funding, and provide evidence of consistent and sustained implementation.

The IT Infrastructure recommendations have been affected primarily by resource constraints and are now being progressed through the Service Management Operational Change Programme. Given their extension history, they will remain subject to oversight to ensure delivery against clear milestones and the provision of appropriate evidence.

The strengthened quality assurance process for management responses, which continues to develop is intended to ensure that the actions to which the Health Board commits are SMART and supported by realistic and achievable implementation dates. Strengthening management responses at the outset should support delivery within the agreed timeframe and reduce the need for subsequent or repeated extensions.

Closing Position

Subject to approval of the completion of 39 recommendations, 74 recommendations will remain live on the Tracker. Of these, 47 remain within their original implementation date and 27 will have an approved revised date.

Number of Extensions	Number of Recommendations
5	1
4	1
3	2
2	2
1	21
0	47

Argymhelliad / Recommendation

The Audit, Risk & Assurance Committee is asked to:

- **APPROVE** the completion of **39** recommendations;
- **APPROVE 27** revised implementation deadlines.

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

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper

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


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

DEEP DIVE REPORT

Audit Recommendations with revised Implementation Dates

Review of relevance, implementation and proposed action

Status of this appendix: Provisional assessment for ARAC information and challenge. The proposed treatments have not been agreed by <u>all</u> relevant Lead Directors and do not amend the formal Quarter 1 tracker position as at 30 June 2026.

Purpose and decision required

This deep dive reviews 36 recommendations for which implementation dates have been extended. It provides an evidence-based assessment of whether each recommendation should close or remain on the Audit Tracker and identifies the governance safeguards that must apply to any closure decision.

Decision requested:

- Endorse the review methodology and proposed treatment of all 36 recommendations;
- Approve closure of the 9 recommendations assessed as having substantially achieved the original audit outcome, and agreed by the Executive Lead;
- Note that 27 recommendations will remain open;
- Require any recommendation that cannot satisfy the closure safeguards to remain open or be returned to the audit tracker; and,
- Note that closure of an audit recommendation does not constitute acceptance of unmanaged risk or completion of wider strategic, operational or improvement activity.

Summary

The review which has been undertaken by the Corporate Governance function, where there is potential for closure, the Executive Director, where possible has been approached for agreement of the assessment and treatment is accepted. Eight recommendations have substantially achieved the original audit outcome and are proposed for closure, subject to the safeguards in this report. Thirty recommendations still lack a specific control, approved product, completed implementation milestone or sufficient operating evidence and should remain open.

The approach avoids keeping finite historic actions open solely to monitor wider business activity, while ensuring that unresolved control weaknesses remain visible and accountable.

Treatment	Number	Basis
Close	9 formally approved by Executive Lead	Outcome substantially achieved; remaining activity is routine delivery or continuous improvement.

Treatment	Number	Basis
Transfer and close	0	Residual risk or delivery continues through a formal programme or risk route.
Remain open	27	Principal control or evidence remains incomplete.

Scope and methodology

The review considered the recommendation wording, priority, management response, expected evidence, original and revised deadlines, number of extensions, progress updates, barriers, national dependencies and the governance arrangements now described. It did not independently test the underlying evidence.

Proposed closure is therefore subject to management retaining the evidence identified in this report and Internal Audit or Audit Wales retaining their normal right to validate implementation

Test	Question
Relevance	Does the recommendation still reflect the current operating model, system or governance structure?
Outcome	Has the intended control or assurance outcome been substantially achieved?
Evidence	Is there documentary or operating evidence, rather than intention alone?
Sustainability	Is the control embedded in a repeatable process with an accountable owner?
Residual risk	If risk remains, is it explicitly recorded, controlled and escalated?
Proportionality	Would continued audit tracking add assurance, or duplicate established governance?

Governance safeguards for closure

The following safeguards should apply before any recommendation approved for closure is removed from active audit tracking:

- **Accountable owner confirmation**: the responsible Executive Director or delegated senior owner confirms that the original audit intent has been met and that the evidence accurately reflects the current position.

- **Outcome-based closure**: closure is based on achievement of the intended control or assurance outcome, not solely on completion of tasks, production of a document, passage of time or recording of a risk.

- **Operating evidence**: where the recommendation concerns a recurring control, proportionate evidence demonstrates that the control is operating in practice. Planned implementation or a newly approved process alone is not sufficient.

- **Residual risk:** any remaining risk is explicitly recorded, scored, assigned to an accountable owner and monitored through the appropriate risk and governance route. Transfer of risk monitoring is not treated as implementation of an incomplete audit action.

- **Clear onward governance:** any continuing delivery, improvement or benefits realisation is assigned to a named committee, programme, project or management forum, with defined reporting and escalation arrangements.

- **No loss of visibility:** closure does not remove material issues from organisational oversight. Where necessary, the Audit Tracker records the receiving governance route and reference before closure.

- **Evidence retention and independent validation rights:** the evidence relied upon for closure is available for review. Internal Audit and Audit Wales retain the right to review the evidence and challenge or reopen a recommendation where implementation cannot be substantiated or the control has not operated as described.

Detailed assessments of all recommendations on the Tracker that have requested extensions to original implementations dates.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
2020 – 21 Audit of Accounts Report, Addendum R1 **3rd Extension**	The recommendation required arrangements ensuring annual leave for all staff is accurately recorded and held centrally.	**Closure** Since January 2026, to meet the requirements of the new Resident Doctor Contract 2026 that was implemented from August 2026, medical e-rostering for Resident Grade Doctors has been rolled out at pace across the Health Board. Resident Doctor roll out has been prioritised during this period and although development work has continued for consultants the full roll out of Medical E-Rostering for Consultants will be delivered over the next 6-8 months.	**Executive Director of WOD has agreed closure** The systems and arrangements are in place and roll out across the medical workforce is progressing to completion. Medical and Dental Workforce Assurance Group has been established, which will provide greater governance around all M&D workforce matters.
2023 IT Infrastructure R2 **5th Extension**	The recommendation sought to ensure a set of formal procedure documentation and guides for managing the infrastructure should be defined.	**Remain Open** The latest update records no progress. Existing documentation alone does not demonstrate completeness, control, ownership or maintenance.	The recommendation should remain open on the Audit Tracker open until the controlled framework, gap assessment and priority documents are evidenced.
2023 IT Infrastructure R4 **3rd Extension**	The recommendation required alert thresholds to be configured so that relevant infrastructure issues are identified promptly.	**Remain Open** The latest update records no progress because of insufficient resources, with future delivery associated with organisational change.	The recommendation should remain open on the Audit Tracker open with a proportionate closure test focused first on critical infrastructure.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
2024 AW Structured Assessment R2.1 **2nd extension**	To improve the quality of Board and committee reporting by consistently presenting targets, benchmarks, milestones and a clear assessment of delivery.	**Remain Open** Templates and guidance have been developed but have not been formally implemented for use.	The recommendation should remain open on the Audit Tracker until the revised templates and guidance have been approved and a proportionate sample of Board or committee reports demonstrates that the required information is being presented consistently.
2024 AW Structured Assessment, R3.1 **2nd extension**	To establish a credible long-term financial plan aligned to the Health Board strategy and triangulated with service, workforce and outcome plans.	**Closure** The requirement to align strategic, service, workforce and financial planning has been absorbed into the Health Board planning architecture. The 2026/27 to 2028/29 Financial Recovery Plan has been approved by the Board & submitted to Welsh Government, and longer-term planning is aligned to the IMTP and long-term strategy.	**Executive Director of Finance has agreed closure** The delivery of the plan will be subject to governance monitoring through the Finance & Performance Committee and the Board.
2024 AW Structured Assessment, R3.2 **2nd extension**	To translate the long-term strategy into a deliverable route map with milestones, dependencies, resources, benefits and clear accountability.	**Closure** The purpose of the recommendation is now delivered through the IMTP, Financial Recovery Plan and delivery arrangements.	**Executive Director of Finance has agreed closure** Linked to 3.1. Strategic delivery should be monitored through established Board, committee and executive arrangements.
2024 End of Life Care R1.1 **1st Extension**	To establish a framework for capture, coordination and management of Future Care Planning documentation.	**Remain Open** Executive support has been given to develop functionality and adopt the All-Wales module, but the local	National developments should be monitored, but interim arrangements should be owned locally through the FCP workstream and relevant clinical governance.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
		guideline cannot yet be completed because digital processes remain uncertain. The core control identified by audit, a clear operating framework for documentation, access, sharing and review, is not yet in place.	
2024 Health and Safety R2.1 **1st Extension**	To review overdue health and safety policies and establish timely monitoring.	**Closure** All policies have been reviewed. Eight are compliant and four have completed Health and Safety Committee consideration, with final approval through the relevant Policy Approval Groups outstanding. The substantive review is complete and the remaining evidence readily obtainable.	**Executive Director of Allied Health Professions and Health Science has agreed closure.** Future review compliance should be monitored through the Health and Safety Committee and policy governance process.
2024 Records Management R2.1 **3rd Extension**	**Paper health records** The original recommendation sought to address poor filing, missing identifiers, overflowing records and documents for multiple patients in one record.	**Remain Open** A sustainable programme of induction, awareness, support and audit is now operating. Recent inpatient record audits show 94% compliance across five standards. Existing checks also consider identifiers and documents relating to multiple patients, but these two elements are not yet formally captured in reported results. Recording them will directly close the remaining evidence gap.	Continue tracking through the Audit Tracker until the two checks to the reported audit results have been captured.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
2024 Records Management R3.1 **4th Extension**	To ensure staff understand and consistently apply WPAS requirements for recording mental-capacity and Lasting Power of Attorney information.	**Remain Open** The proposed WPAS training solution has not been funded or implemented.	Continue tracking through the Audit Tracker until the updated training and guidance has been implemented and test a sample of records.
2024 Records Management R4.1 **1st Extension**	To establish regular ward spot checks and an Information Governance audit function capable of identifying and following up weaknesses in record keeping and data quality**.**	**Remain Open** The progress narrative concerns WPAS training and does not address ward spot checks or establishment of the Information Governance audit function.	Continue tracking through the Audit Tracker. Correct the tracker update and provide the agreed methodology, completed reviews and resulting audit reports.
2024 Records Management R7.1 **4th Extension**	To improve the reliability of ward-level arrangements for locating, transferring, tracking, scanning and safeguarding paper records, including during ward-clerk absence.	**Remain Open** Ward visits, the support network, induction content and contingency arrangements represent strong progress, but effectiveness across the specific record-flow failures has not yet been tested.	Continue tracking through the Audit Tracker. Provide sample audit results covering transfer, WPAS tracking, discharge, scanning, supplementary records and ward-clerk absence.
2024 Job Planning R2.2 **1st Extension**	To ensure every consultant job plan contains meaningful SMART personal and service outcomes before approval**.**	**Remain Open** Training and communications are in place, but the system control is not active and there is no evidence that incomplete job plans are prevented from approval.	Continue tracking through the Audit Tracker until functionality has been activated or an equivalent control has been implemented and complete sample testing.
2024 Technical Continuity R2.1 **1st Extension**	To provide reliable oversight of network-switch patching compliance so vulnerabilities are identified, prioritised and remediated.	**Remain open** The planned Cisco Smart Collector solution is being retired and the replacement, Cisco IQ, is not yet operational. The Health Board therefore cannot yet demonstrate	Continue tracking through the Audit Tracker until the replacement monitoring process has been implemented and evidence current compliance and remediation.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
		the compliance visibility sought by audit.	
2024 Technical Continuity R3.1 **1st Extension**	To maintain a complete service catalogue with agreed service tiers, recovery objectives and restoration priorities to support technical continuity.	**Remain Open** The catalogue is extensive but does not yet cover all digital services or demonstrate complete tiering, RTOs, RPOs and restoration priorities**.**	Continue tracking through the Audit Tracker until completion of the catalogue, ownership, tiers, RTOs, RPOs and restoration sequence.
2024 EDRMS R1.1 **1st Extension**	To ensure that the EDRMS and associated scanning solution are upgraded to supported, fit-for-purpose versions capable of meeting the Health Board's functional and interoperability requirements	**Remain Open** Linear eForms are already used, while future functionality is being addressed through a replacement eForms and workflow business case and through national applications. The issue is now a strategic digital transformation and investment dependency rather than a discrete remedial action. It should not be described as fully implemented, because outcome measures on paper reduction are not yet evidenced.	Continue tracking through the Audit Tracker until eForms has been implemented.
2024 EDRMS R2.1 **1st Extension**	To ensure that the Health Board's Electronic Document and Records Management System and associated scanning solution are upgraded to supported and fit-for-purpose versions, capable of providing the functionality and interoperability required by the organisation.	**Remain Open** Not implemented. Resource constraints within the CWS Software Development Team have delayed the API development required to progress the cCube version 4.4 upgrade, and no confirmed implementation date has been provided. In addition, the Capsure scanning software has reached end of life. Supplier support will continue	Continue tracking through the Audit Tracker until a solution has been implemented.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
		only until the end of March 2027, and a replacement solution remains subject to evaluation and approval. The expected evidence of successful implementation is therefore not available.	
2024 EDRMS R3.1 **1st Extension**	To remove the cyber security and operational exposure arising from hosting cCube on unsupported Windows Server 2012 R2, infrastructure by migrating the system to a supported operating environment.	**Remain Open** Not implemented, with an interim mitigation in place. Extended Security Updates have been applied and provide temporary security patching. However, cCube remains hosted on Windows Server 2012 R2, the version 4.4 upgrade has not been completed, and migration to a supported operating platform has not taken place. The Extended Security Update arrangement expires on 13 October 2026, after which the servers will no longer receive critical security patches.	Continue tracking through the Audit Tracker until migration of cCube has been completed
2024 Declarations of Interest R2.1 **1st Extension**	To ensure staff who are required to declare interests are identified, reminded and monitored through a consistent central process, with non-compliance visible and followed up.	**Remain Open** Awareness work, targeted communications and exploration of ESR are positive, but the central tracking, reminder, escalation and compliance-reporting process is not yet operating.	Continue tracking through the Audit Tracker until implemented.
2024 Mental Health and Learning Disabilities	To ensure long-term improvement actions are subject to detailed monitoring, constructive challenge, formal escalation and remediation when delivery falls behind	**Closure** The original intent of the recommendation has been met through established governance forums, performance dashboards	**Chief Operating Officer has agreed closure.** Future Internal Audit work may provide independent assurance on their continuing effectiveness.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
R2.1 **1st Extension**		and formal reporting routes that support detailed monitoring, constructive challenge, escalation and remedial action where delivery falls behind plan. These arrangements should identify and address any subsequent deterioration The division haS been de-escalated via the performance framework.	
2024 Intelligence Led Organisation R2.1 **1st Extension**	To establish clear organisational data-quality standards, accountabilities and independent assurance over compliance.	**Remain Open** The Data Quality Policy and proposed audit capacity have not been completed and remain dependent on organisational change	Continue tracking through the Audit Tracker until implemented.
2024 Intelligence Led Organisation R3.1 **1st Extension**	To provide consistent analytical standards and a visible quality mark so users can distinguish standard, assured information from locally defined outputs	**Remain Open** The strategy launch is preparatory. The Centre of Excellence, standards and kitemark are not yet evidenced as operating**.**	Continue tracking through the Audit Tracker until implemented.
2025 Medical Equipment and Devices R3.1 1st Extension	To clarify responsibilities and ensure all in-scope patient-connected devices have effective and evidenced maintenance arrangements.	**Remain Open** No progress or operating evidence is recorded against the agreed actions.	Retain until responsibilities, scope, baseline, divisional assurance and sample maintenance testing are complete.
2025 Eye Care Review R2.1 **1st Extension**	To secure an agreed regional resource plan defining the workforce and operational contribution required from each	**Remain Open** The workforce plan has been delayed. Programme oversight is	Continue tracking through the Audit Tracker until partner approval of the quantified regional resource plan has been complete.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
	partner to deliver the Eye Care strategy.	appropriate, but the specific deliverable remains incomplete.	
2025 Eye Care Review R4.1 **1st Extension**	The original recommendation sought to complete a Board-approved, demand-led, costed Eye Care Plan with capacity, resource, milestones and delivery actions.	**Closure** The latest position demonstrates substantive implementation: regional cataract pathways and productivity expectations are in place; capacity and productivity planning are active; theatre-list staggering is used; sustainability plans have been submitted; recruitment has progressed; digital infrastructure is largely deployed; and four task and finish groups report to the Eye Care Board. Unresolved pressures concern delivery of the plan, not absence of planning or governance	**Chief Operating Officer has agreed closure.** Monitor delivery through divisional governance processes.
2025 UEC: Arrangements for Managing Demand R5.1 **1st Extension**	To establish clear ownership and a reliable mechanism for keeping WAST Directory of Services information complete, accurate and current.	**Remain Open** Directory information is being reviewed and updated through Navigation Hub governance, but the current update still identifies unresolved central ownership and resource allocation.	Once an accountable lead and a reliable update mechanism have been confirmed, ongoing maintenance should transfer to Navigation Hub governance.
2025 UEC: Arrangements for Managing Demand R6.1	To ensure front-line staff and WAST can easily access complete, current and clearly owned referral pathways to alternative urgent-care services.	**Closure** The 24/7 single point of access provides an established route for referrals and advice. Flow Centre leads are reviewing pathways to ensure they are	**Chief Operating Officer has agreed closure.** Continue review through Urgent Care governance and manage exceptions through performance and risk routes as business as usual.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
1st Extension		accurate, owned, published and accessible. Work is monitored through the Urgent Care Division improvement plan and Our Next Patient programme. Pathway maintenance is continuous and is now embedded in operational governance.	
2025 UEC Flow out of Hospital R8.1 **1st Extension**	To improve timely, accurate and shared information across the Health Board and local authorities in support of discharge planning and system-flow decisions.	**Remain Open** Existing sharing processes and future IT developments are described, but no implemented improvement or evidence of effective joint information use is provided.	Implement and evidence the agreed information-sharing improvement, partner arrangements and information-governance controls.
2025 Quality Governance Follow-up R4.2 **1st Extension**	To ensure relevant staff complete Duty of Candour and Duty of Quality learning and that compliance is routinely monitored and reported.	**Remain Open** Duty of Candour arrangements are progressing, but Duty of Quality remains subject to approval and monitoring for both is not fully embedded.	Approve, assign and report compliance for both learning requirements
2025 Business Continuity Planning R1.1 **1st Extension**	To ensure local business-continuity plans are tested, action cards are usable and hard-copy arrangements remain available during disruption.	**Remain Open** Questionnaires, checks and planned exercises indicate progress, but completed tests and corrected action cards are not evidenced.	Provide exercise records, updated action cards, hard-copy assurance and audit reporting.
2025 Business Continuity Planning R2.1	To ensure divisional leads and key staff understand and can perform their business-continuity roles through role-specific training and local cascade.	**Remain Open** Digital downtime exercises and roadshows do not demonstrate identified leads,	Provide lead lists, training materials, attendance, cascade records and audit assurance.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
1st Extension		role-specific training and cascade coverage across all divisions.	
2025 Business Continuity Planning R3.1 **1st Extension**	To ensure current stakeholder contact information remains securely and readily available when electronic systems are unavailable.	**Remain Open** The update states what divisions must evidence rather than confirming resilient offline contact arrangements are operating.	Provide sampled folders, current lists, storage evidence and unannounced check results.
2025 Subject Access Requests R6.1 **1st Extension**	To ensure identity verification is consistently completed for every complaint and appeal case, with compliance monitored and exceptions corrected.	**Remain Open** The process is reported as operating, but the SOP is not formally approved and the required monthly audit is not evidenced. Future Civica functionality is not current operating evidence.	This is a specific control weakness that requires evidence of effective operation before closure. The recommendation should remain open on the Audit Tracker until implementation is demonstrated.
2025 Safeguarding R3.1 **1st Extension**	The original recommendation addressed the need to refresh the Safeguarding Strategy to reflect current activity, priorities, reporting and training requirements.	**Closure** The Safeguarding Strategic Group formally approved the roadmap and work plan which supersedes the need for a separate strategy	**Executive Director of Nursing has agreed closure.** The Safeguarding Strategic Group to monitor delivery against the roadmap and work plan.
2025 RGH Central Decontamination Unit R1.1 **1st Extension**	The original recommendation addressed the need to review material delay, liabilities and contractor claims, and capture lessons for future projects.	**Closure** Practical completion was achieved on 31 March 2026. Delay notices were reviewed through progress meetings, programme and risk reviews, project reports and Project Board oversight. The Cost Advisor tested claims against records, invoices, labour and plant evidence, considered	**Executive Director of Strategy, Planning and Partnerships has agreed closure** Conclude the final account through normal commercial governance and retain lessons within capital-project processes.

Audit detail and Recommendation Priority	Root Cause of the Finding and Recommendation	Proposed Treatment and Evidence	Continued Monitoring or Business as Usual
		mitigation and excluded contractor inefficiency. The final account is delayed by additional client-requested works, but this is a residual contractual matter rather than evidence that the audit action remains unimplemented.	
2025 GUH ED Extension, R9.1 **1st Extension**	The original recommendation sought to confirm when benefits measurement should begin and update the benefits realisation plan following Phase 2 delay.	**Remain Open** Phase 1 has delivered additional waiting capacity, enhanced triage and the Senior Rapid Assessment model, but full benefits are constrained by Phase 2 and system-wide flow pressures. The original response committed to a populated Benefits Realisation Model and reporting through PIP and Executive Committee. The schedule does not yet evidence that baseline, measures, ownership and reporting are in place.	The recommendation should remain open on the Audit Tracker until the BRM has been reported to PIP and Executive Committee; then consider closure with ongoing benefits monitoring transferred to programme governance.

Completed Recommendations - 39

Audit Type	Report Title	surance Rati	ble Executive	mendation F	mendation N	Recommendation	Management Response	esponsible Handl	al Completion De	osed Revised Dea	eadline accepted	l completion dat	ised Deadline St	er of Revised Tim	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	ion delayed by N
Internal Audit	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R6	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	Director of Digital	31/12/2022			Completed	Completed	5	Still awaiting completion of Internal Audit work		This recommendation arose from an advisory Internal Audit review undertaken in 2020/21 and was framed as a consideration regarding the suitability of the Health Board's informatics operating model. Given the age of the recommendation, the significant changes in the Health Board's digital operating environment since the report was issued, and the ongoing work currently being undertaken to review digital governance, operating arrangements and associated risks, it is proposed that the recommendation be closed.	
Internal Audit	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	N/A	R14	R6 Consideration should be given to the placement of all informatics provision and support across the Health Board. As part of this the current partially decentralised model should be re-assessed in terms of its suitability for the modern use of technology.	Accepted. Following the exec review of the Target Operating Framework and overarching governance will appraise the hybrid environment of departmental asset ownership, responsibility, risk management. As the report sets out this is a largely historical and organic model which will be complex to resolve in itself. A risk based approach will be adopted andan options paper will be developed forconsideration by the Board.	Director of Digital	31/12/2022			Completed	Completed	5			This recommendation arose from an advisory Internal Audit review undertaken in 2020/21 and was framed as a consideration regarding the suitability of the Health Board's informatics operating model. Given the age of the recommendation, the significant changes in the Health Board's digital operating environment since the report was issued, and the ongoing work currently being undertaken to review digital governance, operating arrangements and associated risks, it is proposed that the recommendation be closed.	
Internal Audit	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R10	R10 The WRIS backups should be subject to regular testing / restore to ensurevalidity.	A request to ensure that a process for regular testing of the back up to ensure their validity will be made.	PACS & RADIS Manager	30/04/2022			Completed	Completed	5	June 2025 - Same as previous RadIS is no longer being developed and the risk will remain until the new RIS is rolled out in ABUHB in line with our current go live date of 24/11/2025 April 2025 - Radis is no longer being developed with the RISP project with all resource being focused on the data migration and rolling up of the RadIS team. We are expected to go live with a new RIS to replace RadIS November 24th 2025 at the moment. The ABUHB RISP Project Board meet monthly and feed into a National Project Board on a monthly basis.January 2024: Please refer to completed assurance report. Nov 2023: WRIS backups with recent upgrade work proved to be reliable.	Aug 2023: Required scoping, testing and development and planned for software development Needs to be agreed locally and product developed to suit ABUHB	July 2026 - We have got a new RIS that has replaced RadIS so no longer an issue.	
Internal Audit	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R5	R5 The Board should investigate an electronic solution to uploading requests into WRIS.	Radiology have requested CWS to work with WCP for fully electronic requesting.	PACS & RADIS Manager	31/03/2022			Completed	Completed	5	June 2025- Software Development in ABUHB are developing an electronic request for that will integrate with the new RIS (Soliton) we will have as a part of RISP. The electronic request from CWS will cover all requests made in CWS in Secondary Care. This was planned for our go live date of 24/11/2025 but is no longer achievable and is planned for early stage of 2026. WCP are rolling out their electronic requesting solution through primary care and currently have 6 GP practices in ABUHB requesting electronically. This Risk will remain until we have the new RIS (Soliton) to replace RadIS and the electronic form has been developed by ABUHB in CWS and DHCW have completed the roll out in primary care with the WCP electronic form. June 2024- we are currently live in two GP practice using WCP's electronic requesting solution that integrates with our RIS so we it process the request electronically. We will be looking to roll this out in another two GP practices over the next 6 months. This is the chosen solution of RISP or whatever we currently have. There will be discussions with software development and the CCIO over the summer along with Philips and Soliton our new PACS/RIS providers to discuss true electronic requesting. Integrated electronic requesting was a part of RISP. The solution provided by Soliton the new RIS provider was not selected. There will be meetings between	Time and resource in RadIS. As well as pending RISP program may not help development.	July 2026 - currently using ~WCP within limited capacity in Primary Care until rolled out fully and WCP ETR has replaced CWS ETR until CWS2 ETR has been developed and rolled out. There is no requirement to integrated WCP ETR into CWS.	
Internal Audit	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R8	R8 The Health Boardshould request that this logging function be developed and should consider feeding WRIS events into the SIEM.	The health board have raised this at DHCW CAB along with other health boards. This is with DHCW to develop it is not in any Live RadIS version currently.	PACS & RADIS Manager	31/03/2022			Completed	Completed	5	June 2025 - RadIS is no longer being developed so this functionality will never be available in RadIS. The new RIS (Soliton) has a full and robust audit trail so this risk will remain until we have the new RIS. Aug 2024: There is no adequate audit functionality within RadIS and with the product being soon end of life there will be no solution until the new PACS/RIS is in place which has thorough audit functionality. June 2024- the position remains the same and would be with DHCW to develop for RadIS. Any enhancements and developments have been stopped by DHCW as they work to migrate the RadIS data over to our new RIS Soliton. DHCW would need to develop this and with RadIS no longer being an NHS system once the new PACS/RIS is in place it won't be an issue then as the audit trail is full and comprehensive in the new solution. March 2024: Position remains the same further progress expected May 24. Currently with DHCW to develop,	Aug 2023: Time and resource in RadIS. As well as pending RISP program may not help development.	July 2026 - Went live with new RIS in June 2025 ~(Soliton) and no longer uses RadIS.	

Internal Audit	IT System Controls (WRIS)	Reasonable	Chief Operating Officer	Medium	R9	R9 A formal disaster recovery plan for WRIS should be developed.	The Disaster recovery plan is to fail over to a mirrored system however, since the upgrade this needs to be re-visited and formally set out. ABUHB have a VMware environment where this is hosted.The Radiology departments have disaster recovery by using emergency packs in each department and a policy that explains how to use these emergency packs in a Radis downtime scenario.	PACS & RADIS Manager	30/04/2022			Completed	Completed	5	June 2025 - we still do not have a mirrored DR system and won't be developed with RadIS no longer being developed. The new RIS will be primarily cloud based with that being mirrored and failing over to kit in a primary DC in GUH If there are issues with full functionality. If there are further issue in our primary DC it will then fail over to the secondary DC in YAB with full functionality with the planned solution. Aug 2024: We don't have a mirrored DR system in place for PACS or RIS. We would still be dependant on setting up mini-PACS at each site which is time consuming and not a true DR system. The new PACS/RIS will be predominently cloud based with short term storage and full functionality of our PACS in RIS in our DC in GUH and a smaller backup in our YAB DC. With the fibre connection between both DC the VLAN should stretch and we could have a true DR system for continumity. June 2024- the position remains the same. The business continuity plans in Radiology are extensive and well versed. There will be a more extensive disaster recovery solution with the new Philips/RIS solution. The solution will be cloud based with 3 years of on site storage with the full PACS and RIS capabilities within which is pencilled in for the GUH datacentre. There will also be a smaller disaster recovery solution with hardware being pencilled into the		July 2026 - No longer have RadIS so can be closed,but there is a redundancy locally and nationally working from two sperate datacentres.	
Internal Audit	Estates Condition - Jan 2024	Limited	Director of Strategy, Planning & Partnerships	Medium	R4.2	Management should update the Estates Strategy (or equivalent) for continued relevance to estates condition as appropriate.	Agreed – this forms part of forward work plan for the Planning, Population Health and Partnerships Committee.	Director of Strategy, Planning and Partnerships	31/03/2024			Completed	Completed	3	November 2025: Work is underway to re-establish estate baseline information in order to then align with strategy. Alongside this the specification for the Facet Survey is being developed in order to procure a company to undertake the surveys on behalf of the Health Board. This work will commence in the new year and is likely to conclude in approx 6-8 months. Following this findings will then be aligned in order to develop the HEalth Boards Estates Strategy.May 2025: Agreement that Estate Strategy refresh follows Organisational Strategy. Aug 2024: Aa per the June update, the Organisational Strategy is expected to be completed by the end of the calendar year. The PPHPC is considering estates development in detail and receives regular updates on the strategy's progress. Update on plans for all owned Estate presented to PPHPC. Board Development sesslion on Estates. Estates Strategy to follow Organisational Strategy. June 2024: Work is ongoing to maintain premises which will remain in the Health Board Estate Portfolio with no immediate plans in place. Plans are currently being progressed for Nevill Hall Hospital and St Woolos in line with the Estate Strategy where estate condition is poor. Organisational Strategy will be complete end of calendar year. March 2024: mCapital priorisiation complete. Estate Strategy will follow org. strat."		Superseeded new report	
External Audit	Audit of Accounts Report, 2020-21 – Addendum issued December 2021	Not Rated	of Workforce	High	R1	The Health Board should review the arrangements in place toensure that annual leave for all staff is accurately recorded and held centrally	The introduction of Medical E-Systems will ensure that all leave is recorded. The Health Board have agreed to procure a suite of Medical E-Systems with roll out in April 2022. However, departments have started recording leave in Electronic Staff Record (ESR). Communications will be sent to Medical Leaders in December 2021 to ensure that leave is recorded onto ESR pending the introduction of full Medical E-Systems.	N/A	30/04/2022			Completed	Completed	3	April 2025 The Health Board are currently in the early stages of entering sickness absences via the roster following a period significant development and testing with Patchwork and ESR. Within the next 6 months the testing of annual leave recording will be undertaken via rostering into ESR. The intention will be to roll this out to all Divisions following successful testing. March 2024: "The Medical Workforce Rostering System will be implemented in the Health Board on a phased basis over an 18 month period. The absence management function of the new rostering system will enable the Health Board to record annual leave entitlements and will have a rolling balance of annual leave taken for individual doctors. The Health Board is in the process of setting up a new interface between ESR and Patchwork Rota to ensure all absence transfers from the new system to ESR. The implementation plan is being progressed and is phased by division and directorate. The plan is for the full implementation to be completed by April 2025. At that point all annual leave should be held on both erostering and ESR systems. The current medical annual leave policy is under review and a decision will be required before implementation on how annual		all leave is added to ESR	
External Audit	tured Assessment	Not Rated	Finance and P	N/A	3.1	To become financially sustainable in the longer-term, the Health Board should: develop a detailed longer-term financial plan that is linked to the new long-term strategy currently in development and ensure progress against delivery is reported appropriately.	The long-term financial plan will be developed alongside the long-term strategy and will triangulate service, workforce and financial aspects of the strategy once measures and metrics of change are clarified. This will be iterative to ensure clarity of affordability and outcome benefits expected.	f Finance and Pro	30/06/2025			Completed	Completed	2	August 2026: 26/27 Financiual Improvement Plan and opportunities pipeline sent to WG April 2026: Date in line with the IMPT Strategy. August 2025: This will be developed as part of the detailed plans aligned with the long term strategy			
External Audit	tured Assessment	Not Rated	Finance and P	N/A	3.2	Develop a detailed route-map to support the delivery of the long- term strategy.	As per recommendation 3.1, the financial plan will be developed alongside the service plan.	f Finance and Pro	30/06/2025			Completed	Completed	2	August 2026: 26/27 Financiual Improvement Plan and opportunities pipeline sent to WG April 2026: Date in line with the IMPT Strategy. August 2025: Refer to above, Also the route map to recovery will need to be refreshed during 2025/26 to ensure financial savings are identified for the major thematic areas within the V&SB categories by the lead executives and delegated budge			

External Audit	y Governance Foll	Not Rated	ector of Nurs	N/A	3.1	Within the next 12 months, the Health Board should evaluate the impact of centralising its Quality and Patient Safety teams to ensure the intended benefits are being achieved. (Paragraph 50)	The Head of Quality & Patient Safety will undertake a comprehensive review of the centralisation process. This review will include an assessment of the effectiveness of the centralised structure in improving patient safety outcomes, staff engagement, operational efficiency and compliance. This review will involve collecting feedback from staff, analysing performance metrics, and identifying any areas for improvement.	Director of Nursin	30/04/2026			Completed	Completed	0			A centralised Quality and Patient Safety structure has been implemented, introducing a business partnering model, standardised governance processes, enhanced corporate oversight and strengthened divisional support arrangements. The model is supported by improved reporting mechanisms, Qlik dashboards, Datix systems and strengthened governance through QMG and PQSOC, providing greater consistency, transparency and organisational oversight of quality and patient safety activities across the Health Board.	NO
External Audit	Eye Care Review	Not Rated	f Operating O	N/A	5.1	Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery.	The Eye Care Plan has now been approved by the Eye Care Board, which meets bi-monthly to review progress against key workstreams. Updates on performance, risks, and mitigation actions are discussed regularly through this forum, ensuring continuous oversight and alignment with Board governance expectations. Once the Eye Care Plan is approved by the Board, the Health Board will ensure that the Finance and Performance Committee receives updates on delivery at least twice a year. These updates will clearly articulate progress, risks to delivery, and any mitigating actions to support transparency and accountability. This will be ensured by adding the Eye Care Plan to the Committee's Forward Work Programme.	ned Care / Directo	30/04/2026			Completed	Completed	0			Meeting Governance in place for oversight (see information in updates)	
External Audit	tured Assessment	Not Rated	f Corporate G	N/A	1.1	The Health Board should report every six months to the Audit, Risk and Assurance Committee compliance with declarations of interest by staff cohort, identifying actions the Health Board is taking to address non compliance (paragraph 13).	The Health Board has an established implementation plan for embedding the Standards of Business Conduct Policy. This plan includes monitoring compliance across staff cohorts and identifying areas of non-compliance. Findings from this monitoring will inform twice yearly reports to the Audit, Risk and Assurance Committee, which will include details of actions being taken to address any non-compliance.	of Corporate Gov	30/04/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Training compliance has increased to 85% demonstrating a significant improvement in organisational awaareness and engagements with mandatory IG requirements. This positive position reflects the targeted programme of work undertaken by the IG Team including enhanced monitoring and reporting.	
External Audit	tured Assessment	Not Rated	f Corporate G	N/A	2.1	To ensure that the staff voice is heard at Board, the Health Board should ensure that staff stories are routinely used at both Board and committee meetings (paragraph 23).	The Board's Forward Workplan for 2026/27 will include a specific commitment to routinely incorporate staff stories at both Board and committee meetings to ensure the staff voice is heard. In addition, the Health Board is exploring informal mechanisms to further enhance staff engagement at Board level.	rd Business Mana	30/04/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Staff stories established and built into the board's business plan	
External Audit	tured Assessment	Not Rated	ector of Nurs	N/A	4.1	The Health Board should redevelop its Quality Outcomes Framework report to better highlight issues and provide assurance. This should include improving the report format, presentation of data, trends, targets and actions (paragraph 37).	Phase 1 – Report Redesign Improvements to the Quality Outcomes Framework (QOF) report format will be evident in the Q2 report presented to PQSOC in December 2025. Key enhancements include: A redesigned layout that is shorter, more concise, and standardised for consistency. • Enhanced visual presentation of data using run charts to show variation and trends over time. • Clear definitions accompanying each metric to explain what is being measured and why it matters. • Inclusion of performance against agreed targets alongside actual results to strengthen assurance. • A dedicated section outlining implications and associated improvement actions to address areas of concern and improve patient outcomes. Phase 2 – Enhanced Statistical Analysis The QOF report will transition to Statistical Process Control Charts (SPCC), enabling statistically significant variations to be visually highlighted and tracked over time. This enhancement will improve assurance by clearly distinguishing normal variation from signals that require action. In addition, work is underway with the Health Board's Data and Digital team to migrate QOF metrics into a live digital application (Qlik), beginning with RL Datix information for Quarter 3 reporting. Phase 3 – Full Integration All remaining QOF metrics will be transitioned to SPCC within the digital platform, ensuring consistent, real-time monitoring of trends, targets, and improvement actions across the framework.	ity Director of Nu	31/05/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		"Quarter 4 2025/26 Quality Outcomes Framework Report included use of SPC charts, refined reporting metrics and a focus on themes and learning. Quality Management Group saw a review of the quality reporting structure (including the QOF) in July 2026, this included a number of recommendations for imrpovement that will form part of the wider QMF review taking place in 2026 and going to the Executive Board for approval in January 2027. The QOF is likely to continue to undergo iterative improvements for the years to come as Qlik is further developed, data availability improves and the wider QMF reaches maturity."	NO

External Audit	S Contract Challe	Not Rated	Operating O	N/A	1.1	Strengthen GP business case requirements in the vacant practice policy to ensure that potential GP partners include sufficient detail on its workforce, financial and quality plans.	The Health Board recognises the importance of ensuring that business cases submitted by prospective GP partners for vacant practices are sufficiently detailed, robust and capable of withstanding external scrutiny. The Health Board has operated a well-established and robust Vacant Practice Policy, which has been consistently applied throughout vacant practice processes. This policy requires prospective GP partners to submit comprehensive business cases, supported by a structured interview and a due diligence process. These submissions are assessed by a Vacant Practice Panel, which includes external representation from Llais and the Local Medical Committee, providing independent challenge and assurance in relation to workforce sustainability, financial viability and quality of care arrangements. In response to learning from recent vacant practice processes and findings from internal audit, the Health Board has already strengthened the existing Vacant Practice Policy and associated business case requirements. These enhancements have focused on improving the clarity and consistency of information required from applicants, particularly in relation to workforce plans, financial modelling and quality governance arrangements. The Health Board welcomes this further recommendation from Audit Wales and will take it forward as part of a continued programme of improvement. Further refinements to business case requirements and assessment processes will be incorporated into the Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025), which sets out the procedural steps for the letting of both vacant and Health Board-managed practices. The SOP ensures that requirements are applied consistently, transparently and in line with relevant regulatory and governance expectations.	ead of Primary Ca	30/04/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Final SOPin plae to support the management fo vacant GP practices, incorporating the revised Vacant Practice Policy and clear submission requirements, in accordance with the 2025 procurement regulations. *Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)* The SOP contains; - Updated existing Vacant Practice Policy to reflect 2025 procurement regulations - Operational processes aligned to procurement changes - Communications and Engagement plan - Scoring matrix - Enhanced Monitoring Framework with clear KPI's and triggers for escalation/de-escalation - Strengthened financial due diligence check list including 3 year financial forecasts, back ground checks for all and stipulation regarding record retention.	
External Audit	S Contract Challe	Not Rated	Operating O	N/A	2.1	Strengthen the scrutiny of prospective contractor's financial business plans to include: consideration of the realism of financial and workforce projections; and - risks which might be presented by the nature and complexity of prospective contractors' business interests. • Where concerns are identified, the Health Board should resolve these prior to the letting of the contract.	The Health Board accepts this recommendation and recognises the importance of robust and proportionate scrutiny of prospective contractors' financial and workforce business plans to support the long-term sustainability, safety and quality of General Medical Services (GMS). The Health Board has operated a well-established and robust Vacant Practice Policy, which has been consistently applied throughout vacant practice processes and includes structured assessment of financial viability, workforce proposals and governance arrangements. This process is supported by multi-disciplinary scrutiny and independent challenge through the Vacant Practice Panel membership. In response to learning from recent vacant practice processes and findings from internal audit, the Health Board has already strengthened the existing Vacant Practice Policy and associated assessment tools. In particular: The financial forecast template that prospective contractors are required to complete has been extended to require a minimum three-year projection, enabling enhanced assessment of the realism of workforce assumptions and future income and expenditure expectations; andA formal due diligence checklist has been introduced, which includes a requirement for individuals within a prospective partnership to commit to undergoing a credit check prior to contract award, where appropriate. The due diligence arrangements will be further developed to incorporate a formal review of Companies House records, to inform whether any additional exploration of wider business interests is required where the nature or complexity of those interests presents a potential risk. The Health Board notes that there is no clause or restriction within The National Health Service (General Medical Services) (Contracts) (Wales) Regulations 2023 that places limitations on the wider business interests of independent contractors. However, the Health Board considers it appropriate to understand and assess such interests where they may present a material	ead of Primary Ca	30/04/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Final SOP in place to support the management of vacant GP practices, incorporating a robust due diligence checklist and resource forecast template. *Standard Operating Procedure: Management of General Medical Services Practice Vacancies (2025)* The SOP contains; - Updated existing Vacant Practice Policy to reflect 2025 procurement regulations - Operational processes aligned to procurement changes - Communications and Engagement plan - Scoring matrix - Enhanced Monitoring Framework with clear KPI's and triggers for escalation/de-escalation - Strengthened financial due diligence check list including 3 year financial forecasts, back ground checks for all and stipulation regarding record retention.	
External Audit	gital Transformati	Not Rated	rector of Digi	N/A	1.1	The Health Board should update its Digital assurance report to Finance and Performance committee to include detail on financial reporting, including project level budgets, current and forecast expenditure and any variances (Paragraph 17).	From the June 2026 meeting onwards, the Digital assurance report to the Finance & Performance Committee will include project-level financial reporting for both local and national digital programmes, including agreed budgets, current and forecast expenditure, and any material variances.	Director of Digita	30/06/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		A finance dashboard has been developed which will be reported to DPPSG, DDaT Group and F&P Committee.	
External Audit	gital Transformati	Not Rated	rector of Digi	N/A	2.1	The Health Board should clarify whether the Digital Data and Technology directorate governance structure proposal will proceed (Paragraph 20).	The Health Board has agreed to proceed with the proposed Digital, Data & Technology governance structure. The final component of the structure is the Digital, Data & Technology Group, which will be chaired by Medical Director to ensure strong clinical leadership. The revised terms of reference will be presented to the Executive Committee for approval in April 2026, with meetings scheduled for the next 12 months following approval.	Director of Digita	31/05/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		The DDaT Group ToR have been approved.The inaugral meeting is scheduled for 03/09/26 and will meet quarterly with a meeting series established for th next 12 months and beyond.	
External Audit	gital Transformati	Not Rated	rector of Digi	N/A	3.1	The Health Board should develop a clear standalone cyber security risk, including defined controls and assurance arrangements, to ensure that threats are properly understood and resources are directed to the right mitigations (Paragraph 23).	The Health Board will develop a standalone cyber security risk, setting out key threats, controls and assurance arrangements. This will be added to the Corporate Risk Register, and will reported through established risk management processes to ensure appropriate oversight and prioritisation of mitigations	Director of Digita	31/05/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Risk has been developed and is on tthe CRR	

External Audit	gital Transformati	Not Rated	rector of Digi	N/A	4.1	The Health Board should ensure its digital strategy fully addresses cyber security risks and the arrangements to address them (Paragraph 30).	One of our goals within our strategic mission is to strengthen our cyber security resilience which will be delivered via a clear Infrastructure plan and a roadmap for infrastructure replacements and upgrades.	Director of Digital	30/06/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Strategic Digital Transformation Plan approved by the Board in July 2026.	
External Audit	gital Transformati	Not Rated	rector of Digi	N/A	7.1	The Health Board should ensure formal oversight of regional working is in place, which includes regular reporting on regional digital initiatives, assessment of risks and benefits and alignment of regional strategies with the Health Boards own digital plans (Paragraph 49).	Formal governance arrangements for regional digital initiatives are being developed with Directors of Digital across Southeast Wales and the Regional Collaborative. These arrangements will be presented to the Regional Executive Management Group in May 2026. Once agreed, regular reporting on regional digital initiatives, including risks, benefits and alignment with the Health Board's digital plans, will be provided through existing programme reporting to the Finance & Performance Committee and the Board.	Director of Digital	30/06/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		A Regional Digital Partnership Lead is now in post, hosted by ABUHB, working on behalf of the SE Wales Region. A Digital Steering group and working group have also been established. Reporting to F&P Committee will commence in September 2026.	
External Audit	are: Arrangemen	Not Rated	ector of Nurs	N/A	8.1	Staff feedback on service changes To identify potential weaknesses or learning in relation to recent changes to its urgent and emergency care services, the Health Board should introduce regular mechanisms for staff feedback. This should include feedback from key partners including primary care and WAST (Exhibit 9).	The Health Board recognises the value of staff and partner feedback in identifying potential weaknesses and learning opportunities related to urgent and emergency care (UEC) service changes. Staff engagement currently forms a core part of our project methodology for strategic initiatives such as Same Day Emergency Care (SDEC) and Urgent Primary Care (UPC), with structured involvement before, during, and after implementation. Feedback from these engagements directly informs project evaluation and service improvement.To strengthen this approach and ensure more regular and structured feedback, we will: • introduce periodic roundtable engagement sessions. These sessions will include representation from across the organisation and key partners, such as, Primary Care and WAST, and will be focused on reviewing recent and ongoing UEC service changes.Feedback gathered will be logged, thematically analysed, and shared with relevant service leads and governance groups to support continuous learning and inform future service planning.	Director of Nursin	30/04/2026			Completed	Completed	0	tracking progress at Programme Board level. These improvements will be in place ahead of the September 2025 Programme Board meeting.		"The Health Board has implemented a structured approach to capturing and responding to staff and partner feedback following urgent and emergency care service changes. As part of the Urgent and Emergency Care (UEC) transformation programme, engagement and feedback mechanisms are embedded within project delivery methodologies. Feedback is sought before, during and after implementation to inform both evaluation and continuous improvement. There is regular engagement with key stakeholders, including Primary Care, WAST, clinical teams and operational services. Feedback from these engagements is captured, analysed and reported through appropriate governance structures and service forums, supporting organisational learning, service improvement and future planning. Progress against this recommendation is monitored through the UEC Programme Board, with evidence demonstrating that mechanisms are now in place to systematically capture learning from recent service changes and incorporate this into ongoing service development. "	NO
Internal Audit	claration of Inter	Substantial	Corporate G	Medium	1.1	Monetary Value Gifts We found two exceptions from 20 sampled where declarations were made after the benefit was approved; one was concerning a trolley for a ward and the other one was a £30 voucher for an individual which was received in the person's absence but was over the £25 threshold and in the form of a gift voucher. Whilst the policy allows, in some instances, gifts to be received (e.g. where it may cause offence to the donor), the declarations should be made (and approved) prior to the acceptance of the gifts. Furthermore, any cash, vouchers etc. should be donated to a charitable fund instead.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 14), awareness sessions will be held with managers to set out the requirements of the Policy and ensure these are further cascaded to staff. The Policy also sets out that the importance of continued compliance will be referenced in induction programmes. Expected Evidence of Implementation: Evidence of awareness sessions and inclusion of Standards of Business Conduct in the corporate induction programme.	of Corporate Gov	31/03/2026			Completed	Completed	1	Working with workforce and OD colleagues to include in corporate induction information. Policy and supporting guidance published on the Corporate Governance site on AB Pulse.		Corporate induction updated and guidance issued to staff	
Internal Audit	Health and Safety	Limited	llied Health F	Medium	2.1	Health and Safety Policies Out of 19 applicable policies: • 13 policies were overdue for review. • Three policies were no longer needed. • The remaining three policies had recently been reviewed. Six out of the 13 policies were waiting for final sign-off having been through the Health and Safety Committee.	Policies not being up to date resulting in staff not being aware of the correct procedures resulting in patient / staff harm. Agreed Action: A plan has been developed to review and update all organisational health and safety policies by end of December 2025. Compliance with health and safety policies will be monitored via the Health and Safety Committee to ensure they are reviewed and have timely assessment.	of Health, Safety a	31/12/2025			Completed	Completed	2	August 2026: "All Health and Safety policies across the organisation have now been reviewed. - 8 policies are fully compliant and require no further action. - 4 policies have been presented to the Health and Safety Committee, where feedback has been received and incorporated as appropriate. These 4 policies are scheduled for submission to the relevant Policy Approval Group(s) in August/September 2026 for final approval prior to implementation."			

Internal Audit	t Health and Well	Reasonable	tor of Public H	Medium	7.1	Benefits Realisation Key to post project review is assessment of benefits realisation. Including receipt of intended outputs (provisions). At the time of approval of the business case the benefits realisation model remained to be fully developed, notably in respect of baseline definition and measurements (e.g., a statement of existing services delivered locally, and target reductions in dental waiting times etc) e.g., original and target services as listed at Appendix A. Similarly, the Business Case targeted improved space utilisation within Primary Care (specifically GP premises). Noting the more general aspiration, the measure could usefully be extended to support areas. The business case also contained aspirations not included in the benefits grid, such as increased referrals via the common ailments scheme. As part of the scheduled review of benefits realisation, there was additionally therefore a need to for the Health Board to review the benefits realisation model alongside the business case for completeness Such review could also usefully include benchmarking against similar provisions.	Agreed Action: Full review of Benefits Realisation will be assessed a year after opening as part of the Project Evaluation. Interim monitoring will also be taking place, but there may also be a need to change/ update the intended benefits realisation matrix in order to align to any changes within the service strategy due to the time which elapses from concept to operational delivery of the projects. The BRM will also be linked to the performance dashboard to capture the data and in order to capture the wellbeing information, a ripple map has been created. Expected Evidence of Implementation: Both an Interim review of Benefits Realisation Matrix and Full review at Post Project Evaluation have been shared with auditors. For future projects both an interim review and post project evaluation will be undertaken	ew & Assistant Dir	30/06/2026			Completed	Completed	0			BRM detail provided in the attached Benefits Realisation spreadsheet	
Internal Audit	ject Access Requ	Limited	rector of Digi	Medium	5.1	Staff awareness and training The overall compliance of IG training for September 2025 was 76% which is below the Health Board target of 85%. In September 2025, Facilities had 50% compliance and Planning had 65%, making them the lowest-performing divisions. There should be more focus on training within the Divisions to ensure compliance meets the Health Board target – with particular focus on the Divisions with lowest compliance.	Agreed Action: • Develop and implement an action plan to raise IG training compliance to meet or exceed the target o85%. • Prioritise Divisions with the lowest compliance. • Enhanced monitoring and reporting. • Assign Divisional Managers responsibility for ensuring staff complete training. Expected Evidence of Implementation: • Training Plan. • Monthly Reports. • Committee minutes showing discussion of compliance performance and agreed actions.	Digital Governanc	30/06/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.			
Internal Audit	torate Review - C/	Reasonable	Operating O	Medium	1.1	Risk Management Risk management should be strengthened at a directorate level to ensure risks are consistently scored and aligned with the Health Board's Risk Management Framework. A review of risks within the Directorate found: • There were two different Datix accounts so there was no clear pathway/ instruction for reporting through Datix.Therefore, not all the risks were being processed correctly. • Numerous risk reports from Datix were being used for reporting. • The top five high priority risks had been highlighted but some dated back to 2019 and would benefit from a review/ revisit. All the risks on the Directorate Risk Register had a current risk rating but seven of the risks did not have a target risk rating and did not have a target risk rating score. • Six DSE assessments were also recorded on the Directorate Risk Register. • There was no allocated/ dedicated agenda time at SMT meetings to discuss risk management and no clearescalation of risks at SMT meetings. A Directorate specific Risk Management policy or document would be beneficial in raising awareness and ensuring risks are captured and scored correctly.	Agreed Action: • Ensure staff understand the distinction between the Datix Incident Reporting module and the Datix Risk Register module and receive appropriate training. • Provide local training sessions and maintain a record of staff completion. • Review the Directorate Risk Register monthly to ensure risks are correctly recorded, scored, and include target risk ratings. • Review the top five risks regularly and present updates through the governance framework. • Ensure DSE assessments are managed through the correct Health & Safety process and are removed from the risk register. • Include risk as a standing agenda item at CAMHS QPS and CAMHS Strategic SMT. Ensure processes comply with the Health Board's Risk Policy, including the application of the risk scoring matrix. Expected Evidence of Implementation: • Training materials and training compliance records. • Risk register documentation showing accurate scoring and target ratings. • QPS and SMT agendas, slides and minutes evidencing discussion of risk. • Updated risk reports showing correct placement of DSE issues.	and Advanced Nur	30/04/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Risk management structure in place: monthly review of DSE and Risk register risks including DOC, top three risks identified each month in risk management meetings. Pathway in place to correlate with QPS and Divisional meetings. Themes trends and overdue risks identified and discussed. Trend showing reduction in risks following process. All risks brought to meeting. Training links and materials shared. Exception reporting pathway in place at QPS and SMT and divisional meeting	
Internal Audit	torate Review - C/	Reasonable	Operating O	Medium	2.1	Performance Reporting Reporting of performance needs to be strengthened to ensure there is appropriate accuracy and accountability once the data is collated. Alongside this, the performance dashboard would benefit from more structure in terms of next steps to ensure robust reporting is in place.	Agreed Action: • Collate and present performance data to CAMHS SMT on a quarterly basis. • Strengthen the performance dashboard by adding key actions, leads and timeframes to support clear accountability. • Ensure performance data presented to DMT is accurate and validated. • Explore opportunities to strengthen audit reporting mechanisms, where appropriate. Expected Evidence of Implementation: • SMT agenda and minutes including performance reporting. • Updated performance dashboard. • Supporting performance datasets.	anager, Family an	31/05/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Regular SMT meetings held (quartly) which includes performance reporting. Performance data collected via dashboard and presented to strategic SMT (performance) meetings . Information presented to DMT QPS and divisional meetingsembedded into practice where QPS inofrmation is discussed and shared through the services.	
Internal Audit	torate Review - C/	Reasonable	Operating O	High	3.1	Reporting and Monitoring Arrangements would benefit from a documented plan and pathway to demonstrate compliance against the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Within the new governance structure, focused agenda time should be provided to ensure any incidents are discussed and information cascaded, when necessary, especially regarding Duty of Candour. A documented escalation route would ensure reporting and monitoring are structured.	Agreed Action: • Develop a mapping document demonstrating CAMHS compliance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. • Develop a reporting framework setting out what must be reported, how data will be collected, by whom, and the required frequency. • Adapt the divisional Duty of Candour flowchart for CAMHS and ensure all staff complete the required training. • Ensure CAMHS QPS reviews incidents, Duty of Candour cases and top risks and escalates learning appropriately. • Review governance arrangements within CAMHS to ensure clear reporting lines and escalation routes; update structure charts accordingly. • Develop and share an escalation framework/flowchart outlining reporting pathways. • Ensure key learning related to risk, QPS and Duty of Candour is disseminated across CAMHS to support awareness and compliance. Expected Evidence of Implementation: • Mapping document for the Act. • Updated governance and escalation framework. • CAMHS Duty of Candour flowchart. • Duty of Candour training compliance. • QPS and Divisional meeting TORs, minutes and action logs.	ursing, Family and	31/05/2026			Completed	Completed	0	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Alignment of Quality Pillars to Statutory Duties completed DOC flowchart and SOP developed. DOC meeting established & learning shared DOC training being delivered to staff (compliance 61.34%) CAMHS SOP meeting established Governance structure updated Escalation pathway and assurance & monitoring framework developed and embedded. QPS and divisional meetingsembedded into practice where QPS inofrmation is discussed and shared through the services.	

Internal Audit	Safeguarding	Reasonable	ector of Nurs	Medium	3.1	Safeguarding Strategy The Corporate Safeguarding Team had developed a Safeguarding Strategy for 2022-25. The document would benefit from an update to better reflect the breadth of work being undertaken across the Health Board. A refreshed strategy would not only showcase the current achievements but also clearly outline future safeguarding priorities. There is also an opportunity to update the document to reflect changes in approach e.g. the changed reporting framework, level 3 safeguarding training requirements.	Agreed Action: We acknowledge the need to refresh the Safeguarding Strategy to ensure it reflects the breadth of safeguarding activity across the Health Board and aligns with current priorities and frameworks. Actions will include: • Ratification of the new Safeguarding Strategy for 2025–2028 at the Safeguarding Strategic Group on 18 November 2025. • Incorporation of a review of progress against the 2022–2025 strategy and inclusion of measurable objectives for the new period. • Alignment with the overarching Quality Strategy and integration of recent developments, including the revised reporting framework and Level 3 training requirements. • Publication of the approved strategy on AB Pulse and dissemination through appropriate communication channel Expected Evidence of Implementation: • Minutes from the Safeguarding Strategic Group confirming ratification. • Approved strategy document published on AB Pulse.	ead of Safeguardi	30/06/2026			Completed	Completed	1	The NHS Executive Assurabce and Acountability Framework is yet to be published and is therefore delaying the formalisation of a startegy. This is mitigated by the presence of a Road Map, with a clear work plan and defined areas of accountability.Publication of the NHS Executive Assurabce and Accountability Framework is immenent. As such, it has been agreed to delay the agreement of the startegy until the safeguarding Strategic Group in May 26			NO
Internal Audit	ccupational Healt	Reasonable	of Workforc	Medium	1.1	System and Process Limitations OPAS does not integrate with ESR, resulting in manual verification of job titles, locations, and identity data. The auto-triage function, intended to streamline workflow, has been disabled across NHS Wales due to misclassification risks. As a result, all triage activities require a manual review, increasing administrative workload and introducing potential for variation. Escalation to the supplier will need to take place on an All-Wales basis.	Agreed Action: 1. The limitation regarding OPAS-G2 integration and the disabled auto-triage function will be formally escalated to the All-Wales OPAS-G2 System Group for consideration as a national system development issue. 2. In the interim, the Occupational Health administrative team will continue to undertake manual validation processes using the existing operational booking guides and tracking spreadsheet to ensure referrals are processed consistently. 3. Where administrative demand exceeds available capacity, temporary administrative support will be secured to maintain service delivery and minimise delays Expected Evidence of Implementation: • Minutes from the All-Wales OPAS-G2 system group confirming the escalation. • Operational booking guidance and referral tracking records demonstrating manual validation processes. • Records of temporary administrative support utilised during peak demand periods.	ational Health Nu	30/06/2026			Completed	Completed	0	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Internal Processes are now in place, with evidence avaliable. Evidence of escalation as appropriate to relevant parties in absence of all Wales meetings Evidence of operational booking guidance (Matching a placement) Evidence of admin shifts being requested to support- all shifts were successfully filled. (Admin Shifts)	
Internal Audit	Cyber Security	Reasonable	rector of Digi	High	1.1	Strategic Risk Register The key controls recorded on the Strategic Risk Register against Strategic Risk 006 Part A (SRR 006A) are cyber security focused, however some are outdated or no longer relevant. The current risk and threat recorded for SRR 006A does not explicitly outline cyber security, although all the key controls for this risk and threat are cyber security focused. This could be updated to raise the profile of the cyber security risk to the organisation. The current risk appetite theme for SRR 006A is 'Service Delivery' which indicates an 'Open' risk appetite level. However, the most appropriate risk appetite theme for cyber security may be 'Compliance and Safety' which has a 'Minimal' risk appetite level, and this would mean the current risk score is outside of the risk appetite for the organisation. and, where appropriate, captured and monitored within the CRR.	Agreed Action: At a strategic level, the Strategic Risk Register (SRR) is intended to capture broad organisational risks, rather than focusing on specific areas. Detailed and operationally focused risks, such as those relating specifically to cyber security are more appropriately captured within the Corporate Risk Register (CRR). This approach ensures that sensitive information and specific control measures are managed securely. The SRR will continue to reflect digital risk at a strategic level, with cyber security risks managed and monitored through the CRR where a more granular level of detail and assurance can be maintained. We recognise that some of the key controls currently listed under SRR 006A are outdated or no longer relevant and a comprehensive review will be undertaken to ensure that: • The risk and key controls remain current, relevant, and aligned to the organisation's risk appetite. • References to cyber security within SRR 006A accurately reflect its role within the wider digital risk landscape. Expected Evidence of Implementation: • Updated version of SRR 006A reflecting refreshed risk, controls • Strategic Risk Reports to the Board and Finance and performance Committee with the updated assessment. • Confirmation that specific cyber security risks have been reviewed	ger/ Head of Corp	31/01/2026			Completed	Completed	1	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		SRR 006A - Risk has been reviewed and reworded and strengthened from a cyber security perspective and will be presented at the next Finance & Performance Committee and then to Board.	
Internal Audit	Cyber Security	Reasonable	rector of Digi	Medium	3.1	Staff awareness and training Recent phishing simulations indicate a click rate of 12% across the organisation. The absence of targeted training for compromised staff, combined with mandatory Information Governance and Cyber Security training completion rates falling below the Health Board's 85% target, increases the risk of continued vulnerability. It was suggested that staff awareness should be added as a cyber security risk to raise the profile and ensure further monitoring of progress.	Agreed Action: Management accepts the recommendation and will address the findings through the following actions. • Continue the phishing simulation programme, using the established baseline to drive measurable improvement. • Deliver targeted follow-up training modules to individuals who regularly fail simulations, using tailored content linked directly to the exercises. • Report phishing simulation outcomes monthly through relevant governance groups to support monitoring of staff awareness improvements. • Enhance the visibility of cyber security messaging through regular internal communication and security awareness campaigns. • Work collaboratively with Information Governance, Counter Fraud, and other stakeholders to maximise use of available training resources. • Ensure cyber security staff awareness is appropriately reflected within the corporate risk framework for ongoing oversight. Expected Evidence of Implementation: • Monthly phishing simulation results and reports submitted through governance structures. • Governance and Assurance Group minutes demonstrating review of security awareness materials and outcomes. • Copies of cyber security awareness campaigns and communications issued via multiple channels. • Evidence of a corporate risk register entry to monitor staff awareness as part of the cyber security risk profile.	yber Security Mar	31/01/2026			Completed	Completed	1	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider		Monthy phish sims are underway, focusing on credential compromise due to evidence of actual attacks on ABUHB staff. Targetted training is provided to those that click, or enter information. Click rates vary with June 2026 phish simulation having a click rate of 5.1% Cyber attend bi monthly Health Records awareness sessions to deliver in person security awareness training focused on detecting phising and signposting staff to more resources. Cyber have prepared awareness materials for Cyber Security month in October.	
Internal Audit	Cyber Security	Reasonable	rector of Digi	High	4.1	Cyber Incident Response Plan • The Cyber Incident Response Plan highlights that the plan should be tested every six months but his has not been done. • The Cyber Security Team do not have the capabilities, expertise or resources to deal with a cyber event internally and they do not have third-party support formally agreed. • The incident response plan highlights that there should be action cards that define the duties of everyone in the Cyber Incident Response Team (CIRT), however these have not been drafted. • Communications have not been drafted for any audience outside of the Health Board.	Agreed Action: A tailored tabletop exercise will be undertaken within the next three months to specifically test the current Cyber Incident Response Plan, as required. The scenario will incorporate the areas identified in the audit findings, including clarity of team responsibilities, escalation pathways and communication requirements. Following completion, the Cyber Security Team will produce a formal post-exercise report that clearly documents lessons learned and required improvements. These improvements may include the creation of action cards, enhanced external communication arrangements and the securing of specialist third-party cyber support. Learning and feedback from the recent national DHCW exercise will also be reviewed and used to strengthen the Health Board's Cyber Incident Response capability in line with the existing plan. Expected Evidence of Implementation: • Copy of the tabletop exercise scenario • Post-exercise report including improvement actions and implementation owners • Updated Cyber Incident Response Plan testing schedule (2026–27) • Documentation confirming the review and options appraisal for external specialist support (e.g., forensic retainer) • Draft or completed action cards supporting the Cyber Incident Response Team roles and responsibilities • Communications templates developed in collaboration with the Communications Team for external use during a cyber incident.	yber Security Mar	31/01/2026			Completed	Completed	1	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.		Quarterly TTX are now conducted by the Cyber team, based of real world events. 3rd parties have also hosted TTX, such as Tarian (Southwales police), Rubrick, and KPMG. Additioanlly 2 members of the Cyber team have had NCSC security exercise training.	

Internal Audit	tral Decontamina	Reasonable	ing, Strategy	Medium	1.1	Extension of Time At the conclusion of fieldwork, the contractor's extension of time and associated loss and expense claim submission had not been agreed. Given that the delay was material, potentially representing a 35% extension to the original 42-week programme, a root cause analysis should be undertaken. This should examine the justification for the claim, assess any potential liabilities, and capture lessons to inform the management of future projects. Agreed Action: Work is ongoing through the contractual process and is led by the project's Cost Advisor. This work includes assessment of cause but will also consider what reasonable (if any) mitigation has been put in place by the contractor to manage the impact of the delay, as per the JCT contract. The outcome may not be concluded until the end of the project, but will continue to be monitored through the Commercial Meetings. A financial allowance will be made within the contingency to manage the potential cost pressure. Expected Evidence of Implementation: Conclusion of contractor's extension of time and expense claim. Discussion through Lessons Learnt, including discussion on liabilities in order to inform future projects.	"Agreed Action: Work is ongoing through the contractual process and is led by the project's Cost Advisor. This work includes assessment of cause but will also consider what reasonable (if any) mitigation has been put in place by the contractor to manage the impact of the delay, as per the JCT contract. The outcome may not be concluded until the end of the project, but will continue to be monitored through the Commercial Meetings. A financial allowance will be made within the contingency to manage the potential cost pressure. Expected Evidence of Implementation: Conclusion of contractor's extension of time and expense claim. Discussion through Lessons Learnt, including discussion on liabilities in order to inform future projects."	Project Director	30/04/2026			Completed	Completed	1	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider			
External Audit	Eye Care Review	Not Rated	Chief Operating Officer	N/A	4.1	The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services. • includes capacity plans based on realistically ambitious levels of productivity. • costed, at a minimum, for the medium term (3-5 year). • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models. • supported by clear delivery actions and milestones. • approved by the Board.	The Health Board acknowledges the urgency and importance of completing the Eye Care Plan and is actively progressing work to meet the outlined requirements. The following steps are being taken to ensure the plan is robust, sustainable, and Board-approved: 1. Demand-Based Planning • The draft Eye Care Plan has been completed. • Ophthalmology capacity and demand modelling takes place yearly, ensuring data remains up to date as service capacity flexes. • The plan is being developed using current service activity data and projected demand modelling, including cataract treatment volumes and outpatient trajectories. • Regional benchmarking and national variation intelligence are being used to inform future service needs. 2. Capacity and Productivity • Capacity plans incorporate realistic yet ambitious productivity targets, including improvements in theatre utilisation and outpatient throughput. • Initiatives such as the "golden patient" process, interface GP schemes are being scaled to optimise clinical efficiency and the planned insourcing activity with HBSUK. 3. Medium-Term Costing • Financial modelling has been completed for FY25/26, with further costing underway for a 3–5-year horizon, including sustainability plans for ophthalmology. • Further sustainability plans will be submitted via division by March 2026.	Associate Director of Planned Care	30/04/2026	31/03/2027		Completed	Completed	1	"1. Demand based planning Regional cataract pathways are in place including GIRFT-recommended list numbers throughout core and regional lists 2. capacity & productivity Productivity planning in place with ABC1 team to look at current diagnosti hub capacity Staggering patients throughout NHH and RGH lists will ensure better theatre utilisation. Consultants are being urged to review their theatre utilisation via yearly job planning 3. medium-term costing Savings plans for 2026/27 are with CD for sign off Plans in place to stop locum usage in the coming months, with consultant vacancies now filled Sustainability plans have been submitted via division 4. resource planning All consultant vacancies will be filled by October 2026 EPR now in place and rolled out to all areas, with excpetion of cataract theatres	"2. capacity & productivity Golden patient scheme has been replaced with list staggering for better theatre utilisation coverage. Further insourcing likely into 2026/27 5. Delivery Actions and Milestones • Four key Task and Finish Groups have been established to monitor the workstreams arising from the Eye Care Plan • The Task and Finish Groups meet monthly, with progress updates provided to the Eye Care Board (ECB) on a quarterly basis. The Eye Care Working Group and Programme Board have agreed Terms of Reference and are tracking delivery		
External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Chief Operating Officer	N/A	6.1	Referral pathways R6 To improve access and utilisation of referrals for appropriate alternative urgent and emergency care services, the Health Board should work with key staff, including WAST, to develop referral mechanisms that are clear, well-communicated and easily accessible (Paragraph 39).	To improve access to appropriate urgent and emergency care services, and to support more efficient use of alternative referral options, the Health Board is taking the following steps: ABUHB was the first Health Board in Wales to implement a 24/7 SPOA for referrals and advice between primary care, WAST, and secondary care. While this system is functioning well for direct secondary care access, we recognise the need to further strengthen pathways to alternative services. We have established a Navigation Hub Project Group specifically to improve the clarity and accessibility of referral routes to services such as Frailty, Ambulatory Emergency Care, and Urgent Primary Care. This group is reviewing existing referral mechanisms and identifying opportunities to streamline processes for front-line staff.	Chief Operating Officer	31/03/2026	31/03/2027		Completed	Completed	1	April 2026: Referral routes via the Flow Centre are managed by each Department & Division. Current Flow Centre leads are working through the known pathways to ensure they are up to date, accurate, owned and published for access to all Divisions that do require use of them. This is being monitored via an improvement plan owned by Urgent Care Division & supported by the Associate Director of Operations (Patient Transportation Services) for transparency. Reporting via the Our Next Patient programme during Q1 2026/27.			
Internal Audit	Mental Health and Learning Disabilities	Reasonable	Chief Operating Officer	Medium	2.1	Monitoring and communicating arrangements Whilst discussion and updates are provided at numerous committees, in addition to the Board. However, there is no detailed specific monitoring / challenge over the delivery (or non-delivery) of actions within the Plan against agreed timeframes and the intended outcomes. In addition, where actions are not delivered on time there is no formal escalation or subsequent tracking over any remediation.	Agreed Action: • We will continue discussions and updates at various committees and the Board, emphasising the need for detailed monitoring and challenge over long-term actions and outcomes – using the performance and accountability framework. • The 90-day improvement plan has evolved into a broader, long-term improvement program, focusing on culture change and workforce development, requiring sustained effort and commitment. These measures will enhance accountability and ensure timely delivery ofinitiatives. Expected Evidence of Implementation: • Monthly Divisional Assurance Review Meetings. • Quarterly Divisional Performance Review Meetings. • Corporate teams – 6 monthly assurance review meetings. • Internal Divisional and corporate team arrangements • Performance meeting including key metrics and delivery against agreed trajectories and forecast. • Quality and safety which risk, clinical governance, patient experience, health & safety etc. is discussed.	Divisional Director, General Manager, Divisional Nurse (Triumvirate), Directorates	30/09/2025	31/12/2026		Completed	Completed	1	November 2025:Conntinuous reporting through daily, fortnightly, and monthly meetings and the reinstated MH&LD Committee A range of meetings take place, daily safety flow, weekly patient flow and monthly meetings e.g. DMT, Exec Assurance, Finance, QPSE, wider DMT to include all SLTs within the Division • Regular reporting to the Patient, Safety, Quality, and Outcome Committee with NHS Executive Colleagues' advisory role. Regular attendance at QPSOG with submission of reporting slides monthly • Improvement plan aligns with Health Board's Quality Strategy and new accountability framework. Expected Evidence of Implementation: All Wales MH Strategy now published, Divisional strategy aligns with the principles. Accountability framework in place via Exec Assurance and Divisional dashboards in place • Monitor against the Performance Management and			

Revised Deadlines - 27

ABUHB Ref Number	Audit Type	Report Title	Assurance Rating	Responsible Executive Director	Recommendation Priority	Recommendation Number	Recommendation	Management Response	Responsible Handler	Original Completion Deadline	Proposed Revised Deadline	Date Revised Deadline accepted by Committee	Original completion date status	Revised Deadline Status	Number of Revised Timescales	Progress of work underway	Barriers to implementation	Evidence to complete or close recommednation	Is this recommendation delayed by National requirements
4002EA2024	External Audit	Structured Assessment 2024	Not Rated	Director of Corporate Governance	N/A	2.1	To enable more effective scrutiny of delivery of corporate plans and strategies, the Health Board should ensure that progress reports are clear and contain performance targets and comparative benchmarks, where possible. Reports should also contain clear progress against established milestones to aid scrutiny of progress.	Work is underway to develop report templates and supporting guidance setting out requirements and standards. Report writing training will also be delivered to senior teams responsible for preparing board and committee papers.	Director of Corporate Governance	30/09/2025	30/04/2027		Overdue	Not Yet Due	2	August 2026: External facilitation is paused in light of financial context. Internal mechanisms being established in the meantime. Report templates and guidance has been updated and remains subject to further review. November 2025: A brief has been prepared to secure report writing training with procurement paused in light of the financial outlook for 2025/26. In the meantime the Corporate Governance Team will review templates and guidance, aligning with the Board's recently approved long-term strategy.			
4916A2025	External Audit	Urgent and Emergency Care: Arrangements for Managing Demand	Not Rated	Chief Operating Officer	N/A	5.1	Directory of services R5 To ensure health and care staff can adequately signpost and refer people to the right urgent and emergency services, the Health Board should: • establish a mechanism to ensure the WAST Directory of Services remains up to date, which includes the identification of an officer with lead responsibility for this task	To strengthen the accessibility and accuracy of urgent and emergency care service information, the Health Board is taking the following actions: 5.1A named lead officer will be appointed to oversee all Health Board contributions to the WAST Directory of Services. This individual will act as the central point of contact for service updates, ensuring timely and coordinated entries across departments.	Chief Operating Officer 	30/11/2025	30/09/2026		Overdue	Not Yet Due	1	April 2026: Primary & Community Care are currently piloting an 'in house' Directory of Services for their Divisional use only. Discussions are ongoing about how to implement this on a wider basis. This doesn't form part of the Single Point of Access/Navigation Hub work programme as yet. Further internal discussions need to take place in order to ascertain centralised ownership & resource allocation (people & funding) to progress during Q1 of 2026/27.The development and maintenance of information held within the community directory of services is being continually reviewed and updated; this forms part of the Single Point of Access governance processes (Navigation Hub Project Group), so that changes made to service information, pathways and processes can be cascaded and / or operationalised in a timely manner.			
ABUHB-2425-11	Internal Audit	End of Life Care	Reasonable	Director of Nursing	Medium	1.1	Framework for the capture and management of patient Future Care Planning documentation Whilst we appreciate that it is the responsibility of the individual to share FCP documents with the necessary health care providers (Health Board, GP, OOH GP, Ambulance Service, District Nursing service etc.) there is an absence of a policy within the Health Board and / or a supporting procedure to cover the: capture; coordination; and management of these key documents.	Agreed Action: The Health Board are working towards implementing a robust framework for capturing and managing patient Future Care Planning (FCP)documentation. This will include the following elements: Identification and Targeting: Implement a structured approach to identify patients who would benefit from FCP, such as those with chronic illnesses, frailty, or nearing end-of-life. Tools like the Elderly Risk Assessment score can be useful. Standardised Documentation: Use standardised forms and templates to ensure consistency in FCP documentation. This can include advance directives, anticipatory clinical management plans, and patient preferences for care. Multidisciplinary Collaboration: Encourage daily multidisciplinary huddles to discuss and document FCP for identified patients. This ensures that all relevant healthcare professionals are involved in the planning process. Electronic Health Records (EHR) Integration: Transition to digital ACP plans for better accessibility and efficiency. Integrate FCP documentation into the EHR system to ensure accessibility and continuity of care. This allows for easy sharing and updating of patient care plans across different care settings Education and Training: Provide ongoing education and training for healthcare professionals on the importance of FCP and how to conduct and document these conversations effectively. Establish and expand the role of ACP Practice Educators to	Director of Nursing	30/04/2025	31/12/2026		Overdue	Not Yet Due	1	August 2026: exec approved developing some functionality and widespread training to adopt the All Wales FCP module. Digital are leading the work and I am unaware at present timelines for this to be completed. FCP workstream are developing an FCP guideline but cannot complete this until Digital indicate processes/procedures that will be followed This action has been delayed due to the lack of a national policy on Future Care Planning. in the absence of that policy ABUHB will develop an internal management policy which will be shared with partners by the end of December	Unknown - dependant on national work		Yes
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	2.1	Paper records From our sample review of records for 90 patients we found evidence of poor records management. We also found issues, such as records not being kept in chronological order, files overflowing and the absence of patient IDs on certain records. We came across two instances where multiple patient records were bundled together in one file.	Agreed Action: Although it is not evidenced that ward clerks were in place in each of these wards, the lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled bi-monthly. We recommend mandated Health records management training for all ward clerks during induction, alongside refresher sessions, to provide a more in-depth understanding of the processes involved. Although there is a national Health records Management Module incorporated in the mandatory Information Governance training, this does not provide in-depth records management training in ABUHB processes. We are implementing a schedule of ward visits and training updates across the Health Board, to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. Discussions will be held with the Executive Director of Nursing on including some of these elements in the Ward Accreditation Programme. Expected Evidence of Implementation: Microsoft list with information on all wards and scheduled dates to visit, to commence	Head of Health Records - DHR	31/12/2025	31/12/2026		Overdue	Not Yet Due	3	July 2026 update - Improvement activity remains ongoing and continuous, with positive actions already implemented, including strengthened induction processes for newly registered nurses and junior doctors, records management awareness sessions and the establishment of a Health Records Support Network. The health records team has also contributed to a review of the new version of the national e-learning package for Records Management, Information Governance and Cyber Security, helping to strengthen learning content through the inclusion of standards and assessment questions to support staff knowledge and compliance. Audits of inpatient records returned to Online house demonstrate 94% compliance against five key record keeping standards: use of black ink, dated entries, legible documentation, signed entries and recorded times. As part of the existing audit process, records are checked for the presence of patient identifiers and to ensure documentation relating to multiple patients is not filed within a single record. However these elements are not currently recorded. To strengthen assurance and provide visibility these elements will be formally captured.			
ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	High	2.1	Switch Patching There is currently no report or process to monitor patching compliance within the switching estate. Our testing noted that not all switches are running the latest approved software, with some running old versions which contain security vulnerabilities, including critical ones.	Agreed Action: Partially Agreed. ABUHB does have a network patching framework process in place which is in line with ABUHB Cyber Security Patch Management Policy. As part of our network support contract, we will be implementing network collector that provides patching compliance. Expected Evidence of Implementation: Through the cyber security report	Head of ICT	30/06/2026	30/10/2026		Overdue	Not Yet Due	2	July 2026 - Further resource constraints, workload reprioritisation and in addition the required Cisco Smart Collector is now being retired leading to delays to implement this. The replacement product is Cisco IQ and initial engagement have taken place around to have this implemented.			

ABUHB-2425-23	Internal Audit	Technical Continuity	Reasonable	Director of Digital	Medium	3.1	Application Record There is no full record of applications in use within the Health Board and the tier to which they belong, as such, clarity and understanding of RTO/RPO within the services may be lacking, neither is there a clear prioritised order to systems to be restored that is based on a business impact analysis and agreed with the services.	Agreed Action: Agreed. Service Management is documenting the services and CIs that we are aware and appreciate that there is more to uncover. In conjunction with our Business Continuity Lead we will ensure this is captured alongside the agreed tier they belong to in the Service Catalogue. For new services on-boarded this will be included in the service transition process going forward. Expected Evidence of Implementation: Service catalogue	Head of digital service management	30/06/2026	30/09/2026		Overdue	Not Yet Due	1	Service Catalogue is extensive and holds all service known to DDAT currently. Work is underway to extend the scope of the catalogue to include digital services not currently managed by DDAT. Priority services (11) have been identified with the Digital Business Continuity Clinical Lead. In the event of a P1 incident these systems are prioritised for monitoring and restoration. Other critical systems are also identified Further work required to undertake formal business impact analysis, and establish RTO/RPO for each of the services			
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	Medium	1.1	E forms The lack of eForms functionality means the approach remains focused on paper transformation rather than true paper avoidance.	Agreed Action: Limited development of eForms took place prior to 2019, after which responsibility for development transferred to the informatics budget, and the Health Board's software development team. Since 2018/19, linear eForms have been available within Clinical Workstation, the Health Board's clinical portal, and are in regular use. However, this functionality is outdated and poses a risk to the organisation. To address this, a business case is being developed to procure a replacement eForms and workflow solution. This will enable form and workflow development in both inpatient and outpatient settings supporting clinical safety, productivity and efficiency benefits. This will also release DHR capacity to focus on digitising historical paper records for mental health and learning disabilities services as they transition to the new EPR in 2026. With the roll out to primary & community care services, in the futureFurther reductions in paper usage will also be achieved through the implementation of national applications, such as Welsh Nursing Care Record (WNCR) Badgernet for Maternity services, subject to their respective implementation roadmaps. Expected Evidence of Implementation: • Reduction in use of inpatient and outpatient supplementary scanning in acute care settings. • Reduction in the use of paper forms • Increase in the use of eForms	Head of Digitised Health Records Service	31/05/2026	31/12/2026		Overdue	Not Yet Due	1	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.			
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	2.1	Current suitability A lack of upgrades has meant that the Health Board is on an old, unsupported version of cCube which is not able to provide modern functionality and interoperability with other clinical systems. Consequently, the system has not evolved with organisational requirements.	Agreed Action: The Health Board acknowledges that remaining on an unsupported version of cCube limits functionality and interoperability with other clinical systems and no longer meets organisational requirements. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Further development planning sessions are scheduled for September 2025 to agree a timeline for completion of the upgrade. However, completion is dependent on approval of the CWS Risk Business Case and the reorganisation of the service to establish a core support team to undertake the required API amendment. Subject to these dependencies, completion is estimated for early 2026/27. A risk has been raised relating to cCube on the directorate risk register: • 1829 – cCube out of support (Score 6)Support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions) Electronic Document Management System and corresponding capsure scanning software to the latest version 4.4.	Head of Digitised Health Records Service	31/05/2026	31/12/2026		Overdue	Not Yet Due	1	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider whether the contractor took reasonable steps to mitigate the impact and exclude any costs arising from the contractor's own inefficiencies or delays. The cost advisor will prepare a Final Account Statement; however this is on hold until the			
ABUHB-2425-24	Internal Audit	EDRMS	Reasonable	Director of Digital	High	3.1	Servers: cCube is hosted on Windows Server 2012 R2, which is now unsupported and exposed to known security vulnerabilities.	Agreed Action: The Health Board acknowledges that cCube is currently hosted on Windows Server 2012 R2, which is unsupported and presents known security vulnerabilities. To mitigate this risk in the short term, Extended Security Update (ESU) support has been applied to the web and importer servers for a 12-month period, as confirmed by the Business Systems Unit. This provides continued security patching and reduces the immediate exposure.For the long term, a business case and upgrade plan are in place to move to cCube version 4.4, which will run on a supported operating system. Progression to the required version, 4.4, is dependent on amendments to an API code by the Health Board's software development team however, internal development required to progress with the upgrade will not be completed prior to September 2025. Subject to this dependency, migration to the supported version and operating platform is expected thereafter. A risk has been raised relating to cCube on the directorate risk register: • 1739 – cCube Cyber Security Vulnerability (Score 12)Standard mitigations have been put in place by our Cyber Security Team to ensure the system is protected from cyber security threats and support is provided by the supplier for issues although no development requests can be submitted. Expected Evidence of Implementation: Successful upgrade of the Noveva software group (formerly known as cCube solutions)	Head of Digitised Health Records Service	31/05/2026	31/12/2026		Overdue	Not Yet Due	1	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.			
ABUHB-2526-04	Internal Audit	Subject Access Requests	Limited	Director of Digital	High	6.1	Complaints and appeals Testing of seven complaints found that six of them were initially processed through the Putting Things Right process: • One had their details checked and driver's licence submitted for verification. • For the remaining five, it was assumed that the PTR team had already verified the requestor's identity. However, it was confirmed that the PTR team had not undertaken these checks. Accordingly, ID check procedures for complaints were inconsistent.	Agreed Action: • Update complaints and appeals procedures to require mandatory ID verification for all cases regardless of whether they originate from the PTR process. • Update SOPs. • Communicate the process to both A2HR and IG staff to ensure consistent application. • Implement a monthly audit of complaints and appeals to confirm to confirm ID verification compliance. • Escalate non-compliance to senior management and record corrective actions. Expected Evidence of Implementation: • Copies of revised SOPs. • Audit report summarising checks over a defined period. • Evidence that A2HR & IG teams have been briefed on the updated process.	Assistant Director of Digital Governance & Assurance / DPO	30/06/2026	31/12/2026		Overdue	Not Yet Due	1	Original Completion date :- 27th October 2025 EOT 1 = 12th Feb 2026 EOT 2= 19th Feb 2026 EOT 3 = 27th March Practical Completion 31st March 2026. Any delay notice received was raised formally during the monthly contractor progress meeting, subsequent programme and risk mitigation reviews took place on teams or onsite with the key relevant parties. (EOTs contain outline details of cause of delay) These were also issued in the PM monthly reports to client and raised within the project board meetings. L&E A budget cost was issued by contractor relating to anticipated loss and expense claim for each event. These were only agreed once full substantiation was accepted by the cost advisor and were generally reduced to align with actual loss. The assessment reviewed the contractor's notices, records, cost breakdowns, labour and plant records, and supporting invoices to verify that the costs were actually incurred, reasonably incurred, and not duplicated elsewhere. Meetings / discussions also took place to consider whether the contractor took reasonable steps to mitigate the impact and exclude any costs arising from the contractor's own inefficiencies or delays. The cost advisor will prepare a Final Account Statement; however this is on hold until the			

2023.17	Internal Audit	IT Infrastructure	Reasonable	Director of Digital	Low	R4.1	Alert thresholds should be configured to identify relevant issues promptly	ABUHB accepts this recommendation. Event management and alerting is under review with the aim to provide a consolidated platform (single pane of glass) for all alerts. Once the procedure outlined in 4.2 has been implemented this will be applied to any new infrastructure at install with existing assets being addressed over time.	Head of Ict	31/07/2025	31/07/2026		Overdue	Not Yet Due	5	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
2023.17	Internal Audit	IT Infrastructure	Reasonable	Director of Digital	Medium	R.2	A set of formal procedure documentation and guides for managing the infrastructure should be defined.	ABUHB accepts this recommendation. There is already a large amount of documentation available for infrastructure management – mostly done to coincide with our Service Desk Institute Audit of policies and processes. Gap analysis will be undertaken to ensure that comprehensive documentation is developed and maintained for all infrastructure services	Chief Technology Officer	31/07/2024	31/07/2026		Overdue	Not Yet Due	3	March 2026: No progress due to insufficient resources to complete, now the OCP within Service Management this will now be taken forward in the summer.			
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	3.1	System alerts We found some examples where mental capacity limitations are not always accurately reflected on CWS. While there are warning flags available in the system to alert system users about specific conditions of a patient, these flags are required to be switched on manually. We found six patients where the "This is me" document was on file, but no flag was turned on within CWS. We also note that Lasting Power of Attorney (LPA) is listed as a clinical alert in CWS, which links through from WPAS keynotes. This alert is added to WPAS by the Health Records Team when the LPA document is received for scanning, and this should also be recorded at ward level when documents are presented.	Agreed Action: We recommend that this forms part of the basic WPAS training for new starters, and also the refresher WPAS training. We will link in with the WPAS systems team to ensure this is incorporated into the new training packages that are being developed as part of the Planned Care Academy work. Expected Evidence of Implementation: Evident in training and guidance documentation for all staff.	Head of Health Records - DHR	30/06/2025	30/11/2026		Overdue	Not Yet Due	4	The proposal has been developed but funding not yet identified			
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	Medium	4.1	Spot checks Spot checks of patient records are conducted regularly; however, these assessments primarily take place at or near the final stages of the digitalisation process or following its completion. As a result, it is challenging to address any issues identified at this point of the time.	Agreed Action: The Information Governance Team are in the process of gaining approval for an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit. Expected Evidence of Implementation: Audit reports from the newly established IG Audit team.	Head of IG & DPO	31/03/2026	31/01/2027		Overdue	Not Yet Due	1	March 2026: March 2026: Progress continues across the WPAS training workstream, with core lesson plan development moving forward and wider training materials being refreshed to ensure consistency and alignment with current operational requirements. Userguides are undergoing further revision, and related updates on ABPulse. Phase one of the training programme remains fully operational, supported by the booking app and appropriate training facilities, and additional materials are nearing completion. Planning is progressing for the next phase of refresher and review activity, which is helping to broaden the overall training offer. Work is also underway to strengthen organisational support through RBC's dedicated training resource, to support raising awareness and promote consistent standards across booking processes. A Training Hub has been developed within the RBC ABPulse page, providing a central repository for standard operating procedures. Functionality within WPAS to prompt users to check keynotes is being explored, with ongoing engagement across other Health Boards already using this feature.			
ABUHB-2425-16	Internal Audit	Records Management	Limited	Director of Digital	High	7.1	Access to paper records We reviewed records for 90 patients from 18 different wards (see ward details listed under objective 2), we found the following issues: Ref Description of the issue Number of patients 1 The alive / deceased patient file was not sent for scanning. - 47 2 The patient was not formally discharged within 24 hours after left the hospital in CWS,and physical records were left behind at the ward. - 4 3 The Patient was transferred without physical patient record within the HB. - 4 4 The Patient was transferred with the physical records within the HB, but the DHR files were not tracked to the new location in WPAS. - 4 5 No patient file was raised in WPAS during the inpatient period or after the discharge at the time of our visit. -10 6 Various supplementary paper records left behind after the patient's DHR file was sent for scanning. - 8 We note that many of the issues outlined above resulted from the pro-longed absence of the local ward clerk (for example: • no ward clerk worked at the Cas Gwent ward at Chepstow Community Hospital in the last 6 months; or • the Health Records Services were provided by temporary staff who had no access to any of the health records	Agreed Action: The lack of records management does require to be addressed across the organisation. The service has previously requested for local health records management training to be mandatory. This was not approved and therefore there is limited engagement at Health Records Awareness sessions that are scheduled monthly. We recommend mandated Health records training for all ward clerks during induction to provide a more in-depth understanding of the processes involved. We are implementing a schedule of ward visits and training updates across the Health board to promote best practice and provide evidence of where there are gaps that need to be addressed but there is a resource gap to undertake extensive training across all sites. A board development session will also be undertaken on records management to improve support by the executive team and independent members. Expected Evidence of Implementation: A Microsoft list with information on all wards and scheduled dates to visit, to commence from 21/02/2025. Microsoft form to gather information from the ward clerk regarding current processes which we can analyse and support where required. A formal report can be generated from these findings The Information Governance Team are in the process of establishing an internal audit team who will undertake regular spot checks on wards, with data quality and record keeping being part of the remit.	Head of Health Records – DHR	31/12/2025	31/07/2026		Overdue	Not Yet Due	4	March 2026 Update: Completed ward engagement visits, providing hands on support and advice to ward clerks with issues that were reported in the Audit. Following feedback from ward clerks, who reported uncertainty with role expectations and records management standards, The Health Records Support Network was established. This network enables real time advice, best practice sharing and access to Standard Operating Procedures. The Network has introduced a Monthly "Spotlight on" feature where a topic, issue or prrocess is selected to share tips and best practice. Supplementary health records management training has been integrated into Corporate Induction for newly qualified nurses & ward accreditation. This training directly addresses issues with access to paper records and provides best practice guidance for nurses and ward managers. A proposal presented to the Core Learning Committee in February 2026 to make this training mandatory for specific staff groups is currently awaiting decision. A Health Records Survey was shared with all General Managers (Open November 2025 - April 2026) and the insights will be used to help shape improvement activity, and create a comprehensive Health Records Standards Plan. A contingency plan for ward clerk absences has been shared with Senior Divsional Nurses, outlining responsibilites and the process on how to notify The DHR service of ward clerk long term absences. The DHR service remains committed to continue these actions, improvements and engagement efforts to support continuous improvement and open			

ABUHB-2425-17	Internal Audit	Job Planning	Limited	Medical Director	High	2.2	Quality of approved of job plans Our testing of approved job plans showed: • 10 out of the 20 job plans did not contain personal outcomes for individuals even though this is stipulated in the guidance. The L2P function for recording service outcomes is not currently activated and thus, not being recorded. This position should be reviewed once the compliance position with contracted sessions and personal outcomes has been improved. These aspects need to be improved to ensure contractual obligations are adhered to and they are completed correctly.	Agreed Action: The Service outcome section in L2P will be activated once all consultants have an up-to-date job plan on the system and have identified personal job planning outcomes. Personal outcomes are based on the individual doctor's needs (career development etc.) and the service needs are discussed at the job plan review meeting. Expected Evidence of Implementation: SMART objectives are evident in the operational section of each job plan. Job plans are not signed off until these are complete.	Medical Director/Director of Workforce & OD	31/10/2025	31/12/2026		Overdue	Not Yet Due	1	This requirement was not part of our original contract with L2P however the company has agreed in principle to include this in the systems development. The timescales for this are unclear at present due to other priorities. The Medical e-Systems Team will provide updates following their regular meetings with L2P. The SMART element is included in the job planning training which all consultants have been asked to undertake previously. It has also been included in the communication to all consultants and management teams. (Update provided to ARAC Jan 2026).			
ABUHB-2425-07	Internal Audit	Declaration of Interests	Substantial	Director of Corporate Governance	Medium	2.1	Mandatory Declarations Whilst it is the responsibility of individuals to declare interests, there is a requirement for some staff groups (e.g. Band 8A and above) to complete a mandatory declaration (either nil or otherwise). Currently, there is no central process (including reminders) for ensuring all staff required to do this complete the declaration process in a timely manner.	Agreed Action: As set out within the Standards of Business Conduct Policy (section 6), Line Managers are responsible for ensuring employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy is to be be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate. In addition, the Corporate Governance Directorate will establish a centralised process to monitor and track the submission of declarations by all those staff required to submit a return in-line with the policy.	Director of Corporate Governance	31/03/2026	30/09/2026		Overdue	Not Yet Due	1	Working with Woorkforce and OD colleagues to include list of 'high risk' groups in PADR documentation. Joint letter sent from DoCG and MD to all consultants reminding them if the requirement to declare interests. List of band 8a and above staff requested to target this cohort of 'high risk' staff. Meetings held with other Health Boards on the use of ESR to record DoIs in order to facilitate monitoring of compliance levels.			
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	Medium	2.1	A Data Quality Policy should be developed to underpin the commitments made within the Data, Analytics and Information Strategy and to act as an actionable statement of intent to all staff.	A formal data quality policy will be developed alongside a proposal for an audit team within Digital, Data & Technology to provide assurance over implementation and compliance.	Chief Information Officer	30/09/2026	30/09/2026		Overdue	Not Yet Due	2	OCP still to be completed. The DQ policy will follow when the OCP is completed.			
ABUHB-2425-22	Internal Audit	Intelligence Led Organisation	Reasonable	Director of Digital	High	3.1	Management should ensure that all information products produced outside of Information Services clearly indicate where definitions differ from the standard.	Through the implementation of the Data & Analytics Information Management Strategy a Centre of Excellence will be established led by the Chief Information Officer to ensure outputs where relevant comply with standards and a ABUHB "kitemark" will be added to reports so this will be clearly visible.	Chief Information Officer	31/07/2025	30/09/2026		Overdue	Not Yet Due	1	Data strategy launch is scheduled for 13th May. The |CoE will be established followuing this launch.			
ABUHB-2425-15	Internal Audit	Medical Equipment and Devices	Reasonable	Director of Allied Health Professionals	High	3.1	From the sample, six cases identified that the equipment user was responsible for the service/ maintenance cover of the item, but we were unable to obtain any records to evidence this was currently active in any of these cases.	Agreed Action: Executive Director of Allied Health Professions and Health Science to communicate with divisions, highlighting divisional roles and responsibilities with respect to medical equipment management and adherence to organisational policies. Risk assessment to be undertaken with respect to equipment maintenance. This will be held on the medical devices group risk register with progress being monitored by the group through risk agenda item. Time limited multi-divisional working group to undertake work to establish: - Develop divisions of responsibility document – this will support understanding of who is responsible for what aspects of medical equipment management - Definitive list of patient-connected electronic medical devices that are in-scope - Current state baseline audit of in-scope equipment where equipment maintenance is service responsibility - Seek divisional assurance that identified equipment has adequate maintenance arrangements This recommendation and agreed actions will form part of the medical devices group forward work plan for 25/26 and progress will be discussed as an 'internal audit' standing agenda item. Barriers to completion will be escalated to quality management group as required. Expected Evidence of Implementation:	Health Science Chair of Medical Devices Group	31/03/2026	30/06/2027		Overdue	Not Yet Due	1				

4007EA2025	External Audit	Eye Care Review	Not Rated	Chief Operating Officer	N/A	2.1	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	Chair of Regional Ophthalmology Programme Board	31/03/2026	31/03/2027		Overdue	Not Yet Due	1	Workforce plan delayed due to outsouricng project. Workforce plan is a priority for 26/27 with work due to start in April 2026.			
4006EA2025	External Audit	Urgent and Emergency Care: Flow out of Hospital – Gwent Region	Not Rated	Director of Nursing	N/A	8.1	The Health Board and local authorities should implement ways in which patient information can be shared more effectively, including opportunities to provide wider access to organisational systems and ultimately joint IT solutions.	Local Authorities in the process of replacing the existing IT client record (WCCIS) over the next 18 months. There is potential with a new system for it to link with the Health Board system over time. There are processes in place to share information to support discharge planning, but this does not amount to a joint IT solution. Health Board progressing with scoping an IT solution to merge the Complex List with CWS2, with sharing of data across Local Authorities to support meaningful, real-time data analysis	Director of Nursing and Director of Digital	31/12/2025	31/12/2026		Overdue	Not Yet Due	1				
4004EA2025	External Audit	Quality Governance Follow Up	Not Rated	Director of Workforce and OD	N/A	4.2	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: monitoring and reporting on completion rates for the Duty of Quality and Duty of Candour e-learning.	Monitoring of all statutory and mandatory training compliance is published on a monthly basis, including Duty of Candour. Duty of Quality will be included once approved by the Core Learning Advisory Committee.	Director of Workforce & Organisational Development	30/07/2025	31/12/2026		Overdue	Not Yet Due	1	Duty of Candour has been through the Core Learning Committee and the Staff Segment Report completed, which identifies the staff groups requiring this training in ESR. This information has been sent to the Organisational Development Coordinator to move to stage 4 of the process. Duty of Quality to go through Core Learning Advisory Committee for approval.			
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	High	1.1	BCP and action cards We noted none of the three sampled services had conducted nor scheduled any test exercises of their BCPs. Additionally, we noted the following weaknesses with BCP action cards: • action cards do not record triggers i.e. the event that would trigger their use; • action cards are not role specific; • not all action cards are critical function specific, but are more broad-based describing generic level actions; and • hard copy action cards are not stored in a safe place ready for use.	Agreed Action: The EPRR team will work with all service areas to ensure that local Business Continuity Plans (BCPs) are regularly tested and that action cards are updated to address identified weaknesses.Specifically: • Develop and roll out a train-the-trainer package and supporting test and exercise toolkit to enable divisions/directorates to conduct and record regular BCP exercises. • Support services to review and update all action cards to: o include clear activation triggers; o define role-specific responsibilities; and o align actions to critical functions. • Ensure that hard copies of BCPs and action cards are securely stored and readily accessible in key operational areas. Monitor completion and effectiveness through local BCP assurance audits and reporting to the EPRR Group. Expected Evidence of Implementation • Approved train-the-trainer and test/exercise toolkit. • Records of completed BCP exercises conducted by services. • Sample updated BCP action cards showing: o documented activation triggers, o named roles/responsibilities, and o linkage to critical functions. • Confirmation and/or photographs of securely stored hard copies in operational areas. • Divisional/local BCP audit reports confirming plan review and compliance.	Head of Planning – Civil Contingencies	31/03/2026	30/09/2026		Overdue	Not Yet Due	1	Internal audit questionnaire, monthly compliance checks, exercises, and a 2026 training programme are being used to strengthen BC planning and address audit gaps.			
ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	2.1	Training for key staff in their role and responsibilities in respect of delivering business continuity We were advised that in the sample services that we examined, only a small number of senior staff are familiar with the BCP protocols. All three sample services examined acknowledged the need to extend business continuity plan training to further key staff, but had not yet scheduled any training events.	Agreed Action: The EPRR team will ensure that key operational and managerial staff across all divisions/directorates receive appropriate training in their roles and responsibilities for delivering business continuity. Specifically: • Identify and confirm Business Continuity (BC) leads within each division/directorate. • Develop and deliver a stand-alone, role-specific training package focused on staff responsibilities for activating, managing, and maintaining BCPs. • Ensure BC leads are equipped to cascade this training to other key staff within their areas. • Monitor completion and effectiveness through service level audits and regular reporting to the EPRR Group. These actions will ensure that all key staff understand their specific roles within the business continuity framework and can implement BCPs effectively during service disruption. List of appointed BC leads for all divisions / directorates • Approved and issued BC role-specific training package. • Training attendance records demonstrating that BC leads and key staff have completed training. • Evidence that training has been cascaded to relevant operational staff (e.g., attendance logs, training summaries). • Local BCP audit reports confirming that staff are aware of their responsibilities and	Head of Planning – Civil Contingencies	31/03/2026	30/09/2026		Overdue	Not Yet Due	1	Bespoke IT downtime exercises and BC assurance for new digital systems are being rolled out with DDaT, alongside continued BC roadshows to raise awareness.			

ABUHB-2526-06	Internal Audit	Business Continuity Planning	Reasonable	Director of Planning, Strategy and Partnerships	Medium	3.1	BCP contact details protocols We noted an instance in the testing where BCP stakeholder contact details were recorded in the form of a SharePoint location that may not be operable in an interruption event and mean key resources cannot be mobilised.	Agreed Action: The EPRR team will ensure that current and accessible contact details for all key stakeholders is available and usable during any service interruption. Specifically: • Each service area will maintain hard copy BCP and action card folders containing up-to-date contact details for all critical staff, partner organisations, and stakeholders. • These folders will be stored securely and accessibly in designated operational areas to ensure they can be used if electronic systems (e.g., SharePoint) are unavailable. These actions will ensure that essential contact information remains accessible during an interruption, enabling timely and effective incident response. Expected Evidence of Implementation: • Confirmation showing hard copy BCP and action card folders are available in each service area.10 • Evidence of up-to-date contact lists included within those folders. • EPRR audit reports confirming that hard copy plans and contact details are in place, accurate, and accessible. Divisional assurance updates presented to the EPRR Group demonstrating ongoing compliance.	Head of Planning – Civil Contingencies	31/03/2026	30/09/2026		Overdue	Not Yet Due	1	Divisions must evidence BCP coverage, testing, and risk-register gaps, supported by unannounced compliance checks and targeted support for vulnerable services.			
ABUHB-2526-27	Internal Audit	GUH ED Extension	Limited	Director of Planning, Strategy and Partnerships	Medium	9.1	Updated Benefits Realisation Plan The Benefits Realisation Plan included within the business case anticipated measurement of benefits achieved from quarter 1 2025/26 (following completion of both phases of the project).Recognising the slippage in timescales, assessment of benefits realisation had therefore not yet commenced. Noting the recent postponement of Phase 2, the UHB should confirm when benefits measurement should commence in respect of Phase 1 (if this is possible ahead of delivery of Phase 2), supported by an updated benefits realisation plan if appropriate.	Agreed Action: Benefits will be tracked from Qtr4 of 25/26. BRM will be reviewed and updated if appropriate. Benefits realisation will be reported back through Investment Panel and Executive Committee. Expected Evidence of Implementation: Populated BRM at end of qtr1 and will continue to be tracked throughout the year.	General Manager – Urgent and Emergency Care	30/06/2026	31/12/2026		Overdue	Not Yet Due	1	Whilst Phase 1 of the ED Extension has delivered the planned increase in waiting room capacity, enhanced triage facilities and the Senior Rapid Assessment model, the full benefits have been constrained by delays to Phase 2 and ongoing system-wide flow challenges. High hospital occupancy, delays in discharge and limited inpatient capacity continue to result in prolonged ED stays, crowding and corridor care, reducing the extent to which the expanded ED footprint can improve patient flow and experience. It is also important to note that significant work is underway through the Our Next Patient (ONP) programme and Urgent and Emergency Care Sprint activity to improve whole-system flow. These initiatives are focused on addressing the wider constraints around hospital capacity, discharge performance and patient movement, which are essential to fully realising the benefits of the ED Extension.			

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Audit Recommendation Tracking Procedure:** Review and Approval of Revised Procedure
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit Recommendation Tracking Procedure has been reviewed and updated to strengthen the governance, monitoring and assurance arrangements relating to the implementation of Internal and External Audit recommendations.

The revised procedure has been developed to provide greater clarity regarding management responses, implementation timescales, monitoring arrangements, quality assurance requirements and the management of recommendations subject to internal or external dependencies.

Cefndir / Background

The Audit Recommendation Tracking Procedure was originally approved by ARAC in September 2024 and established a consistent process for receiving, monitoring and reporting progress against Internal and External Audit recommendations.

Following practical implementation of the procedure, a review has been undertaken to ensure that:

- management responses adequately address identified control weaknesses and associated risks;
- implementation dates are realistic and deliverable;

- recommendations with national or external dependencies are appropriately managed and monitored;
- timely commencement of actions in accordance with the priority assigned to recommendations;
- quality assurance arrangements are clearly defined; and
- ARAC receives sufficient information to undertake effective oversight and challenge.

Asesiad / Assessment

The key amendments introduced within the revised procedure are summarised below.

Realistic Implementation Dates

The procedure has been strengthened to ensure that management responses include realistic implementation timescales supported by appropriate consideration of:

- Workforce capacity;
- Financial implications;
- Capital requirements;
- External dependencies;
- Operational constraints; and
- Associated risks.

Where recommendations are expected to take longer to implement, management responses are asked to include interim milestone and progress measures, where possible, to demonstrate ongoing delivery and risk reduction.

Recommendations with External Dependencies

Additional guidance has been included regarding recommendations that are dependent on:

- Welsh Government decisions;
- National programmes;
- Funding approvals;
- National digital developments; or
- Third-party organisations.

The procedure now requires:

- External dependencies to be clearly identified;
- Implementation dates to reflect realistic external timelines;
- Local mitigating actions to be implemented wherever possible;
- Interim progress updates to continue to be reported; and
- Recommendations to be clearly categorised within the audit recommendation tracker.

Enhanced Scrutiny of Extension Requests

The revised procedure strengthens the arrangements for managing revised implementation dates.

Executive Directors seeking an extension to an agreed implementation date must provide:

- A clear rationale for the delay;
- Evidence of progress made to date;
- Confirmation of interim mitigating actions;
- Confirmation that the revised date is realistic and achievable; and
- Consideration of any associated risk escalation requirements.

The Committee's existing approach to enhanced scrutiny following multiple implementation date revisions has been retained and strengthened. This reflects the expectation that implementation dates approved at the outset should be realistic and that repeated extensions should be the exception rather than the norm.

Commencement of Actions

The procedure now clarifies that the implementation date and the commencement of action are not the same.

Auditor expects management to commence work on recommendations within timeframes aligned to the priority assigned to the recommendation.

Whilst implementation dates will vary depending on complexity and available resources, management should normally ensure that:

- **High priority recommendations** commence with immediate effect of the final audit report;
- **Medium priority recommendations** commence within one month of the final audit report;

This reflects the expectation that management should begin addressing identified control weaknesses promptly, even where full implementation will require a longer delivery period.

Quality Assurance Arrangements

A new Appendix (Appendix C) has been introduced which sets out formal quality assurance arrangements covering:

- management responses;
- progress updates;
- requests for revised implementation dates;
- recommendation closure requests; and
- committee oversight.

The appendix clarifies responsibilities, minimum assurance requirements and record retention expectations for each stage of the process.

Closure of Recommendations

The procedure now makes clear that recommendation closure should not be based solely on completion of an action.

Prior to recommending closure, the responsible Executive Director must be satisfied that:

- The recommendation has been implemented;
- The intended improvement has been embedded;
- The associated control is operating effectively; and
- Supporting evidence has been retained and can be produced if requested.

Evidence supporting closure must be retained within the approved corporate repository and referenced within the Audit Recommendation Tracker.

Argymhelliad / Recommendation

The Committee is asked to:

1. **Approve** the revised Audit Recommendation Tracking Procedure.

2. **Note** the strengthened arrangements relating to implementation dates, progress monitoring and recommendation closure.

3. **Note** the enhanced scrutiny arrangements for requests to revise implementation dates.

4. **Note** the requirement for management to commence action on recommendations within the expected timeframe associated with the priority level assigned by auditors.

5. **Note** the introduction of formal quality assurance arrangements through Appendix C.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix 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. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

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

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	Choose an item. Choose an item. Not applicable to this report

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

PROCEDURE FOR THE MANAGEMENT OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

Implemented: September 2024 **Status:** Version 2
Updated: September 2026 **Approving Forum:** Audit Risk and Assurance Committee

CONTENTS

1. PURPOSE

Effective implementation of audit recommendations is a key component of the Health Board's assurance framework. This procedure supports the timely resolution of control weaknesses, promotes accountability, and provides the Board and its Committees with assurance that risks identified through internal and external audit are being appropriately managed and mitigated.

The purpose of this Procedure is to set out the:

- requirement to have a comprehensive and considered management response and action plan in response to Internal and External Audit Reviews (signed off by the lead Executive Director);

- requirement for management responses and action plans to facilitate scrutiny and provide assurance that actions have been implemented in a robust and timely way;

- the role of the Audit, Risk & Assurance Committee (ARAC) in:

    - receiving final Internal and External reports, alongside management responses and action plans;
    - being assured of the adequacy of the management response to issues identified by internal and external audit and the arrangements for monitoring respective actions going forward;
    - challenging the pace of delivery of actions and approving any changes to the agreed timescales of actions;
    - agreeing the frequency of monitoring based on the level of risk and priority of actions; and
    - overseeing the closure of action plans;

- requirement to have one central point for the receipt, logging, tracking, monitoring and reporting of progress against internal and external audit reviews and associated recommendations.

In addition, the purpose of monitoring audit recommendations is not solely to track completion of actions, but to provide assurance that identified control weaknesses have been appropriately addressed, associated risks mitigated, and sustainable improvements embedded within normal business processes.

The implementation of audit recommendations forms an important component of the Health Board’s overall assurance framework and supports the Board in discharging its responsibilities for governance, risk management and internal control.

N.B. This procedure does not extend to the management of improvement actions arising from regulatory inspections or independent reviews (such as those conducted by Llais). The nature of which is handled separately and overseen by the Board's Patient Quality, Safety, and Outcomes Committee.

2. ROLES AND RESPONSIBILITIES

The Role of the Board in Respect of Internal and External Audit

As set out within Standing Orders, the Board is expected to set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Health Board business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. The Board shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

In doing so, the Board shall ensure that its assurance arrangements are operating effectively, advised by its ARAC

The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards.

The Board will also seek assurance from the work carried out by external audit on the adequacy of the Health Board's assurance framework. However, that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

The Role of the Audit, Risk & Assurance (ARAC)

The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 *[WHC (2006) 090]* establishes the requirement for every NHS Board to establish an ARAC, and this has been incorporated into Standing Orders for Local Health Boards. At its meeting on 23 March 2022, the Board reviewed its Committee structure and approved the establishment of the ARAC, which can be found here.

The ARAC supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. At the corporate level these will include a risk management system and a performance management system underpinned by an effective system of assurance.

The ARAC's primary role is to ensure the system of assurance is valid and suitable for the Board's requirements. The ARAC will review whether:

- The system of assurance is appropriate for the organisation;
- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

In fulfilling its role, the ARAC will rely on the organisation's internal arrangements and consider any audit work.

The Role of Internal Audit

Internal Audit is a key source of independent internal assurance to the Board and Accountable Officer (Chief Executive Officer). The Public Sector Internal Audit Standards (PSAIS_1_April_2017.pdf (publishing.service.gov.uk)) describe the role of internal audit as enhancing and protecting organisational value by providing risk-based and objective assurance, advice and insight.

As such, its role embraces two key areas:

1. The provision of an independent and objective opinion (the Head of Internal Audit Opinion) to the Accountable Officer, the Board, and the ARAC based on an objective assessment of the framework of governance, risk management and control; and

2. The provision of an independent and objective advisory service, with the aim of supporting management to improve governance, risk management and control and contributing to the overall opinion of the Head of Internal Audit.

The Public Sector Internal Audit Standards provide an essential reference source for the ARAC in understanding what it can expect from internal audit and when assessing the service provided.

To support the system of assurance, Internal Audit will develop a risk based annual internal audit plan which details all the audit reviews to be undertaken in the coming financial year.

The Role of External Audit

The Auditor General for Wales (the Auditor General) is the external auditor of NHS Wales. The statutory duties of the Auditor General in

respect of individual NHS bodies fall under two broad headings – to review and report on:

- The audited body's financial statements, and on its Annual Governance Statement; and

- Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The external audit role is exercised in accordance with statutory provisions and the work of external auditors is subject to the 'Code of Audit Practice of the Auditor General for Wales' (Code of Audit Practice | Audit Wales) and 'the Statement of the responsibilities of the Auditor General for Wales and of the bodies that he or she audits'.

The Auditor General's representatives (the External Audit Team) will develop an annual audit plan designed to deliver a safe opinion on the accounts and to enable the Auditor General to draw conclusions on whether the NHS body has made proper arrangements for securing economy, efficient and effectiveness in its use of resources.

The audit plan will also cover issues such as regularity, propriety and value for money.

In developing the annual audit plan the Auditor General's representatives will consider the audit needs of the organisation, using a risk-based approach.

3. MANAGEMENT AND TRACKING OF AUDIT REPORTS

Internal and External Audit – Audit Scope

The Annual Audit Plans will detail the audit assignments, lead executive officers, scopes, and proposed timelines. Before each audit, the responsible executive director(s) will receive a draft audit brief outlining the scope, objectives, audit resource requirements, and timing.

Internal Audit performs two primary types of engagements: **advisory reviews** and **assurance reviews**. While both support the organisation's governance, risk management, and internal control objectives, their purpose, approach, and reporting outcomes differ.

Advisory reviews are consulting-oriented engagements undertaken to provide advice, guidance, and value-added insight to management. These reviews are typically forward-looking, supporting process or control improvements during periods of change or system development. Advisory

work does not provide formal assurance or ratings and does not form part of the organisation's assurance opinion. The nature of these reviews is collaborative, with Internal Audit working closely with management to highlight opportunities for enhancement while maintaining professional objectivity and independence.

Assurance reviews provide an independent and objective assessment of the adequacy and effectiveness of governance, risk management, and control processes. These reviews follow the full internal audit methodology, including planning, testing, and evidence-based evaluation. Assurance engagements result in a formal audit report, including a conclusion or rating on control effectiveness, and are used to inform senior management and the ARAC about the current state of risk and compliance within the organisation.

Audit Wales undertakes external audit work across the Welsh public sector, including financial audit and performance audit activities. Their reports may offer commentary or conclusions on the adequacy of governance, risk management, financial sustainability, or performance arrangements within the organisation. While these conclusions contribute to the wider assurance landscape, Audit Wales does **not** consistently issue formal assurance ratings in a standardised or numerical format equivalent to those used by Internal Audit (e.g., substantial / reasonable / limited assurance).

Once both parties have agreed on the draft brief, a final copy of the audit will be issued before fieldwork begins.

At this point in the audit process, the office of the Corporate Governance Director (Director of Corporate Governance and the Head of Corporate Risk and Assurance) should be copied in to ensure awareness.

Internal and External Audit Outcome Reports and Management Responses/Action Plan

At completion of an internal audit an audit report will be issued which includes an assurance opinion (except advisory audits) on how effective the internal controls are in the scope of that review.

Draft reports will be issued to the Health Board via the Corporate Governance Director's office to ensure process consistency and that the report is distributed to the Lead Director(s) and key stakeholders. The Head of Corporate, Risk and Assurance will distribute on behalf of the Director of Corporate Governance.

The Lead Executive should use the draft report clearance process to highlight for the attention of auditors any concerns they have about the wording, practicality or relevance of audit recommendations, this part of

the process will remain between the Lead Director(s) and auditors. The Director of Corporate Governance will support discussion between the Lead Director (s) and auditors where appropriate.

When developing the management response and action plan, management must ensure consideration is given to the capacity and costs required to deliver the actions and any associated risks, ensuring value for money. Where actions require capital investment, consideration also must be given to managing the risk in the interim as capital funding to enable progress may not be available within the timescales committed to in the management response. In these circumstances, other action should be taken to manage the risk which must also be detailed in the action plan and, where appropriate, be added to operational risk registers.

Management responses should clearly demonstrate how the recommendation will be implemented, how the associated risk will be managed, and how the proposed actions will address the underlying control weakness identified by the audit review. Management responses must: -

- Respond directly to the finding and its recommendation;
- Clearly describe how the recommendation will be addressed;
- Demonstrate how the proposed action will mitigate the underlying risk;
- Identify a named individual accountable for implementation;
- Include realistic and achievable implementation timescales;
    - Where full implementation cannot reasonably be achieved within a short timeframe, the action plan must include proportionate interim milestones, named owners and target dates. Interim milestones should demonstrate how progress and risk reduction will be evidenced pending full implementation.

      Unless an alternative timeframe is agreed with the relevant auditor, action on high-priority recommendations should commence with immediate effect and action on medium-priority recommendations should commence within one month of the final report. These expectations relate to commencement and mobilisation; the final implementation date should remain realistic, proportionate to the risk and agreed through the audit clearance process.
- Be specific, measurable and capable of demonstrating completion;
- Be approved by the relevant Executive Director prior to submission to Internal or External Audit.

There may be occasions where recommendations fall outside the remit of the division, directorate, service or team being audited. In such cases,

other Health Board functions (e.g., corporate teams such as IT or Estates) will be required to develop appropriate management responses and take responsibility for delivery.

It is important to establish at an early stage whether recommendations can be implemented solely within the Health Board, or whether delivery is dependent on third-party involvement and therefore outside the Health Board's direct control. Where recommendations have external dependencies, such as national digital developments, Welsh Government approval or funding, or wider national collaboration, this should be clearly articulated from the outset. This distinction is critical in ensuring transparency and in supporting ARAC's understanding of what can be delivered locally.

Where dependencies exist, the Executive should ensure that agreed implementation dates reflect national timeframes or allow sufficient time for external processes to be completed ahead of local delivery.

For recommendations with external or national dependencies, the responsible Executive Director must agree interim local milestones and provide proportionate progress updates at each scheduled reporting point, or more frequently where the level of risk warrants this. Updates must distinguish progress within the Health Board's control from matters awaiting external action and confirm the status of interim mitigating controls.

The existence of a national or external dependency should not prevent the implementation of local mitigating actions wherever these are available. Executive Directors should ensure that all reasonable actions within the Health Board's sphere of control are progressed whilst awaiting national developments or third-party decisions.

Recommendations subject to external dependencies should be categorised within the Audit Recommendation Tracker as a "Dependency" recommendation, this will set these apart on the Tracker and will visually support ARAC in identifying those quickly and will support focused discussion and support where required.

All such circumstances should be clearly communicated to both auditors and ARAC and accurately recorded within the tracking system. Where recommendations arise from national reviews or audits and are not within the Health Board's direct control to implement, they should still be logged for completeness, with an appropriate management response. However, these should be clearly identified as externally dependent and should not be treated as actions requiring ongoing local monitoring of implementation.

Advisory reviews provide management with considerations for improvement; these do not constitute formal audit recommendations and there is no mandatory requirement for management to implement them. However, where management decides to adopt any of the considerations raised, those agreed actions must be incorporated into the Audit Tracker to ensure appropriate oversight and timely delivery.

Following the issue of an advisory report, the Corporate Governance Team will request confirmation from management regarding which considerations they intend to implement, along with corresponding target completion dates. Only those actions that management confirms will be taken forward will be added to the Audit Tracker and monitored in line with the standard action tracking process. Any considerations that management does not intend to implement will be recorded as closed with clear justification.

This approach enables transparency over improvement activity arising from advisory work, while respecting the consultative nature of these engagements and the absence of a formal assurance requirement.

Further detail on how these are monitored is provided in **Section 4**.

Once the relevant director(s) has approved the management response and action plan, they should be submitted to the Corporate Governance Director's office, where management responses will be reviewed to ensure that they meet the expected response standards before being submitted to the respective audit team to ensure that the risks have been adequately addressed and the timescales are acceptable; once approved by the auditors, the report is issued as final.

The final report will be distributed to the Health Board via the Corporate Governance Director's office to ensure dissemination to the Lead Director(s) and key stakeholders, as well as compliance with the Health Board's internal governance process.

The Executive Team will be provided with all final audit reports at an Executive Committee meeting for their awareness before they are presented to the ARAC, with a particular focus on limited or no assurance rated reviews. The ARAC will be required to understand the level of assurance provided, the recommendations for improvement made to management, and the response of management. This will ensure that the ARAC is promptly informed of all audit findings and assurances.

The Director of Corporate Governance will maintain a database of all Internal and External Audit Reports, inclusive of management responses/action plans.

A flowchart setting out the process for the management of audit reports when issued is set out at **Appendix A** with **Appendix C** setting out the quality assurance process.

4. RELATIONSHIP BETWEEN AUDIT RECOMMENDATIONS AND RISK MANAGEMENT

Audit recommendations should not be considered in isolation from the Health Board's wider risk management arrangements.

Where audit findings identify significant control weaknesses that expose the organisation to material risk, consideration should be given to whether the associated risk requires escalation through the Health Board's Risk Management Framework.

Similarly, implementation of an audit recommendation does not automatically mean that the associated risk has been fully mitigated. Management should continue to monitor residual risks through existing governance and risk management arrangements where appropriate.

This approach ensures clear alignment between audit activity, risk management and organisational assurance.

5. MONITORING IMPLEMENTATION OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS

An important responsibility of the ARAC is to monitor the implementation of agreed audit recommendations. The ARAC should ensure the organisation adopts a robust process for monitoring the implementation of agreed audit recommendations and that regular progress reports are provided to the ARAC identifying any that have not been implemented within agreed timescales.

The process for monitoring and reporting progress against the implementation of internal and external audit recommendations within the Health Board will be led by the Director of Corporate Governance.

The key principles associated with the monitoring of internal and external audit recommendations include:

- Audit Recommendations will be added to the Audit Recommendations Tracker, once the final Audit Report has been received by the ARAC;

- Executive Directors retain accountability for the implementation of audit recommendations within their areas of responsibility, irrespective of any operational delegation of actions. Executive Directors must ensure that sufficient oversight arrangements are in

place to monitor delivery and address barriers to implementation;

- The ARAC will monitor progress against the implementation of all audit recommendations, regardless of priority rating (high, medium)

- Executive Directors, with their teams, will be asked to update on progress against the implementation of audit recommendations as the completion date arises and an update will be reported to the next meeting of the ARAC;

- Executive Directors will be responsible for approving the closure of audit recommendations, which will be subject to reporting to the ARAC;

  Prior to recommending closure, management should be satisfied that sufficient evidence exists to demonstrate that the recommendation has been implemented, the intended improvement has been embedded, and the associated control is operating effectively. Evidence supporting closure should be retained and made available upon request.

  Evidence supporting implementation and closure must be retained by the action owner in the approved corporate repository. The Audit Recommendation Tracker must record either the evidence itself or a clear reference or hyperlink to its location, together with the date reviewed and the name of the Executive Director approving closure.

- The ARAC will be asked to approve the revision of any previously agreed dates within action plans, on the advice of internal or external audit;

- Internal and External Audit Teams will assess the position against previous audit recommendations as part of any relevant follow-up audit work;

- Following ARAC's approval, recommendations that have been completed will be transferred to the completed log, while those still in progress will remain on the Tracker until they are fully resolved;

- Both the Executive Team and the ARAC will undertake an in-depth review of the Audit Recommendation Tracker twice-yearly;

If the implementation of local recommendations has stalled due to delays in national progress beyond the expected timeframe, this issue should be highlighted in the Audit Tracking Report to ARAC. ARAC will then decide if escalation to the third-party organisation through the Health Board is necessary.

The ARAC will focus its attention at each meeting on those recommendations that are overdue past the original agreed timeframe for completion, where a recommendation implementation date requires revision due to an ongoing internal or external dependency, the recommendation owner must provide the reason for delay.

Recommendations requiring multiple implementation date revisions will be subject to enhanced scrutiny as follows:

Revised Implementation Date	**Treatment**
First Revision	Acceptable with justification. Routine monitoring.
Second Revision	Acceptable with justification. Enhanced scrutiny by ARAC
Third Revision	Formal explanation required from the responsible Executive Lead, including a recovery plan.
Forth and subsequent revisions	Recommendation classified as a longstanding implementation issue and subject to exception reporting. Deep-dive review by ARAC to determine whether the recommendation should continue to be implemented, be re-scoped, transferred to business-as-usual monitoring arrangements, be escalated through the Health Board's Risk Management Framework, or be closed.

Where a recommendation remains unimplemented following four implementation date revisions, ARAC shall consider whether:

- The underlying risk requires escalation;
- Organisational barriers are preventing implementation;
- Additional management intervention is required; or

- If the operating environment/context has changed, and the scope of the recommendation is no longer reflective, consideration to 'close' should be an option.

The ARAC reserves the right to reject further implementation date revisions where insufficient justification is provided.

The ARAC may approve revised implementation dates where it is satisfied that:

- The delay is attributable to an external dependency.
- Appropriate local mitigating actions have been implemented.
- The residual risk is understood and being monitored/managed through the Health Boards risk management process
- Sufficient progress has been made within the Health Board's sphere of control.

Recommendations subject to national dependencies should remain open until either:

- The recommendation has been fully implemented; or
- The ARAC is satisfied that no further local action can reasonably be taken and an alternative assurance mechanism has been agreed.

Where the ARAC or Head of Internal Audit/External Auditor are concerned about the lack of implementation of audit recommendations in a particular area, the ARAC has the authority to invite the respective Director to attend and provide an update. This will be with a view to ensuring risks and identified weaknesses in internal control are mitigated, recognising that the initial action plan will have been approved by management.

Where it is possible to do so, as part of the updates to the ARAC, and particularly as part of a proposed closure of recommendations, reports will provide an indication of the impact that implementing the recommendation will have had on the Health Board in terms of quality improvement, the provision of more efficient and effective patient care, improved governance, increased security or better use of resources etc.

To ensure transparency and greater oversight of the progress of recommendation implementation and aligned to the oversight of corporate and strategic risks, Board assurance committees will receive an extract of the Audit Tracker relevant to their remit, allowing them to discuss any by exception, e.g., specific recommendations, or to understand where there are issues and provide support to progress implementation.

6. ESCALATION

In most cases, audit reports are issued, finalised, and submitted in sufficient time for Committee meetings. However, there may be instances in which the audit reports for the scheduled ARAC meeting are delayed. In such cases, it may be necessary to escalate the issues to the Director of Corporate Governance, Chief Executive, and Chair of the ARAC. The subsequent section, "Process for Escalation," outlines the specific situations in which this would arise.

As part of the Annual Audit Plan for both Internal and External Audit, there is a schedule outlining the planned audits. These audits are provisionally scheduled for an ARAC meeting. This approach is intended to ensure a balanced distribution of reports received by the ARAC throughout the year.

The audits in the annual plans will adhere to the principles of the respective Audit Charter, ensuring that both parties have sufficient time to fulfil their responsibilities. The timeline for the escalation process starts with the initial draft audit report and concludes with the distribution and receipt of the final report, ensuring it is available for the circulation of ARAC meeting papers. This includes the Executive Committee reviewing any final audit report(s) for oversight prior to its submission to the ARAC.

While both Internal and External Audit must adhere to their respective charters, the Health Board receives a considerably higher number of audit reports from Internal Audit compared to External Audit. The escalation process is established for both bodies, with timeframes determined by the Internal Audit Charter. The same approach would be followed in case of any issues with completing external reports.

The draft outcome report, which includes recommendations and findings, will be received by the Health Board for management responses. The return timeframe is typically 15 working days; however, there may be exceptions. The report will be finalised by the auditing body within ten working days of receiving the draft response. To ensure that the internal governance process has been adhered to, the Health Board should receive final audits at least seven working days before the ARAC meeting.

Process for Escalation

The escalation process should be implemented where delays in agreeing management responses or finalising audit reports place the planned Executive Committee or ARAC reporting timetable at risk. The timing of escalation will depend on the audit timetable, the agreed management response deadline and the proximity of Executive Committee and ARAC meetings.

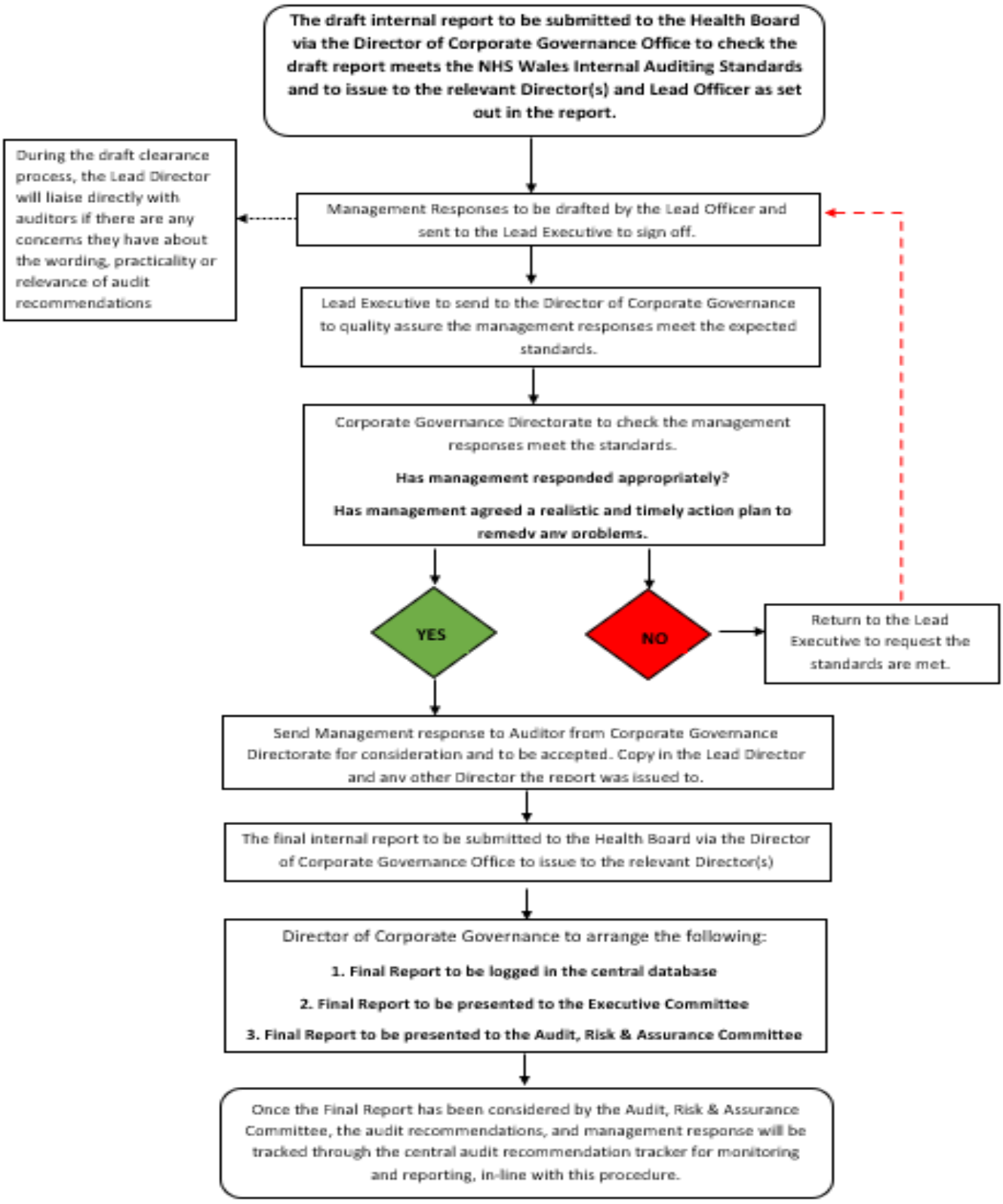
The escalation process is intended to support timely resolution of delays and should be applied proportionately. Escalation will cease once an acceptable management response has been received and the auditor confirms that the report can be finalised within the agreed governance timetable.

An example of the implementation of the escalation process is provided in **Appendix B.**

APPENDICES

- **Appendix A -** Process for Distributing Draft and Final Internal and External Audit Reports
- **Appendix B -** Example of when the Escalation Process should be Implemented
- **Appendix C** - Quality Assurance Arrangements

Appendix A - Process for Distributing Draft and Final Internal and External Audit Reports



NB: Office of the Director of Corporate Governance refers to the Director of Corporate Governance and the Head of Corporate Risk and Assuran

Appendix B: Example of when the Escalation Process should be Implemented

Stage 1

Where the agreed management response deadline has been reached and a response has not been received, the auditing body will send a courtesy reminder to the Lead Executive Director and relevant action owner.

The reminder will outline the governance timetable, emphasise the importance of meeting agreed timescales and highlight the impact that delays may have on the timely finalisation of the audit report and its consideration by the Executive Committee and ARAC.

Stage 2

Where the management response remains outstanding **five working days after the agreed response deadline**, the principal auditor will bring the matter to the attention of the Head of Corporate Risk and Assurance.

The Head of Corporate Risk and Assurance will contact the responsible Executive Director to reinforce the importance of providing a response and to establish whether any support is required to facilitate completion.

Stage 3

Where the management response remains outstanding **ten working days after the agreed response deadline**, or where delays threaten the ability of the report to be considered by the Executive Committee and subsequently reported to ARAC in accordance with the agreed timetable, the matter will be escalated to the Chief Executive.

The Chief Executive will request the responsible Executive Director to prioritise completion and provide the outstanding response within 24 hours, unless an alternative arrangement has been agreed.

Stage 4

Where fewer than **eight working days remain before the ARAC meeting** and the auditor advises that the final report may not be available in time for normal circulation of ARAC papers, the Head of Corporate Risk and Assurance will discuss the position with the auditor to determine whether the report can still be finalised and processed through the Health Board's governance arrangements.

If the final report cannot be completed in time for inclusion within the normal ARAC paper circulation timetable, the Director of Corporate Governance will contact the Chair of ARAC to explain the position and available options.

A decision will then be made regarding whether:

- the report should be removed from the agenda and deferred to a future Executive Committee and ARAC meeting;
- the report should be circulated as a late paper where the auditor confirms that it is in the final stages of completion; or
- an alternative reporting arrangement is required.

Any decision will take account of the significance of the audit findings, the level of assurance provided and the need to maintain effective governance and committee oversight.

Stage	Trigger
Stage 1	Management response deadline reached
Stage 2	5 working days overdue
Stage 3	10 working days overdue
Stage 4	Fewer than 8 working days before ARAC and report not capable of being finalised within normal governance timescales.

Appendix C: Quality Assurance Arrangements

The following quality-assurance arrangements apply to management responses, implementation updates and requests to close audit recommendations. They are intended to ensure that responses are complete, evidence is reliable and closure decisions demonstrate that the underlying control weakness has been addressed.

Stage	Quality-assurance responsibility	Minimum assurance requirement	Record retained
Management response and action plan	Lead Executive Director, supported by the action owner	Response addresses the finding and underlying risk; actions are specific, measurable, deliverable and appropriately resourced; timescales and interim milestones are realistic.	Approved management response and action plan, retained with the final audit report.
Corporate Governance review	Head of Corporate Risk and Assurance on behalf of the Director of Corporate Governance	Completeness, clarity, accountability, priority, dependencies, timescales are checked before submission to the auditor.	Quality-assured response and any clarification correspondence.
Auditor review	Internal Audit or External Audit, as applicable	The auditor confirms that the response and proposed actions adequately address the recommendation and that the implementation timescale is acceptable.	Final audit report and agreed management response.
Progress update	Action owner and responsible Executive Director	Progress is supported by current evidence; barriers, dependencies, interim controls and revised forecasts are transparent; material slippage is escalated.	Update and evidence reference recorded in the Audit Recommendation Tracker.
Request for revised implementation date	Responsible Executive Director, supported by the action owner and reviewed by the Corporate Governance Team	Clear justification for the delay; progress achieved to date; evidence that interim actions and mitigating controls are in place; confirmation that the revised date is realistic and achievable; consideration of any associated risk escalation requirements.	Revised implementation date request, supporting evidence, ARAC decision and updated Audit Recommendation Tracker entry.
Closure approval	Responsible Executive Director	Evidence demonstrates completion, the intended improvement is embedded and the associated control is operating effectively.	Closure evidence approved by the Lead Executive approval recorded in the Tracker.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Review of the Health Board Risk Management Framework Documentation Prior to Board Approval
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

The Committee is asked to review the revised suite of Risk Management documents prior to submission to the Board for approval and to provide any final observations or recommendations.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board's Risk Management Framework documentation has been comprehensively reviewed to ensure alignment with current governance arrangements, best practice in risk management and the Health Board's evolving operating environment.

The revised suite of documents comprises:

- Risk Management Framework (Appendix A);
- Risk Management Procedure (Appendix B);
- Risk Assessment and Scoring Handbook (Appendix C);
- Risk Appetite Statement (Appendix D)

The Framework, Procedure and Risk Scoring Handbook were presented to the Committee at its previous meeting and subsequently circulated to members for further comment and review.

The Risk Appetite Statement was developed following that meeting and circulated to Board members and Committee members at the beginning of August alongside the remaining documentation for comment.

The purpose of this report is to provide the Committee with an overview of the proposed changes and seek final feedback before the full suite of documents is submitted to the Board for approval.

Cefndir / Background

The Health Board's Risk Management Framework provides the foundation for the identification, assessment, management, monitoring and escalation of risks across the organisation.

The review has been undertaken to:

- improve consistency across risk management documentation;
- strengthen alignment between risk management, assurance and performance arrangements;
- support a more mature and proportionate approach to risk management;
- improve clarity regarding risk ownership and accountability; and
- ensure the Health Board's risk appetite is clearly articulated and understood.

The review has also provided an opportunity to consider whether the Health Board's current risk appetite remains appropriate in the context of increasing operational pressures, workforce challenges, financial constraints and system-wide service demands.

Asesiad / Assessment

Overall Documentation Suite

The revised documentation suite seeks to provide a clearer and more integrated approach to risk management across the Health Board.

The Framework, Procedure and Scoring Handbook have been refined to:

- improve alignment between strategic, corporate and operational risk management;
- strengthen the application of the bowtie methodology;
- improve consistency of risk scoring;
- clarify escalation and de-escalation arrangements;
- strengthen accountability for risk ownership and assurance; and
- support a more consistent approach to risk reporting.

Committee members were provided with these documents following the previous meeting and any comments received have been considered and incorporated where appropriate.

Risk Appetite Statement

The Risk Appetite Statement represents a significant development in the Health Board's approach to risk management and is intended to provide clearer guidance regarding the level of risk the organisation is prepared to accept in pursuit of its objectives.

The revised statement introduces updated terminology and a revised structure for articulating risk appetite across a broader range of risk domains.

The proposed appetite categories are intended to provide greater clarity regarding organisational expectations and decision-making, whilst recognising the realities of the current operating environment.

The revised statement also introduces additional risk appetite domains to better reflect the breadth of risks managed by the organisation and to improve alignment with strategic objectives and governance arrangements.

The Committee is invited to consider whether:

- the proposed terminology provides sufficient clarity;
- the proposed domains appropriately reflect the Health Board's principal risk exposures;
- the appetite descriptions appropriately reflect organisational expectations; and
- the proposed scoring thresholds for each appetite level are appropriate or whether these need to be amended to reflect the complex and challenging operating environment.

Risk Appetite Thresholds

A key area for discussion is whether the proposed appetite thresholds remain realistic and achievable within the current NHS operating environment.

Whilst risk appetite should represent the level of exposure the organisation is prepared to tolerate, it is recognised that many strategic and corporate risks currently operate outside the proposed appetite thresholds.

Examples include:

- financial sustainability;
- urgent and emergency care performance;
- system-wide patient flow; and
- elements of digital and estate resilience.

The Committee is therefore invited to consider whether the proposed appetite thresholds:

- appropriately reflect the organisation's aspirations;
- provide meaningful challenge to management;
- remain sufficiently ambitious to drive improvement; and
- realistically recognise the current level of external pressure and organisational constraint.

The Committee may wish to consider whether a more accepting or tolerant position is required in certain domains given the current operating environment, or whether maintaining a more ambitious appetite provides a clearer improvement trajectory and stronger basis for challenge and assurance.

It is recognised that risk appetite should not simply reflect current performance or risk exposure. However, there is also a need to ensure that appetite thresholds remain credible, proportionate and capable of informing decision-making.

The discussion at Committee will help determine whether the balance between aspiration and realism has been appropriately achieved within the proposed statement.

Board Feedback

The Risk Appetite Statement was circulated to Board members at the beginning of August alongside the wider suite of documents.

Any comments received will be reported verbally at the meeting and reflected in the final versions submitted to the Board.

Argymhelliad / Recommendation

The Committee is asked to:

1. **PROVIDE** any final observations or recommendations in relation to the documentation suite.

2. **CONSIDER** whether the proposed risk appetite terminology and domains are appropriate.

3. **CONSIDER** whether the proposed appetite thresholds appropriately reflect the Health Board's current operating environment and future ambitions.

4. **RECOMMEND** the final suite of documents to the Board for approval, subject to any amendments agreed by the Committee.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix 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. Risk management supports delivery of the full IMTP
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. N/A

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Set out throughout the document, where appropriate
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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

Aneurin Bevan University Health Board

Risk Management and Assurance Framework

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

Status: Issue 3 DRAFT
Approved by: Aneurin Bevan UHB Board
Owner: Corporate Governance Directorate
Issue date: MM 2026
Review by date: MM 2028
Ref No: ABUHB_Corporate_0277

Contents:

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 (the level of risk the organisation is willing to accept, which may vary depending on the nature of the activity and risk type) 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 – If the new Risk Appetite Statement is agreed this will be updated.

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 determined by risk score alone. Risks should remain at the lowest appropriate level within the organisation, provided they can be effectively owned, managed and mitigated.

A risk should be considered for escalation where it exceeds local capability, capacity, authority or resources; requires decisions or intervention from a higher level of management; has cross-cutting implications across multiple services, divisions or directorates; falls outside the agreed risk appetite; or poses a significant threat to patient safety, statutory compliance, service delivery or the achievement of strategic objectives.

Escalation should not be viewed simply as the transfer of a risk from one risk register to another. As risks move through the organisation, the perspective from which they are assessed may change. Whilst the underlying risk theme may remain the same, the scope, causes, consequences, controls and assurance requirements are likely to differ depending on the level at which the risk is being managed.

For example, a divisional risk relating to planned care performance may focus on local workforce, capacity and operational delivery. If escalated to the Corporate Risk Register, the risk may be reframed to reflect Health Board-wide performance, strategic objectives, regulatory requirements and Executive accountability.

The purpose of escalation is therefore to ensure that risks are considered and managed at the level where the causes, consequences and required actions can be most effectively addressed. Escalation does not remove the requirement to manage the risk at the level where it manifests, and local controls and mitigating actions should remain in place unless superseded by higher-level arrangements.

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.
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.
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.

Risk trajectory describes the expected direction of travel of a risk over time, taking into account the effectiveness of controls, progress in delivering mitigating actions and the strength of assurance. It provides a forward-looking assessment of whether the risk is improving, stable or deteriorating and whether it is on course to achieve its target risk within the agreed timescale.

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.

Audience	Training / Support Requirement
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.
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 Summary
- Appendix B - Minimum Risk Register Data Standards
- Appendix C - Risk Maturity Model

Appendix A - Risk Appetite Statement - If the new Risk Appetite Statement is agreed this will be updated.

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.
Initial, 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.

Appendix D – Glossary of Terms

Term	Description
Board Assurance Framework (BAF)	A structured approach used by the Board to understand principal risks to strategic objectives, the adequacy of controls, and the level of assurance available (represented through the Strategic Risk Register).
Datix	The Health Board's electronic system used as the single source of organisational risk information.
De-escalation	The process of moving a risk to a lower level of management when it can be effectively controlled and managed within that level.
Escalation	The process of raising a risk to a higher level of management when it exceeds local authority, capacity, appetite or impact thresholds.
Initial Risk	The level of risk before any controls are applied.
Mitigating Action	An action taken to reduce the likelihood or impact of a risk.
Residual (Current) **Risk**	The level of risk remaining after controls have been applied.
Risk	The effect of uncertainty on objectives, described in terms of cause, event and impact.
Risk Appetite Themes	Defined categories describing the organisation's willingness to accept risk across different areas, such as safety, finance, or service delivery.
Risk Assessment	The systematic process of identifying, analysing and evaluating risks, including their likelihood and impact.
Risk Description	A structured statement of a risk using cause–event–impact format.
Risk Lifecycle	The continuous process of identifying, analysing, evaluating, treating, monitoring and reporting risks.
Risk Management	The coordinated activities to direct and control the organisation with regard to risk.
Risk Register	A structured record of identified risks, including their assessment, controls, actions, assurances and ownership.
Risk Scoring (5x5 Matrix)	A method of assessing risk based on likelihood and consequence, typically producing a numerical score
Risk Tolerance	The threshold at which a risk is considered acceptable or requires further action or escalation.
Target Risk	The desired level of risk after further mitigating actions have been implemented.

Risk Management Procedure

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

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CONTENTS:

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

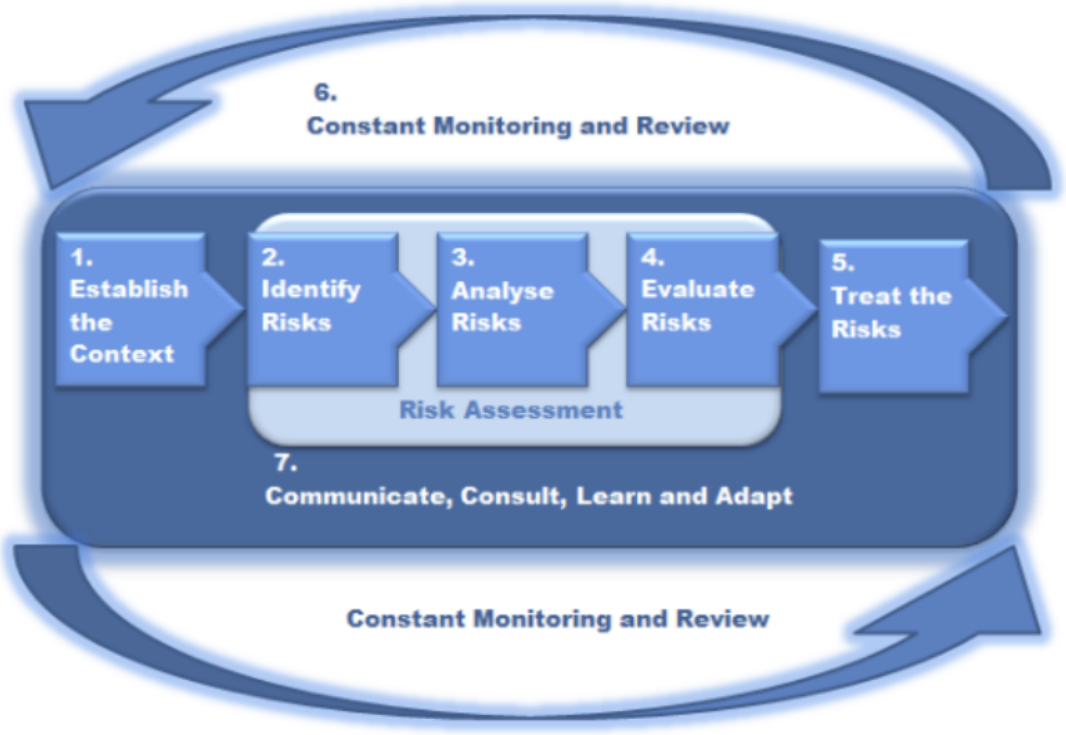
This procedure applies to all staff and services and outlines the process for identifying, assessing, managing, and escalating risks.

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.

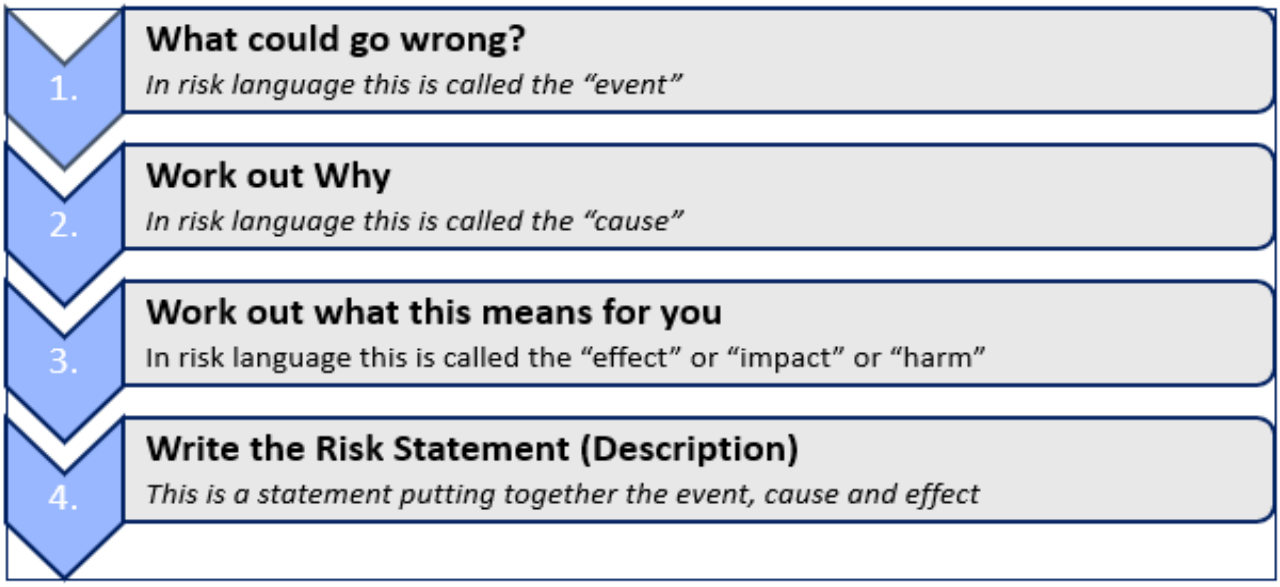
An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

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 *(Dependant if the risk is malicious e.g., Cyber or Fraud (2y) or non-malicious e.g., error, system failure (5y)*	**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.

In addition to determining Initial, Current and Target risk scores, each review should assess the overall trajectory of the risk (Improving, Stable or Deteriorating) to demonstrate whether the Health Board is making sufficient progress towards the target level.

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 each review, risk owners should:

- Update the current risk score where appropriate.
- Review progress against mitigating actions.
- Assess the effectiveness of key controls.
- Consider the adequacy of sources of assurance and identify any assurance gaps.
- Identify any new or emerging risks, changes in context or external influences.
- Determine the risk trajectory (Improving, Stable or Deteriorating), taking into account the effectiveness of controls, progress of mitigating actions, assurance findings and changes in the operating environment.
- Consider whether the target risk remains achievable and whether escalation or de-escalation is required.

Risk trajectory should not be based solely on changes to the numerical risk score. A risk score may remain unchanged whilst the overall trajectory is improving or deteriorating as a result of changes in control effectiveness, assurance or external factors.

Trajectory	Descriptor
Improving	Controls are becoming more effective, actions are progressing as planned, and the risk is reducing or is expected to reduce towards the target level.
Stable	The overall level of risk remains broadly unchanged, with no significant improvement or deterioration in controls, assurance or external factors.
Deteriorating	Control effectiveness or assurance has weakened, mitigating actions are delayed or external factors have increased exposure, making achievement of the target risk less likely.

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:

- 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 5×5 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 5×5 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**
Compliance & Governance	No breach of legislation, policy or governance requirements.	Minor breach requiring local corrective action.	Significant governance weakness or regulatory concern requiring formal improvement.	Major governance failure, enforcement action, or statutory breach.	Failure to meet statutory duties, prosecution, loss of organisational control, or special measures intervention.
Digital & Information	Minimal disruption with no impact on service delivery.	Short-term disruption with effective workarounds available.	Loss of functionality affecting operational delivery and increasing risk of delays.	Critical system outage affecting patient care, operational delivery, or information security.	Complete failure of critical digital services, major cyber incident, or widespread loss of information.
Emergency Preparedness & Security	No threat realised.	Minor incident managed through normal processes.	Incident requiring coordinated response with some operational strain.	Major incident requiring significant emergency response and affecting service continuity.	Failure to respond effectively to a critical incident resulting in mass casualties or prolonged service failure.
Estates, Facilities & Environmental Safety	No impact on safety, estate condition, or environment.	Minor maintenance issues causing inconvenience.	Service disruption due to estate failure or environmental impact requiring intervention.	Serious health and safety breach, relocation of services, or major environmental impact.	Major incident such as fire, structural failure, fatal accident, or catastrophic environmental event.

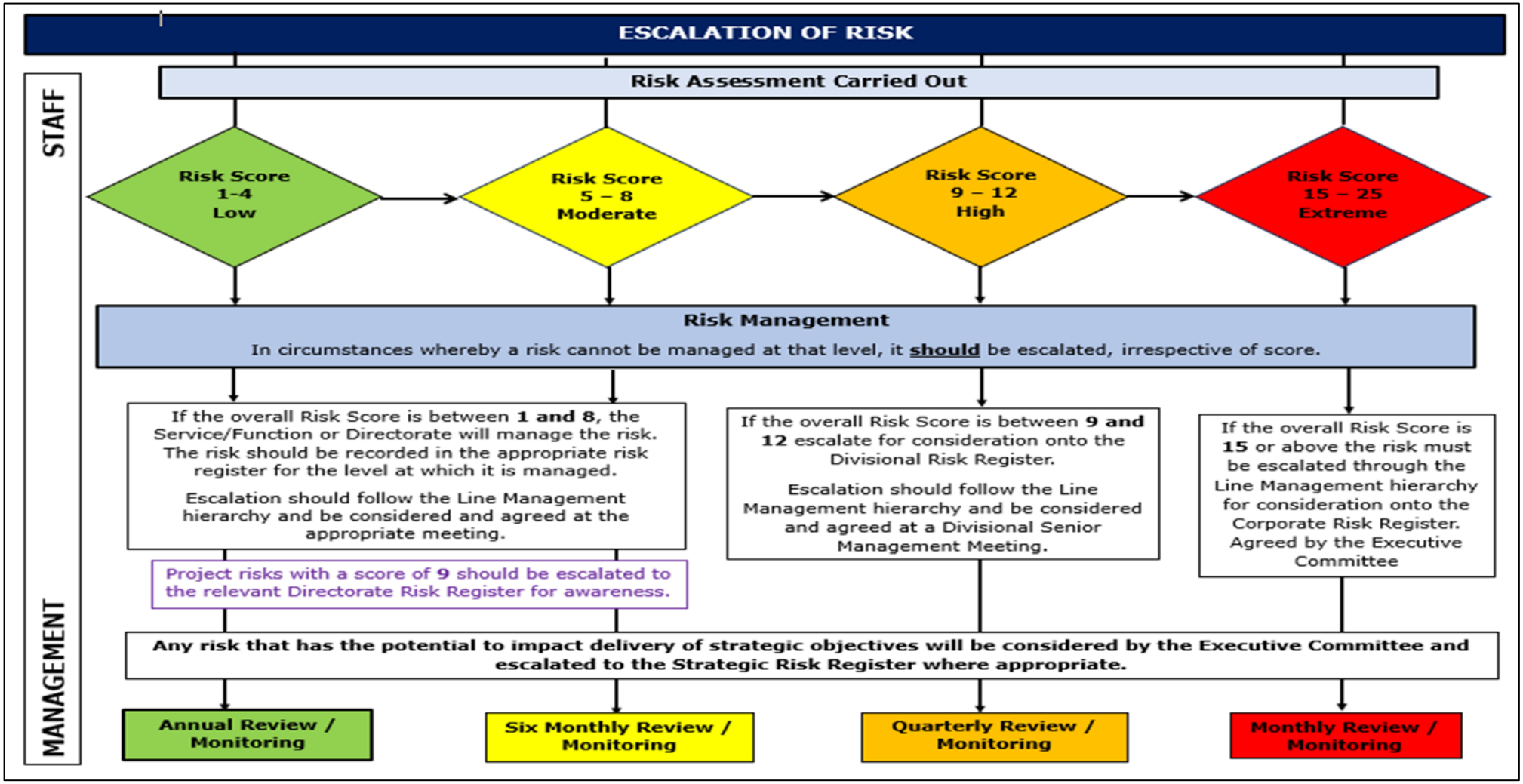
Finance & Resources	Financial impact < £100k. No impact on financial plans.	Financial impact £100k–£500k. Manageable within existing budgets.	Financial impact £500k–£2m. Recovery action required.	Financial impact £2m–£10m. Significant impact on delivery of financial plan.	Financial impact > £10m. Threatens financial sustainability or organisational viability.
Fraud & Commercial	Negligible financial loss and no reputational impact.	Minor financial loss with limited organisational impact.	Material financial loss requiring investigation and recovery action.	Significant fraud, commercial loss, or litigation with external scrutiny.	Major fraud, significant financial loss, prosecution, or severe reputational damage.
Patient Safety & Clinical Outcomes	No injury or negligible harm. No treatment required.	Minor injury or harm requiring minimal intervention. No lasting effects.	Moderate harm requiring professional intervention. Potential for temporary harm or extended recovery.	Serious harm resulting in long-term effects, disability, or life-changing injury.	Avoidable death, multiple deaths, or widespread severe harm. Systemic patient safety failure.
Programme & Strategic Delivery	No impact on delivery of plans or programmes.	Minor delay with benefits still achievable.	Significant delay requiring intervention and re-planning.	Major delay threatening achievement of strategic benefits or Annual Plan commitments.	Programme failure resulting in loss of strategic benefits or failure to deliver organisational objectives.
Quality & Experience	No measurable impact on quality or patient experience.	Localised reduction in quality or patient experience.	Significant reduction in quality requiring management intervention.	Serious deterioration in quality affecting multiple services or	Sustained failure in quality standards resulting in widespread

				patient groups.	harm or loss of confidence.
Reputation & Public Confidence	Minimal stakeholder concern.	Local concern or isolated complaints.	Regional concern attracting external scrutiny.	National concern affecting stakeholder confidence and organisational credibility.	Sustained loss of public, political, regulator, or partner confidence resulting in significant reputational harm.
Programme & Change Management	No impact on delivery	Minor slippage, benefits intact	Some delay or cost pressure	Major delay or overspend; limited benefits delivered	Critical programme failure; transformation benefits lost
Service Delivery & Performance	No disruption to services or objectives.	Minor delays or disruption managed locally.	Service disruption affecting multiple teams or objectives. Performance targets at risk.	Significant disruption to key services. Failure to achieve major objectives.	Sustained service failure resulting in inability to deliver statutory or essential services.
Workforce	Minimal staffing pressures. No impact on service delivery.	Short-term staffing shortages or competency gaps affecting service quality.	Staffing shortages or competency concerns affecting service delivery and performance.	Unsafe staffing levels, loss of key personnel, significant workforce instability.	Sustained workforce failure resulting in inability to safely deliver services.

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 when new template approved)*

RISK THEME	USE RISK APPETITE DOCUMENT TO DETERMINE					
LINK TO IMTP / ANNUAL PLAN	USE IMTP 2025 - 28					
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 –**	
					SUMMARY	
Lead Director		**Risk Exposure**	**Current Level**	**Target Level**		
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 form 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**

15 Appendix 5: Risk Assessment Template Divisional/Directorate Risk

Local/Directorate/Divisional Risk Assessment - SELECT				
OBJECTIVE / PRIOIRTY	ADD WHICH OBJECTIVE / PRIORITY THE RISK IS LINKED TO			
Risk ID & Description				
Threat				
Impact	Patient	Staff	Organisation	
Risk Handler		Risk Exposure	Current Level	Target
Monitoring Forum		Likelihood		
Initial Date of Assessment		Impact		
Last Reviewed		Risk rating		
Next Review				

Notes for completion:
When a potential risk threatens the achievement of objectives/priorities or is deemed a high-level operational risk, it should be escalated through the hierarchical structure and a request to the Lead Executive Director for consideration by the Executive Committee for inclusion on the Corporate Risk Register (CRR).

The **Threshold** for escalation to the:
- Directorate Risk Register is set at **8 and above,**
- Divisional Risk Register **12 and above,**
- Corporate Risk Register **15 and above.**

However, risks can be escalated, if they are beyond the scope of the current level to mitigate.

The timeframe for actions to be implemented must be aligned to the risk score/level.

Score	Overall Risk	Timeframe for implementing Actions
1 - 3	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit
4 - 8	Moderate	Actions implemented as soon as possible but no later than a year
8 - 12	High	Actions implemented as soon as possible but no later than six months
15 - 25	Extreme	Requires urgent action

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Gaps in Control *(Are further controls possible to reduce risk exposure to target level)*	Implementation Date for further controls	Person Responsible for Implementing further controls	Progress against Actions to Improve Control *(What has been implemented)*

Risk Assessor's Handbook

Supporting the development of high-quality risk assessments

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

1. Purpose

This guidance supports staff in the identification, assessment, scoring and review of risks and should be read in conjunction with the Health Board's Risk Management Framework and Risk Management Procedure. It should be used when: ADD LINK WHEN APPROVED

- Creating a new risk;
- Reviewing an existing risk;
- Assessing whether a risk score remains appropriate;
- Developing controls and mitigating actions; or,
- Considering escalation of a risk

2. Completing the Assessment

The table below is designed to support the development of a robust and evidence-based risk assessment. It provides a series of challenge questions to help ensure that risks are clearly defined, appropriately scored, supported by effective controls and assurance, and accompanied by meaningful actions to reduce the likelihood and/or impact of the risk materialising. Appendix A contains a completed risk assessment, provided to illustrate the intended outcome of the steps outlined below.

Steps	Supporting Information
Assessing the Scope of the Risk or Issue	
By definition is this a Risk or an Issue?	**Risk -** An uncertain event or set of circumstances that, if it occurs, could impact the achievement of objectives**.** **Issue -** An event or circumstance that has already occurred or is currently occurring and requires active management to resolve.
If an issue, at what stage? An 'Issue' needs constant management until resolved.	**Stages include:** 1. **Developing** - Early indicators suggest the issue may emerge. 2. **Happening Now**- The issue is currently occurring and requires active management. 3. **Occurred** - The issue has happened and immediate actions are being taken to address the consequences. Consider whether there is an ongoing risk of recurrence or further impact. 4. **Could happen again** - The issue has previously occurred and there is a risk of recurrence if underlying causes are not addressed. A risk assessment should be completed to identify and implement preventative controls.

If a risk - Is the risk event title accurate? Does it follow in a clear and succinct way?	**'There is a risk that/of… Due to…could lead to…..'** **Example:** *"There is a risk that planned care targets will not be achieved due to persistent workforce shortages and increasing demand, leading to delays in treatment, poorer patient outcomes and deterioration in organisational performance."*
Understanding the risk is a critical first step in developing a meaningful risk assessment. The questions throughout the table are intended to help identify the causes, consequences, existing controls and evidence required to support an informed assessment of risk.	**Questions to Ask** **About the Cause** • Why does this risk exist? • What is creating the risk? • Is the cause internal or external? • Are there multiple causes? **About the Impact** • Who could be affected? • What objectives could be affected? • What services could be affected? • What is the worst credible outcome? **Is there Evidence** • What evidence supports the assessment? • What data is available? • What trends are emerging? • Are there any known incidents or near misses?
A common mistake is to score a risk based on the worst credible outcome without considering the controls that are already in place. Before determining the likelihood and consequence scores, assess the effectiveness of existing controls and any available assurance. The risk score should reflect the residual level of risk that remains once current controls have been taken into account. **Risk Identified → Existing Controls → Control Effectiveness → Residual Risk Score → Additional Actions Required**	
Assessing the Control Environment	

Assessing Controls Controls are measures already in place that reduce either the likelihood of the risk occurring; or the, impact if the risk occurs.	**Questions to Ask** • What controls currently exist? • Are they documented? • Are they consistently applied? • Are they effective? • How do we know they are effective? • Have they been tested? • Are there gaps?
Control Type	**Purpose**
Preventive	**Prevent the risk occurring**
Directive	**Direct how activities should be undertaken**
Detective	**Identify issues after they occur**
Corrective	**Reduce consequences and support recovery**
If a newly identified risk you should consider: • **Initial risk score** • **Current risk score** • **Target risk score**	**Initial Risk -** The level of risk before any controls or mitigating actions are considered. This reflects the full extent of the risk exposure. **Current (Residual) Risk -** The level of risk that remains after taking existing controls and their effectiveness into account. This represents the current level of risk being managed. **Target Risk -** The level of risk that can reasonably be achieved following the implementation of additional controls or mitigating actions. This should normally be within the Health Board's risk appetite
If a known risk is being reviewed you need to consider: • whether the risk assessment remains accurate; • whether the controls continue to effectively manage the risk.	**Questions to Ask** • Are the controls still in place and operating as intended? • What evidence is available to demonstrate the controls are effective? • Are agreed performance indicators supporting the current risk score? • Have any incidents, audits, inspections or reviews identified control weaknesses? • Has the likelihood or consequence changed since the last review? • Are additional actions required to reduce the risk further? • Is the target risk score still realistic and achievable?

Determining the Consequence and Likelihood	
Assessing Consequence When assessing consequence: • Consider all impact domains. • Select the highest credible impact. • Use evidence wherever possible. • Consider both immediate and longer-term consequences. **APPENDIX A** Consequence Matrix	**Questions to Ask** • What is the worst credible outcome? • Could patient safety be affected? • Could service delivery be affected? • Could there be a financial impact? • Could regulatory intervention occur? • Could public confidence be affected?
Assessing Likelihood Likelihood should reflect the chance of the risk occurring given the controls currently in place. **Appendix B** Likelihood Matrix	**Questions to Ask** • Has this happened before? • How often has it occurred? • Are controls reliable? • Are circumstances changing? • Is demand increasing? • Are there external factors influencing likelihood?
Validating the Risk Score	
Before finalising the **Current** (Residual) **Risk Score**, there should be collective discussion and agreement with relevant colleagues. Risk scoring should not be undertaken in isolation. Collaborative assessment helps ensure that a more balanced and accurate assessment of the risk. **Appendix C** Risk Score and Exposure Determination Matrix	**Questions to Ask** • Does the score reflect the current position rather than the worst-case scenario? • Have existing controls and their effectiveness been fully considered? • Is there evidence to support the likelihood and consequence scores? • Would an independent reviewer reach a similar conclusion? • Does the score align with available performance, quality, workforce, financial or assurance information? • Have recent incidents, audits, inspections or reviews highlighted any reasons to increase or decrease the score? • Have all relevant stakeholders had the opportunity to challenge and validate the assessment? • Is there a clear rationale for the score assigned?

Developing Mitigating Actions	
Mitigating actions should be designed to reduce the likelihood and/or consequence of a risk occurring. Actions should focus on addressing: • Gaps in existing controls. • Gaps in assurance. • Root causes of the risk. • Barriers preventing effective risk management. **N.B.** Before identifying new actions, consideration should be given to whether existing controls can be strengthened, consistently applied or better evidenced.	**Questions to Ask** • What is causing the risk and how can the root cause be addressed? • Are there any gaps or weaknesses in the current controls? • Is additional assurance required to demonstrate that controls are effective? • Can the service be redesigned to reduce the risk? • Can capacity or capability be increased? • Can processes be simplified, standardised or automated? • Can digital or technological solutions support risk reduction? • Are there opportunities to work differently with partners or other services? • Are there opportunities to reduce demand, waste or duplication? • Is additional investment required and, if so, what benefits would it deliver? • What is the most effective action that could be taken to reduce the risk?
Determining Assurance of Control Effectiveness	
Assurance provides confidence that the controls in place are operating as intended and are effectively managing the risk. Assurance should be evidence-based and, where possible, obtained from a range of sources. e.g., • Performance reports and dashboards • Internal / External Audit reviews • External inspections and regulatory reviews • Quality indicators and outcome measures • Benchmarking information • Incident, complaint and claims data • Committee and governance reports	**Questions to Ask** • What assurance is available that the controls are operating effectively? • How confident are we that the controls are reducing the likelihood and/or consequence of the risk? • Is the assurance current, reliable and objective? • Do multiple sources of assurance support the same conclusion? • Have any audits, inspections, incidents or reviews identified weaknesses in the controls? • Are there gaps in assurance that limit our confidence in the effectiveness of the controls? • Is additional assurance required to provide confidence that the risk is being effectively managed?

Escalation Considerations	
Risks should be managed at the lowest appropriate level within the organisation. **Escalation** should only be considered where the nature, impact or management of the risk extends beyond the authority, influence or resources available to the current risk owner.	• Is the risk being managed at the appropriate level? • Does the risk affect multiple teams, services, divisions or directorates? • Does the risk impact the delivery of strategic objectives or organisational priorities? • Does the risk require Executive intervention or decision-making? • Does another service, division or department own the root cause of the risk? • Is the risk outside the agreed risk appetite or tolerance level? • Are additional resources, expertise or authority required to effectively manage the risk? • Would escalation improve the management and mitigation of the risk?

Examples of Controls and Assurance of control effectiveness

Control	Control Type	Example Assurance
Business Continuity Plan	**Corrective**	Annual BCP testing results, exercise reports, lessons learned reviews
Mandatory Training Process	**Directive**	Training compliance reports, competency assessments
Waiting List Validation Procedure	**Detective**	Internal Audit reviews, performance reports, validation outcomes
Cyber Security Controls	**Preventive**	Penetration testing reports, cyber audits, security monitoring reports
Escalation Processes	**Directive**	Governance reports, escalation logs, committee oversight
Digital System Controls and Access Restrictions	**Preventive**	Access audits, user access reviews, information governance reports
Maintenance Programmes	**Preventive**	Maintenance schedules, compliance reports, statutory inspection results
Service Level Agreements	**Directive**	Performance reports, contract monitoring reports, provider review meetings
Recruitment and Pre-employment Checks	**Preventive**	Recruitment audits, workforce reports, compliance monitoring
Incident Reporting Systems	**Detective**	Incident trend analysis, quality reports, learning review outcomes
Clinical Guidelines and Pathways	**Directive**	Clinical audit results, compliance reviews, peer reviews

Appendix A - Severity/Consequence scores

Choose the most appropriate domain for the identified risk from the left-hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

When assessing consequence, consideration should be given to all relevant domains. The overall consequence score should reflect the highest credible impact identified across any domain. Where multiple domains are affected, professional judgement should be applied to ensure the overall score appropriately reflects the cumulative impact on the organisation.

Where there is uncertainty regarding the scale of impact, the precautionary principle should be applied and the higher reasonable consequence score selected until further evidence becomes available.

Severity/Consequence score (severity levels) and examples of descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Compliance & Governance	No breach of legislation, policy or governance requirements.	Minor breach requiring local corrective action.	Significant governance weakness or regulatory concern requiring formal improvement.	Major governance failure, enforcement action, or statutory breach.	Failure to meet statutory duties, prosecution, loss of organisational control, or special measures intervention.
Digital & Information	Minimal disruption with no impact on service delivery.	Short-term disruption with effective workarounds available.	Loss of functionality affecting operational delivery and increasing risk of delays.	Critical system outage affecting patient care, operational delivery, or information security.	Complete failure of critical digital services, major cyber incident, or widespread loss of information.
Emergency Preparedness & Security	No threat realised.	Minor incident managed through normal processes.	Incident requiring coordinated response with some operational strain.	Major incident requiring significant emergency response and affecting service continuity.	Failure to respond effectively to a critical incident resulting in mass casualties or prolonged service failure.

Estates, Facilities & Environmental Safety	No impact on safety, estate condition, or environment.	Minor maintenance issues causing inconvenience.	Service disruption due to estate failure or environmental impact requiring intervention.	Serious health and safety breach, relocation of services, or major environmental impact.	Major incident such as fire, structural failure, fatal accident, or catastrophic environmental event.
Finance & Resources	Financial impact < £100k. No impact on financial plans.	Financial impact £100k–£500k. Manageable within existing budgets.	Financial impact £500k–£2m. Recovery action required.	Financial impact £2m–£10m. Significant impact on delivery of financial plan.	Financial impact > £10m. Threatens financial sustainability or organisational viability.
Fraud & Commercial	Negligible financial loss and no reputational impact.	Minor financial loss with limited organisational impact.	Material financial loss requiring investigation and recovery action.	Significant fraud, commercial loss, or litigation with external scrutiny.	Major fraud, significant financial loss, prosecution, or severe reputational damage.
Patient Safety & Clinical Outcomes	No injury or negligible harm. No treatment required.	Minor injury or harm requiring minimal intervention. No lasting effects.	Moderate harm requiring professional intervention. Potential for temporary harm or extended recovery.	Serious harm resulting in long-term effects, disability, or life-changing injury.	Avoidable death, multiple deaths, or widespread severe harm. Systemic patient safety failure.
Programme & Strategic Delivery	No impact on delivery of plans or programmes.	Minor delay with benefits still achievable.	Significant delay requiring intervention and re-planning.	Major delay threatening achievement of strategic benefits or Annual Plan commitments.	Programme failure resulting in loss of strategic benefits or failure to deliver organisational objectives.
Quality & Experience	No measurable impact on quality or patient experience.	Localised reduction in quality or patient experience.	Significant reduction in quality requiring management intervention.	Serious deterioration in quality affecting multiple services or patient groups.	Sustained failure in quality standards resulting in widespread

					harm or loss of confidence.
Reputation & Public Confidence	Minimal stakeholder concern.	Local concern or isolated complaints.	Regional concern attracting external scrutiny.	National concern affecting stakeholder confidence and organisational credibility.	Sustained loss of public, political, regulator, or partner confidence resulting in significant reputational harm.
Programme & Change Management	No impact on delivery	Minor slippage, benefits intact	Some delay or cost pressure	Major delay or overspend; limited benefits delivered	Critical programme failure; transformation benefits lost
Service Delivery & Performance	No disruption to services or objectives.	Minor delays or disruption managed locally.	Service disruption affecting multiple teams or objectives. Performance targets at risk.	Significant disruption to key services. Failure to achieve major objectives.	Sustained service failure resulting in inability to deliver statutory or essential services.
Workforce	Minimal staffing pressures. No impact on service delivery.	Short-term staffing shortages or competency gaps affecting service quality.	Staffing shortages or competency concerns affecting service delivery and performance.	Unsafe staffing levels, loss of key personnel, significant workforce instability.	Sustained workforce failure resulting in inability to safely deliver services.

Appendix B - Likelihood/Frequency Score

Choose the most appropriate likelihood/frequency for the identified risk.

	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)

Appendix C: Risk Score and Exposure Determination Matrix

When the consequence and the likelihood score has been determined. The matrix 5 x 5 risk matrix will determine the level of risk exposure qualitatively and quantitively to input into the risk assessment

Risk Scoring Matrix					
Likelihood / Frequency	**Consequence/Impact**				
	1	**2**	**3**	**4**	**5**
	Negligible Minimal consequences; no real disruption	**Minor** Minor deviation from expected performance; easily managed locally	**Moderate** Noticeable disruption; intervention required; localised recovery needed	**Major** Significant harm or disruption; regulatory intervention; major recovery effort required	**Catastrophic** Severe, widespread, long-term harm; organisational failure; national concern
5. Almost Certain Expected to occur frequently (e.g., several times a year)	**5** *(Moderate)*	**10** *(High)*	**15** *(Extreme)*	**20** *(Extreme)*	**25** *(Extreme)*
4. Likely Expected to occur annually or more	**4** *(Low)*	**8** *(Moderate)*	**12** *(High)*	**16** *(Extreme)*	**20** *(Extreme)*
3. Possible Might occur once every 1 to 2 years	**3** *(Low)*	**6** *(Moderate)*	**9** *(High)*	**12** *(High)*	**15** *(Extreme)*
2. Unlikely Could occur once every 2 to 5 years	**2** *(Low)*	**4** *(Low)*	**6** *(Moderate)*	**8** *(Moderate)*	**10** *(High)*
1. Rare May occur once in 5 years or more	**1** *(Low)*	**2** *(Low)*	**3** *(Low)*	**4** *(Low)*	**5** *(Moderate)*

Appendix D - Review Checklist

Review Checklist Before submitting or reviewing a risk
Has the risk assessment been completed with key stakeholders
Is it a risk rather than an issue?
Is the risk statement clear?
Is the score evidence based?
Are controls clearly described?
Are actions to implement further controls realistic and deliverable?
Is assurance identified?
Is ownership clear?
Has escalation been considered?
If escalating a risk. Do you know how to escalate a risk through your hierarchy? Link to Procedure

Aneurin Bevan University Health Board

Risk Appetite Statement

2026

Issue No: v2
Approved by: Aneurin Bevan University Health Board
Owner: Aneurin Bevan University Health Board

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Review Date: XX 2029
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CONTENTS

INTRODUCTION

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's (the Health Board's) ability to achieve its objectives.

Risk is neither inherently positive nor negative. Managed effectively, it enables opportunities to be realised and strategic objectives to be achieved, whilst recognising that uncertainty may also give rise to threats. Through informed decision-making and the effective management of risk, the Health Board seeks to maximise opportunities while minimising the likelihood and impact of adverse events.

Risk appetite defines the maximum level of residual risk the Health Board is willing to tolerate in pursuit of its strategic objectives. It provides a framework for informed decision-making by balancing the anticipated benefits of taking risk against the effectiveness of controls, the strength of assurance, and the Health Board's statutory, regulatory and fiduciary responsibilities.

The Health Board recognises that its appetite for risk is not uniform. It varies according to the nature of the risk, the strategic objectives being pursued, and the prevailing internal and external operating environment.

The Board recognises that, on occasion, residual risks may remain above the agreed appetite threshold where there is a compelling strategic, operational or statutory justification. In such circumstances, the rationale for accepting the risk, together with the effectiveness of existing controls, available sources of assurance, and any actions required to reduce the risk where reasonably practicable, must be explicitly documented, formally approved through the appropriate governance arrangements and subject to enhanced oversight and regular review.

This Risk Appetite Statement supports consistent, evidence-based decision-making by providing a framework for determining the level of residual risk the Health Board is prepared to accept. It should be applied alongside the Risk Management and Assurance Framework to ensure that decisions are proportionate, transparent and supported by appropriate controls, assurance and governance.

RISK APPETITE DESCRIPTION

The Board has agreed the following levels of risk appetite.

Risk Appetite	Interpretation
Averse	Only minimal exposure is acceptable. Risks above 5 require immediate mitigation or avoidance.
Limited	Low levels of risk are acceptable where strong controls and assurance are in place.
Measured	Moderate risk may be accepted where benefits are evidenced, controls are effective and assurance is robust.
Progressive	Higher risk can be accepted where there is a clear strategic benefit, Executive oversight and a credible mitigation plan.
Transformational	Significant risk may be accepted where transformational benefits justify the exposure, subject to Board oversight and rigorous governance.

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**
Limited	**Score 8 and below**
Measured	**Score 12 and below**
Progressive	**Score 16 and below**
Transformational	**Score 20 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.

Patient Safety & Quality
Risk Appetite: Limited

The Health Board has a limited appetite for risks that may adversely affect patient safety, quality of care, safeguarding or clinical outcomes. Risks will only be accepted where they are well understood, tightly controlled and supported by robust assurance that patient harm is minimised and statutory duties are met.

Workforce
Risk Appetite: Measured

The Health Board recognises that delivering high-quality services depends on attracting, developing and retaining a skilled, engaged and healthy workforce. It has a measured appetite for risks associated with workforce transformation, new ways of working and service redesign, provided staff wellbeing, capability and patient safety remain protected through effective governance and assurance.

Service Delivery & Performance
Risk Appetite: Measured

The Health Board has a measured appetite for risks associated with improving operational performance, patient access and service delivery. Moderate levels of risk may be accepted where decisions are evidence-based, controls are effective and there is a clear plan to deliver sustainable improvements without compromising quality or safety.

Financial Sustainability
Risk Appetite: Measured

The Health Board has a measured appetite for financial risk in pursuit of long-term sustainability. Decisions that improve financial resilience and value for money will be supported where risks are proportionate, informed by sound financial management and do not have an unacceptable impact on patient care, staff wellbeing or statutory responsibilities.

Digital, Data & Cyber
Risk Appetite: Progressive

The Health Board has a progressive appetite for risks associated with digital transformation, information management and the adoption of new technologies where these improve patient care, productivity or organisational resilience. Innovation will be supported provided cyber security, information governance, data integrity and system resilience are maintained through robust controls and independent assurance.

Estates & Infrastructure
Risk Appetite: Measured

The Health Board has a measured appetite for risks associated with maintaining, modernising and investing in its estate, equipment and infrastructure. Investment and change will be supported where risks are appropriately managed, statutory compliance is maintained and the safety of patients, staff and visitors is not compromised.

Transformation & Innovation
Risk Appetite: Transformational

The Health Board recognises that delivering sustainable improvements in health outcomes requires innovation and transformational change. It has a transformational appetite for risks where the anticipated benefits are substantial, strategic alignment is clear, mitigations are robust and there is strong governance to oversee delivery and realise intended outcomes.

Partnerships & System Working
Risk Appetite: Progressive

The Health Board has a progressive appetite for risks arising from collaboration with partner organisations, recognising that integrated working is essential to improving population health and delivering

sustainable services. Risks will be accepted where roles, responsibilities, governance arrangements and shared accountability are clearly defined and actively monitored.

Governance, Accountability & Public Trust
Risk Appetite: Limited

The Health Board has a limited appetite for risks that could undermine effective governance, accountability, regulatory compliance or public confidence. Decisions will be transparent, evidence-based and supported by robust assurance to ensure statutory responsibilities are met and the confidence of patients, staff, partners and regulators is maintained.

RISK APPETITE REVIEW

The Health Board will review its Risk Appetite Statement at least every three years, or sooner where there are significant changes to its strategic objectives, operating environment, statutory responsibilities or risk profile. This ensures that the Health Board's appetite for risk remains appropriate, proportionate and aligned to the achievement of its strategic objectives.

The Risk Appetite Statement forms an integral part of the Health Board's Risk Management and Assurance Framework and will be embedded within strategic planning, decision-making and risk management processes. It will be applied consistently across the organisation to support informed decision-making, the effective management of risk and the provision of robust Board Assurance.

The Board will review the continued appropriateness of the agreed risk appetite as part of the annual review of the Strategic Risk Register and Board Assurance Framework, ensuring that it reflects the organisation's strategic priorities and prevailing risk environment.

MONITORING AND REPORTING

The Health Board will align all Strategic, Corporate and Operational risks to the relevant risk appetite theme to enable a consistent assessment of risk exposure against the Board's agreed appetite.

Risk reporting will be undertaken in accordance with the Risk Management Procedure and will provide the Board and its Committees with sufficient information to understand the Health Board's overall risk profile, including:

- the volume and distribution of risks across each risk appetite theme;
- the number and proportion of risks operating within and outside the agreed appetite;
- changes in residual risk exposure and emerging risk trends;
- the effectiveness of key controls and the strength of assurance supporting the management of principal risks; and
- areas where further controls, assurance or management action are required.

Risk register entries will be categorised by risk appetite theme to support organisational analysis, identify cumulative risk exposure and inform strategic decision-making. Reporting will enable the Board to determine whether the Health Board's risk exposure remains consistent with its agreed appetite and whether additional action or formal risk acceptance is required.

Where a residual risk remains outside the agreed appetite threshold, reports will clearly identify the rationale for continued acceptance, the effectiveness of existing controls, the strength of available assurance, the actions being taken to reduce exposure where appropriate, and the governance arrangements for ongoing oversight.

Appendices

- Appendix A – Risk Appetite Summary Table
- Appendix B: Application decision guide

Appendix A – Risk Appetite Summary Table

Risk Theme	Risk Appetite Level	Risk Appetite Description	Risk Appetite Thresholds
Aneurin Bevan University Health Board Activities **(Patient Safety & Quality)**	**Limited**	The Health Board has a limited appetite for risks that may adversely affect patient safety, quality of care, safeguarding or clinical outcomes. Risks will only be accepted where they are well understood, tightly controlled and supported by robust assurance that patient harm is minimised and statutory duties are met.	**Score 8 and below**
Governance, Compliance & Reputation	**Limited**	The Health Board has a limited appetite for risks that could undermine effective governance, accountability, regulatory compliance or public confidence. Decisions will be transparent, evidence-based and supported by robust assurance to ensure statutory responsibilities are met and the confidence of patients, staff, partners and regulators is maintained.	**Score 8 and below**
Aneurin Bevan University Health Board Activities **(Service Delivery & Performance)**	**Measured**	The Health Board has a measured appetite for risks associated with improving operational performance, patient access and service delivery. Moderate levels of risk may be accepted where decisions are evidence-based, controls are effective and there is a clear plan to deliver sustainable improvements without compromising quality or safety	**Score 12 and below**

People **(Workforce)**	**Measured**	The Health Board has a measured appetite for risks associated with improving operational performance, patient access and service delivery. Moderate levels of risk may be accepted where decisions are evidence-based, controls are effective and there is a clear plan to deliver sustainable improvements without compromising quality or safety	**Score 12 and below**
Financial Sustainability	**Measured**	The Health Board has a measured appetite for financial risk in pursuit of long-term sustainability. Decisions that improve financial resilience and value for money will be supported where risks are proportionate, informed by sound financial management and do not have an unacceptable impact on patient care, staff wellbeing or statutory responsibilities.	**Score 12 and below**
Estates & Infrastructure	**Measured**	The Health Board has a measured appetite for risks associated with maintaining, modernising and investing in its estate, equipment and infrastructure. Investment and change will be supported where risks are appropriately managed, statutory compliance is maintained and the safety of patients, staff and visitors is not compromised.	**Score 12 and below**
Digital, Data & Cyber	**Progressive**	The Health Board has a progressive appetite for risks associated with digital transformation, information management and the adoption of new technologies where	**Score 16 and below**

		these improve patient care, productivity or organisational resilience. Innovation will be supported provided cyber security, information governance, data integrity and system resilience are maintained through robust controls and independent assurance.	
Partnerships & System Working	**Progressive**	The Health Board has a progressive appetite for risks arising from collaboration with partner organisations, recognising that integrated working is essential to improving population health and delivering sustainable services. Risks will be accepted where roles, responsibilities, governance arrangements and shared accountability are clearly defined and actively monitored.	**Score 16 and below**
Transformation & Innovation	**Transformational**	The Health Board recognises that delivering sustainable improvements in health outcomes requires innovation and transformational change. It has a transformational appetite for risks where the anticipated benefits are substantial, strategic alignment is clear, mitigations are robust and there is strong governance to oversee delivery and realise intended outcomes.	**Score 20 and below**

Appendix B: Application decision guide

Step	Requirement
1. Define the risk	State the uncertain event, its causes and consequences clearly.
2. Assess residual exposure	Score likelihood and impact after considering current controls.
3. Identify all relevant domains	Select domains according to the nature and consequence of the risk, not organisational ownership.
4. Apply the governing threshold	Use the most restrictive relevant threshold unless an alternative is formally justified and approved.
5. Determine the response	Confirm whether the risk is within appetite, outside appetite with a reduction plan, or proposed for formal acceptance.
6. Evidence and review	Record controls, assurance, actions, trajectory, approval route and next review date.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Strategic Risk Report, September 2026**
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 provides the Committee with an updated assessment of the Health Board's strategic risk profile and the principal risks that may affect delivery of the Integrated Medium-Term Plan (IMTP) 2025–2028 and wider organisational objectives.

The Strategic Risk Register (SRR) comprises nine principal strategic risk themes, supported by 21 individually assessed sub-risks.

The overall profile remains broadly stable, with no changes to the principal risks under Board oversight. However, six sub-risks remain outside the Board's currently approved risk appetite, reflecting continued exposure across financial sustainability, performance, estate resilience, business continuity, and governance and legislative compliance.

The report also provides an update on the Risk Management and Assurance Improvement Programme and presents proposed amendments to strengthen the Strategic Risk Register's role as the Health Board's Board Assurance Framework.

Cefndir / Background

The SRR is the Board's primary mechanism for overseeing the principal uncertainties that may affect delivery of the IMTP and the Health Board's strategic objectives.

Each strategic risk is assigned to an Executive Director, who is responsible for ensuring that appropriate controls, risk treatment plans and assurance.

As reported to the Board in May, a Risk Management and Assurance Improvement Programme is underway to strengthen organisational risk maturity and establish a clearer line of sight between operational risks, corporate risks, strategic risks and delivery of the Health Board's objectives.

Asesiad / Assessment

The strategic risk profile remains broadly stable in terms of the number of principal risks and sub-risks under Board oversight. Stability should not, however, be interpreted as a reduction in exposure, as six of the 21 strategic sub-risks remain outside the Board's currently approved risk appetite and require continued treatment, Executive oversight and Board scrutiny.

The Strategic Risk and Assurance Dashboard is provided at **Appendix A**. The strategic sub-risks currently operating outside appetite are summarised below.

Table 1: Strategic sub-risks outside appetite

Risk ID & Score Threshold	Sub Risk Description	Current Score	Management of the Risk
SRR 001G Score 12 and below	Due to the failure to deliver a sustainable financial position and longer-term financial plan.	**20**	The residual risk is being **treated** through strengthened financial controls, while **opportunities are being taken** to redesign services for long-term sustainability.
SRR 001I Score 8 and below	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**12**	The residual risk is being **treated** and opportunities taken to strengthen services and accountability structures.
SRR 002A Score 8 and below	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**15**	The risk is being **treated** through monitoring, contingency planning and the development of proportionate remediation plans.
SRR 002B Score 8 and below	Due to significant levels of backlog maintenance and structural impairment.	**12**	The risk is being **treated** through proactive estate investment and maintenance planning.
SRR 004B Score 8 and below	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident	**12**	The risk is being **treated** through the development, standardisation, and testing of business continuity and incident response plans.
SRR 010 Score 8 and below	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act.	**12**	The risk is being **treated** through strengthening governance and **taking the opportunity** to enhance staff safety culture.

Application of the revised Risk Appetite Statement

The assessment in this report is based on the Risk Appetite Statement and associated thresholds currently approved by the Board.

The Committee is being asked separately, under agenda item 3.1, to consider and endorse a revised Risk Appetite Statement, prior to formal approval by the Board at its meeting on 28 September 2026, the revised domains and score thresholds will be applied to the Strategic and Corporate Risk Registers.

This may change whether individual risks are reported as within or outside appetite, but it will not, in itself, change their current risk scores or the underlying level of exposure. Executive risk owners will therefore be required to:

- review the alignment of each risk to the revised appetite domains;
- confirm the applicable appetite threshold;
- review target risk scores;
- consider whether risk treatment or escalation arrangements remain appropriate; and
- identify any implications for assurance and reporting.

If approved, the recalibrated position will be reported through the next formal reporting cycle.

Risk Management and Assurance Improvement Programme

The first phase of the improvement programme involved a comprehensive review of the Health Board's risk management suite of documents. The revised documents are presented separately for Committee endorsement under agenda item 3.1, prior to formal approval by the Board at its meeting on 28 September 2026.

The second phase involved a review of Datix to assess the risk profile across divisions and corporate directorates. This work sought to:

- Identify material themes and concentrations of exposure;
- Assess whether risks were held at the appropriate organisational level;
- Identify potential gaps in corporate reporting; and
- Strengthen the connection between local, corporate and strategic risks.

The review identified eight additional areas of potential corporate risk. Following further assessment, the CRR now contains 40 material corporate-level risks requiring Executive oversight because of their potential impact on the IMTP, the quality and safety of services, or the Health Board's statutory and operational responsibilities.

The identification of additional corporate risks does not necessarily indicate an increase in the Health Board's underlying exposure. It reflects improved visibility and more systematic consideration of whether material risks are being managed and reported at the appropriate level.

Similarly, transferring a risk between registers does not represent a reduction in exposure. Escalation and de-escalation decisions must be informed by:

- the nature and scale of the current exposure;
- the effectiveness of existing controls;
- progress in delivering agreed actions;
- the strength of available assurance;
- the relationship to strategic objectives; and
- the authority and capability of the proposed risk owner.

Further intelligence will continue to be drawn from Datix, performance information, incidents and concerns, assurance meetings, internal and external reviews, and divisional and committee reporting. This will support the aggregation of systemic and thematic risks and their escalation to the Corporate Risk Register or Strategic Risk Register where appropriate.

Establishing a clear line of sight

An effective enterprise risk management system requires a demonstrable line of sight from ward to Board and from Board to ward. This enables the Board to understand the Health Board's principal risk exposures and ensures that strategic priorities, risk appetite and Board decisions inform risk management throughout the Health Board.

Work is underway to align the Strategic and Corporate Risk Registers with:

Key areas to align	Status
IMTP and Gwent 2035 Strategy	Complete
Health Board's strategic objectives and priorities	Complete
Divisional and corporate risk registers	Complete
Performance and control measures	Partially Complete
Intelligence from Datix and other assurance sources	Partially Complete
Executive and divisional assurance meetings	Partially Complete
Committee and governance reporting arrangements	Partially Complete

These connections improve traceability across the risk hierarchy but do not, on their own, constitute assurance. Assurance conclusions must be supported by evidence that controls are operating effectively and that risk exposure is being maintained within appetite or moving towards the agreed target position.

If the revised Risk Appetite Statement is approved, its domains and thresholds will be incorporated into the risk hierarchy and reporting arrangements to support consistent risk assessment, treatment, escalation and acceptance decisions.

The Risk Maturity Model in Appendix C of the Risk Management Framework sets out the characteristics required for the Health Board to progress towards an optimised approach. The revised framework, supported by the engagement and training

programme, will help embed these principles and strengthen risk-informed decision-making.

Review of the Strategic Risk Register

The improvement programme has included a review of the SRR to determine whether the principal risk and sub-risk descriptions accurately reflect the uncertainties that could affect achievement of the Health Board's strategic objectives.
The review has applied a structured methodology that distinguishes between:

- the principal causes or sources of uncertainty;
- the uncertain event;
- the potential consequences;
- the existing controls;
- further actions required; and
- the evidence needed to demonstrate control effectiveness.

This has resulted in clearer articulation of strategic risks and improved connectivity between divisional risk, corporate risk, Executive oversight and Board-level reporting.
The proposed amendments are set out in **Appendix B** and include:

- clarifying the scope of selected principal strategic risk descriptions;
- revising sub-risk descriptions to make the causes, events and consequences more explicit; and
- considering the transfer of **SRR 002A**, relating to RAAC at Nevill Hall Hospital, from the Strategic Risk Register to the Corporate Risk Register.

SRR 002A is considered primarily operational because the immediate exposure relates to a defined estate issue at Nevill Hall Hospital. Although the risk remains relevant to strategic planning and service transformation, it would be more appropriately owned and managed at Executive level through the CRR.

The transfer would not represent closure or acceptance of the risk. The risk would retain a clear link to the relevant principal strategic risk, and its cumulative or material effect on strategic objectives would remain visible to the Board.

The risk should be re-escalated if:

- the exposure increases materially;
- the control environment deteriorates;
- remediation or contingency arrangements are not delivered;
- available assurance reduces; or
- the potential impact on strategic objectives becomes more significant.

Intended outcome

The proposed changes are intended to enable the SRR to operate more effectively as the Health Board's Board Assurance Framework.

The register should provide the Board with a focused view of:

- the principal uncertainties affecting strategic objectives;
- current exposure relative to appetite;
- the effectiveness of key controls;
- risk treatment plans and delivery trajectories;
- the strength of available assurance;
- gaps in control or assurance; and
- progress towards the target risk position.

This approach will support informed Board decision-making, strengthen challenge of risk ownership and control effectiveness, and highlight the principal threats to the Health Board's short, medium and longer-term sustainability.

Argymhelliad / Recommendation

The Committee is requested to:

- **CONSIDER** whether it has sufficient assurance that strategic risks are being appropriately identified, assessed, managed and monitored.
- **NOTE** the current strategic risk profile and the six strategic sub-risks operating outside the Board's currently approved risk appetite.
- **ENDORSE** the reframing of the nine principal strategic risks and 21 supporting sub-risks, providing the Board with greater clarity on the specific sources of risk and the factors that could affect delivery of the Health Board's strategic objectives.
- **ENDORSE** the transfer of SRR 002A from the Strategic Risk Register to the Corporate Risk Register, retaining a clear link to the relevant principal strategic risk and defined criteria for re-escalation**.**
- **NOTE** the progress made through the Risk Management and Assurance Improvement Programme and the further work required to embed the revised arrangements

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.

STRATEGIC RISK AND ASSURANCE DASHBOARD

9 Strategic risks	**21** Risk components	**7** Above appetite	**8** Positive assurance	**12** Reasonable assurance	**1** Limited assurance

Board Summary

- The dashboard contains 9 strategic risks represented through 21 separately scored risk components.
- 7 components have current scores above their stated appetite thresholds and require focused oversight of control effectiveness and delivery trajectories.
- Assurance Scale: The explanatory text provides context against appetite and target scores and Executive Director's assurance judgement.
- Underpinning Corporate Risk links and IMTP performance measures to support integrated strategic and corporate risk reporting.

ASSURANCE SCALE

Positive	Reasonable	Limited
Controls are operating effectively and sufficient evidence supports the judgement.	Controls are generally operating, but gaps, dependencies or delivery concerns remain.	Significant control weakness, adverse performance or unresolved dependency remains.

KEY: Score cells use the Health Board risk matrix colour bands. Assurance ratings are retained from the source register and should be reviewed alongside current performance and control evidence.

DETAILED STRATEGIC RISK AND ASSURANCE DASHBOARD

RISK INFORMATION	RISK EVENT	PRINCIPAL CAUSE	IMTP LINK	UNDERPINNING CORPORATE RISKS	IMTP PERFORMANCE MEASURES (Not an exhaustive list)	APPETITE	CURRENT	TARGET	ASSURANCE CONCLUSION
SRR 001A Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialties.	**Enabler:** Workforce & Culture	**CRR 001, 004, 006, 008, 011, 012, 024, 025, 026, 030, 036**	• Reduction in vacancies, turnover and time to hire; • 30% reduction in agency spend; • Over 90% consultant job-plan compliance.	17	12	6	**Positive** Current exposure (12) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (6).
SRR 001B Director of workforce and OD		b) Due to a deterioration in, and a failure to improve, the well-being of our staff	**Enabler:** Workforce & Culture	**CRR 006**	• Reduction in sickness absence from the 2024/25 position and Occupational Health waiting times; • Improvement in staff wellbeing indicators.	17	12	9	**Positive** Current exposure (12) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (9).
SRR 001C Director of workforce and OD		c) Due to insufficient and ineffective leadership levels throughout the organisation.	**Enabler:** Workforce & Culture	**CRR 027**	• Improvement in PADR compliance; • Increased leadership-development participation and succession-plan coverage.	17	12	6	**Positive** Current exposure (12) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (6).
SRR 001D Director of workforce and OD		d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	**Enabler:** Workforce & Culture	**No linked risks**	• Reduction in days lost, service disruption and cancelled activity; • Timely recovery of affected activity.	17	16	8	**Reasonable** Current exposure (16) is within appetite (17); continuing oversight is required to evidence progress toward the target score (8).
SRR 001E Director of Strategy, Planning and Partnerships		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	**System Change:** Prevention & Population Health **Enabler:** Performance Expectations	**CRR 010, 017**	• Improvement across the eight Planning Maturity Matrix domains; • Increased delivery of IMTP milestones and performance expectations.	17	8	6	**Positive** Current exposure (8) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (6).
SRR 001F Director of Strategy, Planning and Partnerships		f) Due to unsustainable service models	**System Change:** Prevention & Population Health **Enabler:** Performance Expectations	**CRR 004, 006, 008, 011, 012, 017, 024, 026, 027, 034, 036, 037**	• 100% GP access-standard compliance; • increased community-care capacity; • delivery of service-model and place-based care milestones.	17	8	6	Current exposure (8) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (6).
SRR 001G Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	**Enabler:** Finance	**CRR008, CRR017, CRR024, CRR025, CRR026**	• Achievement of financial balance; • delivery of £40 million savings; • increased recurrent savings; • reduction in the underlying deficit.	13	20	8	**Reasonable** Current exposure (20) is above appetite (13); continuing oversight is required to evidence progress toward the target score (8).
SRR 001I Director of Strategy, Planning and Partnerships		I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**System Change:** Relevant to all **Enablers:** Performance Expectations & Workforce & Culture	**CRR 011, 027, 030, 033**	• Increased delivery of IMTP and Ministerial expectations; • improvement against agreed trajectories; • reduction in escalated measures.	8	12	8	**Reasonable** Current exposure (12) is above appetite (8); continuing oversight is required to evidence progress toward the target score (8).
SRR 002A Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**Enabler:** Estates	**CRR 016**	• Completion of all scheduled RAAC inspections; • reduction in overdue actions and service disruption; • delivery of Nevill Hall business-case milestones.	8	15	2	**Reasonable**. Current exposure (15) is above appetite (8); continuing oversight is required to evidence progress toward the target score (2).
SRR 002B Chief Operating Officer		b) Due to significant levels of backlog maintenance	**Enabler:** Estates	**CRR 005, 016, 021**	• Reduction in high-risk backlog; • increased planned-maintenance completion and statutory compliance; • delivery of Targeted Estates Fund priorities.	8	12	6	**Reasonable**. Current exposure (12) is above appetite (8); continuing oversight is required to evidence progress toward the target score (6).
SRR 004A Director of Strategy, Planning and Partnerships	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	**Enablers:** Quality, Digital, Data & Technology Estates, Workforce	**No linked risks**	• Completion of scheduled plan reviews and exercises; • maintenance of 24-bed level-three surge capacity.	8	8	6	**Positive** Current exposure (8) is within the appetite threshold (8); controls and delivery should continue to be monitored toward the target score (6).
SRR 004B Director of Strategy, Planning and Partnerships		b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.	**Enablers:** Quality, Digital, Data & Technology Estates, Workforce	**CRR0 28, 029, 034, 035**	• Increased proportion of current and tested plans; • reduction in service disruption; • improvement against recovery times.	8	12	6	**Reasonable** Current exposure (12) is above appetite (8); continuing oversight is required to evidence progress toward the target score (6).
SRR 005A Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	**System Change** Urgent & Emergency Care **Enablers:** Quality, Workforce, Digital	**CRR 011, 013, 014 015, 036, 037**	• Reduction in one-hour ambulance handovers to 500 and 12-hour waits to 750; • improvement in four-hour performance to 80%; • reduction in delayed pathways to 160.	17	16	9	**Limited** Material system pressure remains and further evidence of sustained control effectiveness is required to reduce exposure from 16 toward the target score of 9.
SRR 006A Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of testing digital infrastructure and systems	**System Change:** Relevant to all **Enabler:** Digital, Data & Technology	**CRR 028, 029, 032, 036**	• Improvement in critical-system availability; • reduction in critical incidents and unsupported systems; • delivery of infrastructure-renewal milestones.	17	12	8	**Reasonable** Current exposure (12) is within appetite (17); continuing oversight is required to evidence progress toward the target score (8).
SRR 006B Director of Digital		b) Due to an adverse impact on service delivery in the implementation of new digital systems	**System Change:** Relevant to all **Enabler:** Digital, Data & Technology	**CRR0 20, 029, 030**	• Increased delivery to time, cost and scope; • achievement of readiness and training requirements; • reduction in implementation incidents.	17	20	6	**Reasonable** Current exposure (20) is above appetite (17); continuing oversight is required to evidence progress toward the target score (6).
SRR 006C Director of Digital		c) Due to a failure to develop digital solutions that are sustainable and fit for the future	**System Change:** Relevant to all **Enabler:** Digital, Data & Technology	**CRR0 20, 21, 22, 28, 029, 032, 033, 035**	• Delivery of Digital Strategy and infrastructure-renewal milestones; • increased technical-architecture compliance and digital inclusion.	17	12	8	**Reasonable** Current exposure (12) is within appetite (17); continuing oversight is required to evidence progress toward the target score (8).
SRR 007A Director of Strategy, Planning and Partnerships	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	**System Change** Place Based Care Enabler: **Regional Plans**	**CRR 014, 017, 018**	• Increased delivery of partnership milestones; • expansion of Integrated Neighbourhood Teams; • increased delivery against agreed partner commitments.	17	8	4	**Positive** Current exposure (8) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (4).

RISK INFORMATION	RISK EVENT	PRINCIPAL CAUSE	IMTP LINK	UNDERPINNING CORPORATE RISKS	IMTP PERFORMANCE MEASURES (Not an exhaustive list)	APPETITE	CURRENT	TARGET	ASSURANCE CONCLUSION
SRR 007B Director of Strategy, Planning and Partnerships		b) Due to the impact of fragile services across the regional and supra regional geography	**System Change** Place Based Care Enabler: **Regional Plans**	**CRR 012, 018**	• Reduction in fragile services, vacancies and service disruption; • increased delivery of regional programme milestones.	**17**	**9**	**4**	**Reasonable** Current exposure (9) is within appetite (17); continuing oversight is required to evidence progress toward the target score (4).
SRR 008 Director of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	**Enabler:** Quality	**CRR 002, 019 030**	• 100% of live Civica areas collecting and using feedback; • improved response and early-resolution rates; • improved 30-working-day concerns compliance; • increased completion of feedback actions.	**17**	**8**	**4**	**Positive** Current exposure (8) is within the appetite threshold (17); controls and delivery should continue to be monitored toward the target score (4).
SRR 010 Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**Enablers:** Quality & Workforce & Culture	**No linked risks**	• Reduction in RIDDOR incidents and overdue actions; • 85% manual-handling training compliance; • increased completion of risk assessments.	**8**	**12**	**6**	**Reasonable** Current exposure (12) is above appetite (8); continuing oversight is required to evidence progress toward the target score (6).
SRR 011 Director of Finance and Procurement	There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.	a) Due to an ageing and complete estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	**Enabler** Green Health	**CRR 031**	• Reduction in carbon emissions and energy use; • 50% viable renewable-energy installation by 2026; • increased LED coverage and waste compliance.	**17**	**8**	**8**	**Reasonable** Current exposure (8) is within appetite (17); continuing oversight is required to evidence progress toward the target score (8).

Appendix B: Proposed Revised Risk Descriptions

The Bow Tie model was used to provide a clearer, cause-and-consequence-based view of the Health Board's nine principal strategic risks and identify 21 supporting sub-risks. For each strategic risk, the model identifies the central risk event, the key threats that could cause it and the potential consequences should it materialise.

Applying this approach will provide the Board with greater clarity on the specific sources of risk and the factors that could affect delivery of the Health Board's strategic objectives. The revised risk descriptions will support a more consistent understanding and assessment of the current controls, gaps in control, sources of assurance and actions required to manage each risk effectively.

SRR Ref	Current Overarching Strategic Risk Description	UPDATED Overarching Strategic Risk Description for Approval	Current Strategic Sub-Risk Description	UPDATED Strategic Sub-Risk Description for Approval
SRR 001A - D Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population**.**	There is a risk that the Health Board's workforce, resources and service models are insufficiently resilient or aligned to meet current and changing population needs.	a) Due to an inability to recruit and retain staff across all disciplines and specialties.	a) Due to insufficient workforce supply, recruitment constraints, skills shortages and difficulties retaining staff in key disciplines and specialties.
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	b) Due to sustained workload pressures, sickness absence, workplace stressors and insufficient capacity to prevent and respond to deteriorating staff wellbeing.
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	c) Due to gaps in leadership capability, capacity, succession planning and accountability across the organisation.
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	d) Due to unresolved national employment disputes and the potential for industrial action affecting workforce availability.
SRR 001E & F Director of Strategy, Planning and Partnerships			e) Due to inadequate strategic plans which respond to population health and socio-economic needs	e) Due to strategic plans not being sufficiently informed by population need, health inequalities, socio-economic conditions and deliverability
			f) Due to unsustainable service models	f) Due to service models that are not sufficiently integrated, affordable, workforce-resilient or aligned to changing demand
SRR 001G Director of Finance and Procurement			g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	g) Due to recurrent expenditure exceeding available income, insufficient recurrent savings and continued growth in the underlying financial deficit.
SRR 001I Director of Strategy, Planning and Partnerships			i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	i) Due to inconsistent implementation of the Performance Management Framework, insufficient accountability for delivery and failure to intervene promptly where performance is off trajectory.
SRR 002A & B Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	No proposed change	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures Requesting to de-escalate to the CRR	a) No proposed change
			b) Due to significant levels of backlog maintenance	b) No proposed change
SRR 004A & B Director of Strategy, Planning and Partnerships	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	There is a risk that a major, critical or business continuity incident results in sustained disruption to essential Health Board services.	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	a) Due to major-incident plans, command arrangements, exercises, training and operational readiness not being sufficiently current, tested or embedded.
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.	b) Due to inconsistent business continuity planning, incomplete critical-service impact assessments, untested recovery arrangements and dependency on vulnerable infrastructure or suppliers.

SRR Ref	Current Overarching Strategic Risk Description	UPDATED Overarching Strategic Risk Description for Approval	Current Strategic Sub-Risk Description	UPDATED Strategic Sub-Risk Description for Approval
SRR 005A Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	There is a risk that patients are unable to access or move through the most appropriate care setting within a clinically appropriate timescale.	a) Due to inadequate arrangements to support system-wide patient flow	a) Due to demand and patient acuity exceeding available capacity across emergency, acute, critical care, community, transfer and discharge pathways, compounded by inconsistent escalation and coordination arrangements.
SRR 006A, B & C **Director of Digital**	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of testing digital infrastructure and systems	a) Due to ageing, unsupported, insufficiently resilient or inadequately maintained digital infrastructure and systems
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	b) Due to weaknesses in programme governance, configuration, testing, interoperability, data migration, workforce readiness or implementation planning for new digital systems.
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	c) Due to fragmented architecture, legacy technology, constrained investment, limited specialist capacity and inconsistent adherence to agreed digital standards.
SRR 007A & B Director of Strategy, Planning and Partnerships	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	There is a risk that health and care services across Gwent and the wider regional footprint are not planned, commissioned or delivered in an integrated and sustainable way.	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	a) Due to financial pressures, misaligned organisational priorities, differing planning cycles and insufficiently clear partnership accountability and decision-making arrangements.
			b) Due to the impact of fragile services across the regional and supra regional geography	b) Due to fragile specialist services, workforce shortages, limited capacity and dependency on regional or supra-regional delivery arrangements.
SRR 008 Director of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	There is a risk that patient, staff and public experience, feedback and involvement do not consistently influence decisions, service design and improvement.	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	a) Due to fragmented feedback systems, inconsistent involvement arrangements, delays in responding to concerns and insufficient evidence that learning and engagement have informed decisions and sustained improvement.
SRR 010 Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	There is a risk that the Health Board fails to protect staff, patients, and visitors from avoidable workplace health and safety hazards.	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	a) Due to inconsistent identification, assessment and management of workplace hazards, insufficiently embedded health and safety responsibilities, gaps in training and weaknesses in monitoring, escalation and action completion.
SRR 011 Director of Finance and Procurement	There is a risk that the Health Board does not adequately anticipate, plan for, and respond to the impacts of climate change, green health requirements, and the need to adapt and decarbonise its services, estate and infrastructure.	There is a risk that the Health Board's services, estate and infrastructure are insufficiently resilient to climate change and do not achieve required decarbonisation outcomes.	a) Due to an ageing and complete estate, competing capital and revenue pressures, climate-related service demand and the absence of an organisation-wide climate adaptation approach.	a) Due to an ageing and complex estate, limited capital and revenue funding, competing investment priorities, dependence on carbon-intensive infrastructure and the absence of a sufficiently embedded organisation-wide climate adaptation approach.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Update on Single Quotation and Tender Actions from 1st April 2026 to 31st August 2026**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	**Director of Finance, Procurement and Value Based HealthCare**
SWYDDOG ADRODD: **REPORTING OFFICER:**	**Alex Curley – Head of Procurement**

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

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

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

This report also includes information on SLA agreements which have been agreed by the Health Board to evidence greater grip and control on the organisation spend and input into wider review to ensure that SLA are agreed by the appropriate procurement route where required.

Key Headlines

- 11 STA/SQA requests approved.
- Total annual value: £929k.

- 8 STAs and 3 SQAs.
- No approvals identified as non-compliant with Standing Financial Instructions.
- Largest approval related to additional works at Grange University Hospital car park.
- 23 SLA agreements reviewed with annual value of £7.1m.
  - 3 SLAs identified for potential future procurement exercises.

Cefndir / Background

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

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

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

Asesiad / Assessment

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

There have been 11 requests submitted which have been approved during the period with an annual value of £929,235 Ex VAT. Of the request submitted 8 of these were STAs with the remaining 3 lower value SQA's. The largest of these requests was for an STA for additional works required following planning application for Grange University Hospital car park. A contractor had previously been appointed following an open competition managed by the Estates & Facilities team, but additional works were required following completion of the planning process with the local authority, an STA was endorsed on the basis of a contractor had already been appointed to undertake the works and these works were in addition to those they had been appointed to undertake. 2 further requests were received for follow up works following an open competition. One SQA for coordination of connect 5 training programme and an STA for a 4-month extension of the Mobile Endoscopy Decontamination unit that was already on site whilst works were completed on the decontamination unit.

2 STAs were approved for one Maintenance agreement for the Building Management System and provision of LED Headlights due to compatibility issues. The remaining

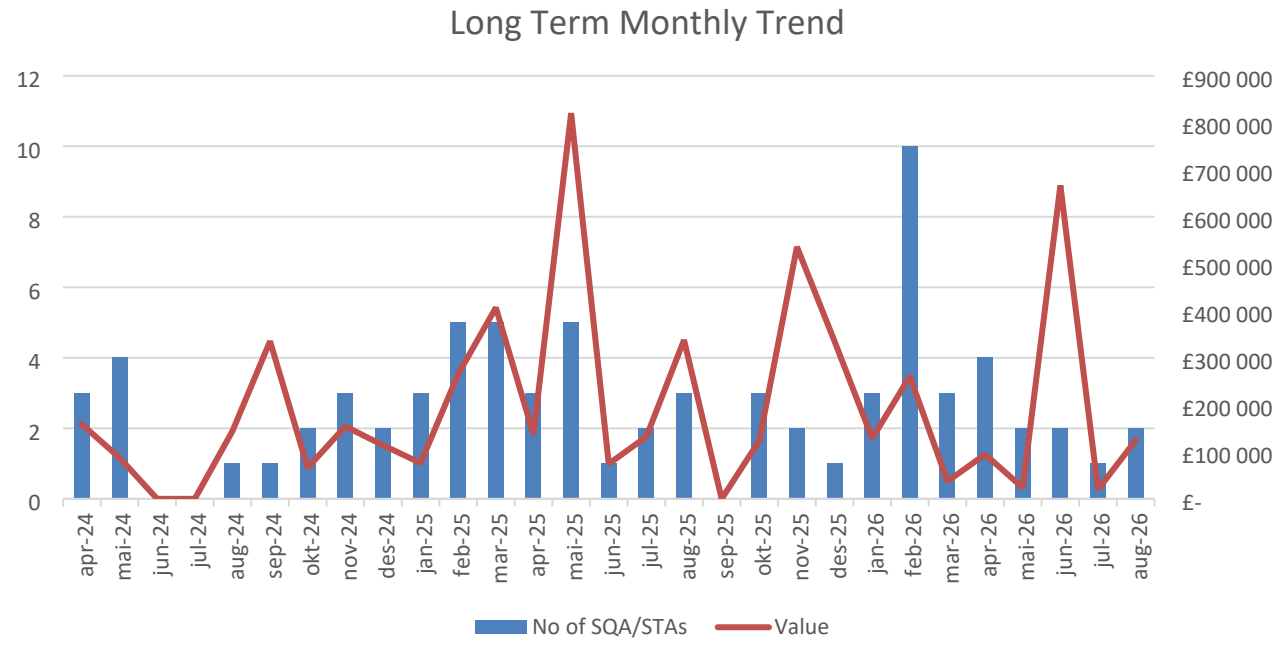
6 approvals (4 STA's and 2 SQA's) were for maintenance agreements whereby only the original equipment manufacturer can maintain the equipment or systems and one SQA for Music License where there is genuinely only one provider.

Category under the SFI justifying the use of SQA/STA	Occurrences (no.)	Value (£/annum)
Follow-up work where a supplier has already undertaken initial work in the same area (and where the initial work was awarded from open competition);	**3**	**689,069**
A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;	**2**	**115,202**
The need to retain a particular contractor for genuine business continuity issues (not just preferences)	**0**	**-**
An interim agreement prior to joining an all-Wales Collaborative Agreement.	**0**	**-**
Genuinely Only one Provider	**6**	**124,964**
In line with Policy and justified STA	**11**	**929,235**
Not in accordance with STA rationale	**0**	**-**

In addition to the SQA/STA process Procurement and Finance have commenced a process of reviewing historic and new Service Level Agreements across the Health Board. The process is being used as way of identifying spend that could potentially be competed under one of the procurement routes and also to ensure that good contract management practice is in place to measure the effectiveness of these agreements.

Trend Analysis

Period	Number of STAs/SQAs	Value £
Apr-Nov 2025	8	£305k
Nov-Mar 2025/26	11	£725k
Apr-Aug 2026	11	£929k



Volumes remain reasonably static in terms of number of STA/SQA requests.

Service Level Agreement

To date a total of 23 SLA agreements have been approved in line with the STA approval route totalling £7.1 million per annum. These SLA agreements range from agreement with Local Authorities/NHS Health Boards & Trusts to 3rd sector organisations. Pathology dominates the expenditure within this area with circa 84% of the total annual value. Health Promotion represents 9.6% of the annual spend with the remaining vale attributed Primary Care and Public Health type agreements.

Divisions have been asked to take greater in-depth reviews of these SLAs to ensure appropriate levels of management and performance monitoring are taking place. Divisions have been informed of 3 agreements whereby a procurement process maybe the most appropriate route to market and have been instructed to work with procurement to review any ongoing requirements for these agreements.

Argymhelliad / Recommendation

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

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

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	STA – Single Tender Action SQA – Single Quotation Action SFI – Standing Financial Instructions SLA- Service Level Agreement
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.

Agenda Item:3.4

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Mid-Year Report September 2026
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe, Director of Finance, Procurement and Value Based Healthcare
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Lavington, Head of Counter Fraud

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

Er Gwybodaeth/For Information

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

NHS bodies in Wales are required to maintain effective arrangements to prevent, detect, and respond to fraud, bribery, and corruption in accordance with the Welsh Government Directions on Counter Fraud Measures, the service agreement under section 83 of the Government of Wales Act 2006, and the principles set out in the NHS Counter Fraud Authority standards aligned to the Government Functional Standard 013 (Counter Fraud).

In addition, the new, Economic Crime and Corporate Transparency Act 2023 (ECCTA) requires that 'large organisations' have in place reasonable measures to prevent fraud. This report provides assurance to the Board/ARAC on the effectiveness of the organisation's counter fraud arrangements, including governance, risk assessment, awareness, reporting, investigation, and recovery

activity, and demonstrates compliance with the required standards and legislation through the work delivered by the Counter Fraud team during the year.

The work carried out through the year is now directly aligned with the pillars set out in the new NHS Wales Counter Fraud Strategy 2026–2030, and the reporting reflects compliance with these areas.

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

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

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

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

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

Asesiad / Assessment

Period of reporting – 01/04/2026 – 24/08/2026

1. Workstream Review

1.1 Education and Awareness (*Prevent*)

Overview

A local Counter Fraud Education Strategy exists within the department to ensure a consistent, effective, and high-quality approach to fraud awareness across the organisation. The strategy is designed to maintain and strengthen fraud awareness at all levels, supporting the delivery of a proactive and prevention-focused counter fraud service.

Education is delivered through a blended approach, incorporating both digital and face-to-face engagement, including internal and external newsletters, Fraud Clinics, bespoke presentations, e-learning modules, corporate induction sessions, site visits, and targeted social media communications.

Significant progress has been maintained with demonstrable impact across the organisation. Key outcomes are listed below.

E-Learning

Staff Compliance at end Quarter 1 (June 30) – **91%.**

543 further members of **staff completed the training** during Quarter 1. E learning remains a **mandatory training package** with the requirement to refresh the training being every 3 years.

Corporate Induction

Counter Fraud continues to feature as a core component of Corporate Induction, ensuring early engagement with new starters.

Awareness Presentations

12 tailored presentations to a range of teams. Each session designed to be bespoke to the audience, focusing on risks and issues relevant to them. These sessions have been delivered to the following cohorts.

- Medical (15)
- Nursing (Adult and Paediatric) (130)
- MHLD (20)
- Physiotherapy (30)
- Facilities & Estates (20 Senior Managers)

Focus is being placed on the Medical and Facilities and Estates Division with further sessions arranged throughout the year.

ABUHB Counter Fraud Hub (Viva Engage MO365)

The ABUHB Counter Fraud Hub remains highly impactive, and the most effective method of communication across the organisation. It continues to significantly enhance staff engagement with all things Counter Fraud.

- **45** posts published
- **362** members
- Over **3.5K** views per month

Feedback to date has been overwhelmingly positive. An example post is provided below.

🕵️ **Whodunit Series**
🔍 **Introduction**

Fraud and misconduct don't always start with something obvious.
Often, they begin with small actions — things that feel harmless, routine, or easy to overlook.

This July, we're inviting you to put on your investigator hat and step into our **Whodunit series**. Each week, you'll be presented with a short scenario based on situations that can happen in any workplace.

💬 **Your challenge:**

- What doesn't feel quite right?
- What are the risks?
- Would you know what to do?

You'll see a mix of possible responses — some appropriate, some not. Your task is to decide **which ONE is not appropriate**.

🧠 **Why it matters:**
Fraud isn't always about money. It can involve time, access, data, or trust — and it often builds over time if concerns aren't raised early.

1.2 Investigation Activity (*Respond*)

The Local Counter Fraud Specialist (LCFS) receives information and intelligence from a range of internal and external sources. Robust processes are in place to ensure that all referrals are appropriately assessed, prioritised, and investigated in line with agreed procedures.

In accordance with national reporting requirements, all notified concerns are recorded on the NHS Counter Fraud Authority (NHSCFA) crime reporting system, CLUE, which is used to log, monitor, and manage all current cases.

Case Volumes and Outcomes

Over the course of the financial year to date:

- **14 active investigations** were open at April 1st
- **18 new referrals** have been received and recorded
- **10 cases** remain open and are being actively investigated at time of reporting
- **0 cases** transferred to the NHS Counter Fraud Service (CFS) Wales Team
- **22** investigations have been **closed**
- **4** Civil Recoveries have been made
- **1** internal disciplinary sanction resulting in dismissal

A sanitised table of cases for 26-27 is provided at **Appendix 1**

Investigations of Note

There are currently two investigations of note.

1. Staff member suspected of using Non-Medical Prescribing pads for own use over a protracted period of time. This case has resulted in the arrest of subject, search of

home address and suspect interview at Newport Central Police Station by Counter Fraud Team. Liaison with Torfaen Safeguarding team at Torfaen County Council ongoing. Prosecution file being prepared for submission to the Crown Prosecution Service. Liaison with WOD carried out and subject currently suspended from the workplace. Disciplinary investigation commenced.

2. Community Pharmacy Group suspected of illegitimately altering issued prescriptions for financial gain. It has not been possible to substantiate the intelligence in relation to this referral to the evidential threshold required. However, disruption activity has been undertaken to prevent further occurrence. In addition, a financial recovery of £1,100 made.

1.3 Proactive and Risk Led Counter Fraud Activity (Detect, Prevent)

The Counter Fraud Team prioritises the expansion of its proactive, risk led work. Much resource continues to be dedicated to this workstream, reflecting the strategic shift towards early identification, prevention, and system strengthening.

Risk Reviews and Fraud Risk Assessment

The fraud risk process complies with the local Risk Management Policy and conforms to the methodology required by the Cabinet Office. Each assessment considers fraud risk exposure, existing controls, vulnerabilities, and recommended mitigating actions. The table at **Appendix 2** provides an overview of the fraud risk assessment work carried out to date.

Local Proactive Exercises

In addition to formal risk assessments and reviews, the team are currently working on **21** Local Proactive Exercises (LPEs).

A number of positive outcomes have been recorded against the Proactive exercises this year, including – Policy and Procedure change, the introduction of new Standard Operating Procedures and the implementation of Fraud Action Plans.

2 comprehensive LPE exercises have now been completed and the final reports disseminated to the relevant Executive Directors. These are:

- **Extra Duties Claims by Consultants and SAS Doctors** – Medical Director has commented briefly on the accuracy of specific aspects of the report and those comments have been addressed by the Head of Counter Fraud. The Fraud Risk Assessment which forms part of the LPE still awaits formal response

- **Impersonation of HCSW/Nursing Agency Staff** – Formal response received and Fraud Action Plan implemented

The final reports are provided **at Appendices 3 & 4**.

The Fraud Action plan in response to the Impersonation LPE is provided at **Appendix 5**

A further comprehensive LPE is underway in relation to the use of 'Fleet Services and Fuel Cards' in response to the risk identified associated with rising fuel costs. It is anticipated this will be completed by the close of Quarter 2.

1.4 Collaboration, Governance and Training (Build Capability, Collaborate)

Collaboration

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

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

Training and Professional Development

All members of the Counter Fraud Team have attended the training sessions provided by the NHS Counter Fraud Authority (NHSCFA). No external training has been undertaken during the reporting period. The team has actively participated in the regular webinar programme delivered by the NHSCFA and continues to utilise the Engage website for self-directed learning and professional development. The resources available through Engage provide valuable guidance and support for Local Counter Fraud Specialists (LCFSs).

Governance

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

2. Conclusion

During the reporting period 1 April 2026 to 24 August 2026, the Counter Fraud Team has continued to deliver a comprehensive and effective counter fraud service across Aneurin Bevan University Health Board, in line with Welsh Government Directions, NHS Counter Fraud Authority requirements, Government Functional Standard 013, and the emerging obligations under the Economic Crime and Corporate Transparency Act 2023.

Activity undertaken throughout the period demonstrates a balanced approach across all five pillars of the NHS Wales Counter Fraud Strategy 2026-2030. Significant progress has been made in raising awareness and promoting a strong anti-fraud culture through education, engagement, and mandatory training compliance. Investigation activity has remained robust, with all referrals appropriately assessed and managed, resulting in positive outcomes including recoveries, disciplinary action, and the progression of significant criminal investigations.

The department has continued to strengthen its proactive and risk-led approach through the completion of Local Proactive Exercises, fraud risk assessments, and the implementation of targeted fraud action plans designed to strengthen systems and controls. This work supports the Health Board's broader objective of preventing fraud before losses occur and ensuring resources are protected for patient care.

Strong governance arrangements remain in place, supported by effective engagement with Executive Directors, the Director of Finance, Fraud Champion, NHS Counter Fraud Authority, and partner agencies.

Overall, the work undertaken during the reporting period provides reasonable assurance that the Health Board has effective arrangements in place to prevent, detect, investigate, and respond to fraud, bribery, and corruption. The Counter Fraud Team will continue to

focus on proactive prevention activity, intelligence-led investigations, and organisational resilience to support compliance with national standards and protect NHS resources.
Argymhelliad / Recommendation That the Audit, Risk and Assurance Committee take assurance from the information provided in this report that the Counter Fraud provision remains effective, compliant and focussed.

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

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

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

Appendix 1

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/23/01521	Paid for shifts not worked	28/07/24 C/F		Enqs ongoing
INV/23/01520	Failure to notify non-payment of salary sacrifice	28/07/24 C/F	22/06/2026	No fraud identified. Protracted Civil Matter. Closed.
INV/23/02427	Salary Overpayment	27/10/23 C/F	24/07/2026	No fraud identified. Civil Financial recovery made.
INV/24/01199	Salary Overpayment	13/05/24 C/F		Awaits legal outcome re recovery
INV/25/01471	Receiving treatment to which not entitled	28/05/2025 C/F	13/05/2026	As a direct result of Counter Fraud intervention, £14700.00 invoice raised for treatment due to OSV status and no entitlement to free treatment. Payment contested and legal process underway. Closed - No Fraud Offences.
INV/25/02989	Working at St Josephs during AB contracted time	10/10/2025 C/F	20/07/2026	Case to be closed subject has provided mitigating evidence of a change to rota authorised two years ago and lack of toil oversight. Evidence supplied by the dept. inaccurate. Improvement advice provided and implemented
INV/25/03043	Working elsewhere when sick	16/10/2025 C/F	22/05/2026	Full investigation undertaken. Subject interviewed. Fraud identified; Financial Loss recovered. Due to all surrounding circumstances - internal action only.
INV/26/00531	Pharmacy Contractor false claims	16/02/2025 C/F		ND & WRS - Unable to substantiate to the required threshold - Civil recovery agreed and in process - £1,012.23 for 3 x scripts high-cost drugs
INV/26/00753	Working via HBS / ABUHB clinic typing while on sick	27/02/2026 C/F	22/05/2026	Investigation Complete. Managerial concern issues found only. Referred back to department and HR. Pending Fast Track disciplinary
INV/26/00690	Theft of medical supplies/needles	24/02/2026 C/F	22/05/2026	No fraud offences identified., believed to be vexatious reporting
INV/26/00882	Salary o/p / reduction in hours	11/03/2026 C/F	13/05/2026	No Fraud identified. Pursued as a financial recovery only. OP recovery set up via payroll deductions to commence May 2026 pay.
INV/26/00982	Assisting Avon/Somerset Police	12/03/2026 C/F	03/06/2026	Disciplinary hearing completed - written warning issued in relation to nonfraud offences. No losses to fraud identified.
INV/26/00961	Working elsewhere during contracted hours and while sick	19/03/2026 C/F		Awaits HR Outcome
INV/26/00979	Altered date on WP10	23/03/2026 C/F	14/04/2026	No fraud identified. Possible Medications Act offences. Referred back to GP Practice for local resolution.
INV/26/01206	Claiming for shifts not worked	08/04/2026	14/04/2026	Enquiries have failed to substantiate the allegations made. Closed
INV/26/01224	Working at University as lecturer whilst sick from role within Facilities	10/04/2026		Enqs ongoing

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
INV/26/01375	Individual selling privately prescribed cannabis from a cannabis clinic	23/04/2026	28/04/2026	No further action required by CF team, referred to Gwent Police and GP for safeguarding
INV/26/01386	Not working contracted hours	24/04/2026	28/04/2026	Enquiries have failed to substantiate the allegations made. Closed
INV/26/01400	Theft of scrap metal	27/04/2026	24/07/2026	Evidence of theft identified. Low value and mitigating circumstances make this appropriate for internal resolution only. Fast track disciplinary carried out. Written warning applied and financial recovery sought.
INV/26/01481	Falsely using Ambulance Transport	05/05/2026	12/05/2026	Enquiries have failed to substantiate the allegations made. Closed
INV/26/01487	Finishing work early every day	29/04/2026	28/07/2026	No fraud offences identified following review. All leave has been authorised by manager.
INV/26/01716	Living in England registered with GP in Wales for free prescriptions	27/05/2026	03/06/2026	Located an individual with name but different DOB to the intel, referred to GP Practice for review of care/entitlement to free prescriptions. Not possible to identify correct permanent address for Subject. Case closed as unsubstantiated - relevant information passed to GP Practice for the purposes of patient review
INV/26/01862	Suspected of Issuing and collecting prescriptions dishonestly	08/06/2026		Case active and enquiries ongoing
INV/26/01793	Anon Intel - Working in contracted time - running own counselling service	08/06/2026		Case active enqs ongoing
INV/26/02061	Anon Intel- accessing patient details and selling these on	23/06/2026	28/07/2026	No fraud identified. Not able to substantiate allegation without further information. Intelligence supplied from an anonymous source and therefore closed.
INV/26/01909	Salary Overpayment	11/06/2026	24/07/2026	As subject made contact Invoice raised for £33,571.26 (gross £49,371) Closed
INV/26/01907	Staff member organising care package for patient who does not qualify for this health care	12/06/2026	24/07/2026	No offences Identified following initial review. No further action taken.
INV/26/02288	staff member suspected of working elsewhere whilst sick.	10/07/2026	31/07/2026	Investigated - not able to prove fraud due to undermining circumstances. Disciplinary only resulting in dismissal.
INV/26/02446	Member of the public alleged to have altered prescription in order to obtain oramorph	27/07/2026	27/07/2026	Not suitable for CF. Referred to Gwent Police.
INV/26/02545	Anon Intel re Agencies	30/07/2026		Enquiries commenced

Investigation Number	Investigation Subject	Date Opened	Date Closed	Outcome
	undertaking sharp practice			
INV/26/02721	Convicted July 26 using fraudulent driving licence (DVLA)	13/08/2026		Enquiries commenced

APPENDIX 2

Fraud Risk	Department	Status	Comments	Formal Response
Expenses	Finance	Complete and subject to future reviews	No action required. Subject to future review	YES
Retention of Salary Overpayments	Finance/WOD	Complete	Disseminated 14/08/2026 to Finance / WOD. Receipt acknowledged by finance only	AWAITS
Agency Worker PEC's	WOD/Bank	Complete	Awaits Review	NA
Direct Recruitment PEC's	WOD/NWSSP	Complete	Awaits Review	NA
Petty Cash	Finance	Commenced	Awaits completion	NA
Primary Care WP10	Primary Care Team	Complete – awaits response	Disseminated – 25 April 25. New procedures implemented. Subject to future review	YES
Secondary Care WP10	Medicines Management	Complete and subject to future reviews	Recommendations implemented New SOP developed all actions complete	YES
Omnicell Storage	Medicines Management/Pharmacy	Complete	Disseminated. No action required. Subject to future review.	YES
Impersonating Medical Personnel	WOD/Medical Directorate/Security	Complete	Disseminated. Recommendations made. Fraud action plan designed and implemented by Division. Subject to future review.	YES
Staff Leavers	WOD/Security/Data and Digital	Complete	Disseminated 08/01/2026. Awaits formal response	AWAITS
Special Leave	WOD	Complete	Disseminated 30/10/2025 October – formal response received. Subject to future review.	YES
Weight loss Medication	Medicines Management/Primary Care	Complete	Recommendations implemented all actions complete	YES
Agile Working	WOD	Complete	Disseminated –23 July 25. Meetings	AWAITS

APPENDIX 2

Fraud Risk	Department	Status	Comments	Formal Response
			held with WOD to discuss. Formal Response awaited	
Extra Duties Drs	Medical	Complete	Disseminated 19/06/2026. Receipt acknowledged	AWAITS
Mandate/Payment Diversion	Finance	Complete	Provided by NWSSP	YES
Fuel Cards/Fleet Services	Estates and Facilities	Complete	Awaits dissemination	NA

Fraud Risk Investigation Project

Ref: CLUE LPE/25/00814

Final Report

Contents

1. OVERVIEW

Project Background and Purpose

This project constitutes a structured and evidence-led examination of the risk of fraud, financial irregularity, and financial loss arising from medical staff undertaking private work or additional Health Board duties during contracted working hours at Aneurin Bevan University Health Board (ABUHB).

Additional Health Board activity was identified as presenting a heightened fraud risk due to the nature of the arrangements and includes, but is not limited to, Locum, Waiting List Initiative (WLI), and Backfill work.

The review was initiated in response to historic allegations of inappropriate working and claiming practices, which have resulted in formal Counter Fraud investigations.

Scope and Approach

The investigation focused on identifying the top ten highest-earning medical staff in respect of claims for additional duties. These claims were subject to targeted audit and analysis and were assessed against the core contractual obligations of the individuals concerned to determine whether additional duties were legitimate, appropriately authorised, and delivered outside of contracted time.

The review also examined the design and operation of relevant systems, processes, and controls used to administer both core and additional work. This included consideration of the adequacy of oversight arrangements, segregation of duties, recording mechanisms, and approval processes. Relevant policies and guidance were reviewed to identify any gaps, inconsistencies, or weaknesses that may increase the opportunity for fraud, error, or misuse.

Risk Assessment

As part of this work, a formal fraud risk assessment was undertaken to evaluate inherent risks associated with additional duty arrangements for medical staff. The risk assessment, mirrors the findings of this report, and, has been shared with the Medical Division and remains open pending management response.

Findings and Outcomes

The findings of the investigation are set out in the relevant sections of this report and highlight areas where control weaknesses and assurance gaps were identified. Recommendations have been developed to address these issues and to reduce the opportunity for fraud and financial loss, as well as to strengthen accountability and compliance with contractual and policy requirements.

Governance and Strategic Alignment

This project supports the NHS Counter Fraud Authority (NHSCFA) requirement for proactive fraud detection and prevention activity and aligns with Government Functional Standard 13: Fraud.

This project also provides assurance that ABUHB is committed to preventing fraud in compliance with the Economic Crime and Corporate Transparency Act 2023.

The work forms part of the ABUHB Counter Fraud Annual Work Plan 2026–27 and will be reported through established governance arrangements, including consideration by the Variable Pay Board.

2. EXTRA DUTIES AND SYSTEMS REVIEW

The principal strand of this project was the completion of a targeted, risk-based audit of Extra Duties activity undertaken by the ten (10) highest-earning medical staff by value of Extra Duties payments. All individuals within scope hold Consultant-level appointments.

The purpose of the audit was to obtain assurance over the adequacy and effectiveness of controls governing the rostering, authorisation, delivery, and payment of Extra Duties work, and to determine whether there was sufficient and consistent evidence to substantiate that work claimed was:

- properly authorised in advance,
- delivered as rostered,
- compliant with contractual, policy, and job-planning requirements, and
- accurately recorded and remunerated.

This review examined Extra Duties activity undertaken by the ten (10) highest earning Consultants (by value of Extra Duties payments) during the period M01–M07 2025/26.

The total amount of extra duties claims reviewed for this period was £884,508.95

WLI accounted for £768,669.05

Backfill accounted for £115,839.90

These are funded from separate budgets. WLI activity is generally funded through dedicated, specialist budgets to support the achievement of Welsh Government targets, whereas backfill work is funded from standard departmental budgets.

Based on the evidence reviewed, moderate assurance can be provided.

The audit did not identify evidence of systemic abuse, deliberate misrepresentation, or fraud. In most cases, Extra Duties were appropriately authorised in advance, delivered as rostered, and accurately recorded and paid. Working Time Regulation breaches were not identified.

However, the review identified a number of recurring control weaknesses, particularly relating to SPA displacement, Job Plan governance, and evidential recording, which reduce the strength of assurance and increase the risk of irregular payment, and the opportunity of Fraud to occur.

Key Themes (Appendix 1 provides a detailed breakdown of each Consultant review)

a. Volume and Nature of Extra Duties

- A high volume of Extra Duties was identified across the cohort- Backfill categorised duties were largely driven by vacancies, sickness absence, and leave; and WLI categorised duties driven by significant demand and capacity pressures.
- Extra Duties were predominantly undertaken outside core contracted hours (evenings, weekends, and overnight).
- A small number of actual overlaps between Extra Duties and core contracted time were identified (e.g., one-hour overlaps).
- Additional potential overlaps were identified where activity is recorded using points-based systems without precise time capture, making definitive determination impossible.
- For multiple Consultants, Extra Duties and WLI activity resulted in the displacement of SPA time.
- While local agreements permit SPA displacement, or non-scheduled SPA time, there was no formal or contemporaneous evidence demonstrating when displaced scheduled SPA activity was subsequently undertaken or recovered.
- Assurance is, in the main, currently reliant on annual appraisal outcomes, which provides retrospective but not auditable confirmation of SPA delivery.

b. Job Plan Governance

- Several Consultants operated under annualised, condensed, or flexible Job Plans, limiting the effectiveness of weekly-profile checks.
- In 20% of cases relevant to this project (including long-term locum arrangements), Job Plans were not actively used, not signed off, or not in place for the relevant period, restricting the ability to audit Extra Duties directly against contractual commitments.

c. Recording and Rostering Controls

- A number of different methods of rostering were Identified during the review. They included Local Workbooks, Medi Rota, Health Rota and Patchwork Rota.
- Patchwork Rota has been identified as the proposed organisation wide rostering system for the future. It is not being used at this time in any of the Directorates subject to review. The common response was that the system did not adequately meet service needs.
- Departments using Medi Rota demonstrated stronger controls and clearer assurance over separation of core and extra work.
- Locally maintained workbooks and Consultant-administered rota systems provided some operational assurance but are inherently weaker, particularly where:
    - annual leave is inconsistently recorded, or

- Health Rota systems rely on retrospective validation and self-reporting.

- The system identified as most popular and effective with Management was Medi Rota.

3. JOB PLANNING REVIEW

In addition to the staff-level audit a review was undertaken of the current position of Aneurin Bevan University Health Board (ABUHB) in relation to Consultant Job Planning arrangements.

Job Planning System

Aneurin Bevan University Health Board (ABUHB) uses L2P as its electronic job planning platform for senior doctors. L2P is a specialized UK-based digital platform providing workforce management solutions for healthcare organisations. Its core systems offer integrated job planning, medical appraisals, revalidation, 360-degree feedback, and rostering, focusing on improving efficiency, compliance, and clinician satisfaction.

As at 10 April 2026, the number of doctors listed on L2P as requiring a job plan is 710, comprising:

- Consultants: 529
- Other Specialty Doctors: 181

Job Plan Status

Status	Number of Clinicians	Percentage of Clinicians
Active	415	58.45%
In Draft	87	12.25%
Not Started	150	21.13%
In Sign-off Process	58	8.17%
In Mediation or Appeal	0	0.00%
Total	710	100.00%

Key observation:

- Welsh Government minimum expectation is 90% compliance (by September 2025).

- 150 clinicians (21.13%) have not yet started the job planning process.
- A further 145 clinicians (20.42%) have job plans that remain either in draft or in the sign-off stage.
- No job plans were recorded as being in mediation or appeal at the time of review.

Compliance by Division

Division	Percentage Compliance
Family and Therapies	51.17%
Clinical Support Services	77.71%
Medicine	53.00%
Mental Health	89.67%
Primary Care and Communities	88.25%
Surgery	52.00%
Urgent Care	90.00%

Key observation:

- Urgent Care, Mental Health, and Primary Care and Communities demonstrate high levels of compliance (above 88%).
- Family and Therapies, Surgery, and Medicine show comparatively lower compliance levels, all close to or below 53%, indicating a greater risk of non-compliance within these divisions.

While over half of clinicians (58.45%) have an active job plan recorded on L2P, a significant proportion (41.55%) either do not yet have an agreed and active job plan or have not started the process.

The absence of current, active job plans represents a significant inherent control weakness, materially undermining the ability to effectively identify contractual commitments. Without this, it is not possible to reliably evidence whether additional duties have been undertaken outside contracted hours, thereby impairing the effective investigation of potential financial irregularity, misrepresentation, or fraud.

4. POLICY REVIEW

The following policies were reviewed as part of this project:

All-Wales Consultant Contract

The All-Wales Consultant Contract is a, negotiated framework (introduced in 2003 and subsequently amended) covering terms, conditions, and pay for senior doctors

Job Planning: Each consultant must have a, mutually agreed job plan, detailing duties, responsibilities, and time commitments, which includes all DCC, SPA, and NHS responsibilities.

Hours and Sessions: Based on a 37.5-hour week (10 sessions of 3–4 hours). Additional work is paid separately.

Pay Structure (Updated): The pay scale has been reduced from 14 points to 8, intended to increase earnings earlier in a consultant's career, with a range starting at £100,000 to £146,000 as of late 2025.

Private Practice: Consultants may undertake private work, provided it does not have a detrimental effect on NHS services or cause conflicts of interest. Private commitments must be declared.

ABUHB Medical Staff Private Practice Policy

The Aneurin Bevan University Health Board (ABUHB) policy regarding private practice for medical staff, particularly consultants, is designed to ensure that private work does not conflict with NHS commitments, patient safety, or the use of NHS resources.

ABUHB Standards of Business Conduct Policy

Aneurin Bevan University Health Board (ABUHB) operates a Standards of Business Conduct Policy designed to ensure that all staff, including board members and volunteers, maintain the highest ethical standards, act with integrity, and adhere to public service values, including the Nolan Principles.

Key Observation

The All-Wales Consultant Contract requires consultants to declare Private work.

The Medical Staff Private Practice Policy requires all medical staff, including medical consultants, to declare any outside employment or self-employment where this could present a perceived or

actual conflict of interest with NHS duties. This requirement explicitly includes private practice activity.

The ABUHB Standards of Business Conduct Policy requires all staff to declare an interest including secondary employment.

Consultants are required to:

1. Complete an annual Declaration of Interest form; and
2. Ensure that the declaration is formally lodged with the Director of Corporate Governance.

A dedicated form is in existence for this purpose and is available to all staff on the ABUHB Pulse Intranet.

Review

A targeted review was undertaken to identify ABUHB consultants who undertake private practice.

Information was gathered using open-source intelligence, focusing specifically on private hospitals located in close geographical proximity to the Health Board area. Consequently, the findings are limited to consultants advertised within these parameters and may not capture all private practice activity undertaken by ABUHB consultants outside this scope.

The review identified 80 ABUHB consultants who were advertised as providing private practice services.

An audit was subsequently undertaken to assess whether appropriate Declarations of Interest had been completed and recorded.

Results

Declaration Status	Number	Percentage
Meaningful declaration made	21	26.2%
Nil declaration made	8	10.0%
No declaration recorded	51	63.7%
Total	80	100.0%

A list of those identified as not having complied with Policy in making a Declaration of Interest has been provided to the Medical Directorate for remedy.

5. CONCLUSION

This review found no evidence of fraud in relation to Extra Duties payments to medical staff at Aneurin Bevan University Health Board. Extra Duties activity was largely service-driven and operationally necessary, reflecting workforce pressures, vacancies, sickness absence and leave.

However, the review identified material control weaknesses that reduce the level of assurance that can be provided and increase the residual risk of fraud.

In particular:

- Job planning compliance is inconsistent, with a significant proportion of clinicians lacking an active, agreed job plan.
- SPA displacement is common but not auditable where SPA sessions are scheduled, with limited evidence demonstrating when or how displaced SPA time is recovered.
- Where significant additional duties are undertaken within an already intensive job plan (greater than 12 programmed activities/sessions), there is limited capacity to accommodate any displaced Supporting Professional Activities (SPA) time. This raises concerns regarding compliance with contractual requirements.
- Where it is unscheduled, there is no requirement to evidence core SPA work – (ABUHB Job Planning procedure Appendix 4).
- Extra Duties assurance relies heavily on retrospective and inconsistent controls.
- Rostering and recording systems lack standardisation, with some Directorates relying on weak, locally maintained solutions.
- Declarations of Interest for private practice are significantly incomplete, presenting unmanaged conflicts of interest risk.

Collectively, these weaknesses reduce the ability of the Health Board to:

- Effectively Investigate allegations of fraud, irregular working or misrepresentation; and
- Provide robust assurance to the Audit Committee and Board that there is clear distinction between core contracted duties and additional paid work; and that Private Practice is being adequately declared.

6. RECOMMENDATIONS

1. Strengthen Job Plan Compliance and Oversight

Priority: High

- Ensure all Consultants have a current, signed-off job plan;
- Ensure consistent application of job planning across Divisions;
- Ensure regular management reporting on job plan completion and compliance, with escalation where standards are not met.

2. Formalise SPA Recording and Recovery Arrangements

Priority: High

- Clarify requirement for core SPA activity to be evidenced
- Require SPA displacement arrangements to be:
    - Explicitly agreed in advance;
    - Formally recorded; and
    - Capable of audit.
- Introduce mechanisms to evidence when displaced SPA activity is subsequently delivered or recovered.

3. Improve Assurance over Extra Duties Activity

Priority: High

- Ensure all Extra Duties can be clearly evidenced as delivered outside contracted hours.
- Where possible reduce reliance on points-based or non-time-specific systems where it is difficult to ascertain if work is conflicted.

4. Standardise Rostering and Recording Systems

Priority: High

- Progress adoption of a standardised, corporate rostering system with appropriate management support.
- Minimise reliance on locally maintained spreadsheets and Consultant-administered rotas.
- Ensure annual leave, availability, and worked hours are consistently recorded.

5. Strengthen Declarations of Interest and Private Practice Controls

Priority: High

- Undertake a targeted exercise to:
    - Ensure all Consultants undertaking private practice / secondary employment submit meaningful Declarations of Interest in accordance with Policy.
    - Review existing nil declarations where private practice activity has been identified.
    - Consider mandatory nil declarations for all Medical Staff.

6. Embed Counter-Fraud and Financial Governance

Priority: Medium

- Use job planning and Extra Duties governance as key preventive fraud controls.
- Delivery of education sessions across the medical directorate by Counter Fraud Team.
- Consider a review of the financial efficiency of Extra Duties vs recruitment of substantive staff.

Overall Assurance Statement

While no fraud was identified, the current control environment does not provide sufficient, consistent, auditable assurance commensurate with the value and risk of Extra Duties expenditure. Addressing the above recommendations will reduce the current risk of fraud and enhance transparency.

7. Appendices

Appendix 1 – Top earning Consultants Audit Overview

Consultant No.1.

Specialty	Care of the Elderly		
Main Base	Ystrad Mynach Hospital		
Division	Medicine		
Job Plan – 15 sessions p/w – Signed Off	DCC	SPA	Other
	7	3	5
Extra Duties M01-M07 - 2025/2026	£112,360.57		
Claiming Method	Backfill - Patchwork Bank WLI – N/A		
D.O.I.	YES		
Private Practice	St Joseph' s Hospital, Newport		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	No		
Rostering	Local Worksheets		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes, all shifts have been authorised in advance which is auditable via the Patchwork Bank system.
- Delivered as rostered – Yes, all shifts have been delivered.
- Accurately recorded and remunerated – Yes, all shifts have been accurately recorded within Patchwork Bank
- Compliant with contractual, policy, and job-planning requirements – The audit identified a high volume of Extra Duties activity undertaken. The Extra Duties worked comprised a mix of on-Call and on-Site shifts. No shifts reviewed related to Waiting List Initiative (WLI)

activity. All Extra Duties examined arose as a result of vacancy cover, sickness absence, or leave, and were categorised as Backfill. Based on the information available for review, and as far as it was possible to determine, despite the overall volume of Extra Duties worked, there were no apparent breaches of Working Time Regulations identified within the sample examined. The majority of Extra Duties were undertaken outside contracted working hours, principally during weekends, evenings, and overnight periods, indicating that most activity occurred during uncontracted time.

However, the audit did identify the following exceptions:

11 Extra Duties shifts were identified which overlapped with core contracted duty by approximately one hour, specifically where a core shift of 13:15–17:00 hours overlapped with an Extra Duties shift commencing at 16:00 hours and concluding at 20:00 hours. These instances reflect activity undertaken concurrently with core contractual hours and present a risk of duplicate payment or insufficient separation between substantive and additional work. This has been reported to Department for internal scrutiny.

16 Extra Duties shifts were identified as having been undertaken during contracted Supporting Professional Activities (SPA) time, resulting in the displacement of SPA activity.

- AREAS of CONCERN - The audit identified instances where Extra Duties undertaken by this Consultant potentially overlapped with core contracted duties. The Consultant holds a 15-session Job Plan and has undertaken a high volume of Extra Duties in addition to this commitment.

  It was noted that certain Extra Duties arrangements required the displacement of contracted Supporting Professional Activity (SPA) time. However, there was no recorded evidence demonstrating when the displaced SPA activity was subsequently undertaken, rescheduled, or otherwise recovered.

  Given the volume of Extra Duties also being undertaken during evenings and weekends, there is a risk that sufficient capacity does not exist for displaced SPA activity to be reasonably accommodated, raising concerns in respect of contractual compliance, effective job-plan delivery, and the clear delineation between substantive and additional work.

Consultant No.2

Specialty	Histopathology		
Main Base	Royal Gwent Hospital		
Division	Clinical Support Services		
Job Plan – 12 sessions p/w – Signed Off	DCC	SPA	Other
	9.73	2.00	0.27
Extra Duties M01-M07 - 2025/2026	£152,855.78		
Claiming Method	Backfill – N/A WLI – Departmental Workbook		
D.O.I.	YES		
Private Practice	St Joseph' s Hospital, Newport		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Local		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – Workload allocation and monitoring is based on the 'Royal College of Pathologists (RCPath) - Best practice recommendations - "Staffing and workload for histopathology and cytopathology departments" (5th edition). This updated version of the RCPath points system is already in use in ABUHB and has recently been identified as the standardised approach to be implemented across the three Health Boards in South East Wales. The system assigns points to different activities according to their complexity and the estimated time

required to complete them. This supports consistent workload planning and helps ensure fair distribution of tasks across the consultant workforce.

Demand and capacity analysis within the department has identified a consultant workforce shortfall of approximately 2.5 Whole Time Equivalents (WTE). This deficit has resulted in a sustained backlog of cases requiring reporting.

The current backlog position is managed through a form of Waiting List Initiative (WLI) activity referred to locally as Virtual Pathologist (VP) work. WLI activity is not allowed if Core target Points are not met.

Consultant no. 2 personal annual target is 74284.56. April to January target for 10 months is 61,903.8. Achieved 60,824. (Taking into account 1332 allocated first working day in February Consultant no.2 is on target)

Consultant no. 3

Specialty	General Surgery		
Main Base	Royal Gwent Hospital		
Division	Surgery		
Job Plan – 11 sessions p/w – Signed Off	DCC	SPA	Other
	8.94	2.00	0.00
Extra Duties M01-M07 - 2025/2026	£119,999.81		
Claiming Method	Backfill – N/A WLI – Local Workbook		
D.O.I.	YES		
Private Practice	St Joseph' s Hospital Newport		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – Consultant No. 3 holds a full-time contractual Job Plan, which, due to the nature of their role, is condensed during the working week. The Job Plan operates on an annualised basis and, when reviewed on a weekly profile, identifies a proportion of time that is not contractually allocated to Direct Clinical Care (DCC). Extra Duties have therefore been undertaken during periods where the Consultant is not contracted to DCC activity.

Supporting Professional Activities (SPA) time within the Job Plan is not formally scheduled and may therefore be undertaken flexibly. However, the audit was unable to identify recorded evidence demonstrating when SPA activity was undertaken. An annual, outcomes-based appraisal is undertaken for each Consultant, which includes a review of SPA activity. The underlying assumption is that a satisfactory appraisal outcome provides retrospective assurance that SPA commitments are being fulfilled.

While this mechanism provides a level of retrospective assurance, the absence of a formal record evidencing the timing and delivery of displaced SPA activity represents a control weakness. This limits transparency and reduces the ability to independently verify that SPA obligations are consistently met when SPA time is substituted with remunerated WLI activity.

Consultant no. 4

Specialty	Emergency Medicine		
Main Base	Grange University Hospital		
Division	Urgent Care		
Job Plan – 12 sessions p/w – Signed Off	DCC	SPA	Other
	8.00	2.25	1.75
Extra Duties M01-M07 - 2025/2026	£69,950.13		
Claiming Method	Backfill – Local Workbook (Health Rota)		
D.O.I.	YES		
Private Practice	NO		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	LOCAL (Health Rota)		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements –. Consultant No. 4 holds a full-time contractual Job Plan and also undertakes external work for another NHS organisation. The Job Plan operates on an annualised basis and, when reviewed on a weekly profile, identifies a proportion of time that is not contractually allocated to Direct Clinical Care (DCC). Extra Duties have therefore been undertaken during periods where the Consultant is not contracted to DCC activity.

  Supporting Professional Activity (SPA) time within the Job Plan is non-scheduled and may be undertaken flexibly.

The department utilises a local electronic rostering system (Health Rota), which is administered directly by the Consultants. Rosters are submitted in advance and are subject to retrospective review by Departmental Management to confirm that contractual core hours have been fulfilled. All Extra Duties undertaken are also recorded within Health Rota. Based on the evidence reviewed, this approach appears to provide reasonable assurance that Extra Duties do not conflict with core DCC contracted hours, and no clashes between core duties and additional work were identified within the scope of this review.

However, it was noted that annual leave does not consistently appear to be recorded within the Health Rota system. The absence of a complete record of annual leave represents a control weakness, as it limits full visibility of availability, reduces the effectiveness of retrospective validation.

In the context of an annualised Job Plan, flexible SPA arrangements, and external NHS work commitments, comprehensive and accurate recording of all non-working time, including annual leave, is critical to maintaining assurance over contractual compliance and the appropriate separation of substantive and additional work.

Consultant no.5

Specialty	Radiology		
Main Base	Royal Gwent Hospital		
Division	Clinical Support Services		
Job Plan – 10 sessions p/w – Signed Off	DCC	SPA	Other
	8.07	2.00	0.00
Extra Duties M01-M07 - 2025/2026	£86005.55		
Claiming Method	Backfill – N/A WLI – Local Workbook		
D.O.I.	NO		
Private Practice	NO		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements –. Consultant No. 5 operates under a structured weekly Job Plan, which clearly identifies rostered Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) sessions. Within the department, Waiting List Initiative (WLI) activity is required to be completed in the Consultant' s own time, defined as uncontracted time, evenings, or weekends.

  Remuneration for WLI activity is based on a points system linked to body-part screening, with 33 points equating to one WLI session.

A local agreement is in place that allows SPA sessions to be displaced to accommodate WLI work. However, the audit identified that there is no formal or contemporaneous record documenting when displaced SPA sessions are subsequently undertaken, rescheduled, or otherwise recovered.

An annual, outcomes-based appraisal is undertaken for each Consultant, which includes a review of SPA activity. The underlying assumption is that a satisfactory appraisal outcome provides retrospective assurance that SPA commitments are being fulfilled. In addition, regular audits of clinical activity are conducted by the Directorate Manager and Clinical Directors to provide assurance that core DCC work is being completed.

While these mechanisms provide a level of retrospective assurance, the absence of a formal record evidencing the timing and delivery of displaced SPA activity represents a control weakness. This limits transparency and reduces the ability to independently verify that SPA obligations are consistently met when SPA time is substituted with remunerated WLI activity.

The reliance on appraisal outcomes and periodic audits, rather than contemporaneous recording, increases the risk of ambiguity between substantive contracted duties and additional paid work, particularly where displacement of SPA is routinely permitted.

Area of Concern – The audit identified instances where Extra Duties undertaken by this Consultant potentially overlapped with core contracted duties. However, due to the method by which the timings of screening activity are recorded, it is not possible to determine definitively whether an actual overlap occurred.

The absence of precise start and finish time data for screening activity limits the ability to independently verify whether work claimed as Extra Duties was undertaken wholly outside core contractual hours.

All identified potential clashes have been formally referred to the Directorate for review.

Consultant no.6

Specialty	Radiology		
Main Base	Royal Gwent Hospital		
Division	Clinical Support Services		
Job Plan – 10 sessions p/w – Signed Off	DCC	SPA	Other
	8.10	2.00	0.00
Extra Duties M01-M07 - 2025/2026	£79,713.41		
Claiming Method	Backfill – N/A WLI – Local Workbook		
D.O.I.	NO		
Private Practice	Companies House Private Ltd Company		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – Consultant No. 5 operates under a structured weekly Job Plan, which clearly identifies rostered Direct Clinical Care (DCC) and Supporting Professional Activity (SPA) sessions. Within the department, Waiting List Initiative (WLI) activity is required to be completed in the Consultant' s own time, defined as uncontracted time, evenings, or weekends.

Remuneration for WLI activity is based on a points system linked to body-part screening, with 33 points equating to one WLI session.

A local agreement is in place that allows SPA sessions to be displaced to accommodate WLI work. However, the audit identified that there is no formal or contemporaneous record documenting when displaced SPA sessions are subsequently undertaken, rescheduled, or otherwise recovered.

An annual, outcomes-based appraisal is undertaken for each Consultant, which includes a review of SPA activity. The underlying assumption is that a satisfactory appraisal outcome provides retrospective assurance that SPA commitments are being fulfilled. In addition, regular audits of clinical activity are conducted by the Directorate Manager and Clinical Directors to provide assurance that core DCC work is being completed.

While these mechanisms provide a level retrospective assurance, the absence of a formal record evidencing the timing and delivery of displaced SPA activity represents a control weakness. This limits transparency and reduces the ability to independently verify that SPA obligations are consistently met when SPA time is substituted with remunerated WLI activity.

The reliance on appraisal outcomes and periodic audits, rather than contemporaneous recording, increases the risk of ambiguity between substantive contracted duties and additional paid work, particularly where displacement of SPA is routinely permitted.

Area of Concern – The audit identified instances where Extra Duties undertaken by this Consultant potentially overlapped with core contracted duties. However, due to the method by which the timings of screening activity are recorded, it is not possible to determine definitively whether an actual overlap occurred.

The absence of precise start and finish time data for screening activity limits the ability to independently verify whether work claimed as Extra Duties was undertaken wholly outside core contractual hours.

All identified potential clashes have been formally referred to the Directorate for review.

Consultant no. 7

Specialty	Gastroenterology		
Main Base	Grange University Hospital		
Division	Medicine		
Job Plan – Not agreed/Not Signed off	DCC	SPA	Other
	0.00	0.00	0.00
Extra Duties M01-M07 - 2025/2026	£71,561.91		
Claiming Method	Backfill – N/A WLI – Local Workbook		
D.O.I.	NO		
Private Practice	None Recorded		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Local Workbooks		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements –. Consultant No. 7 is engaged as a Locum Consultant. A Job Plan exists on the L2P system, dated January 2024; however, the Directorate has advised that this Job Plan has not been operated in practice, and that the Consultant' s working arrangements have remained flexible.

As a result, it has not been possible to determine definitively whether there have been any overlaps between core contractual duties and Extra Duties activity, due to the absence of a consistently applied Job Plan against which activity can be assessed.

Operational duties within the Directorate are rostered locally by Directorate Management, and all work undertaken by the Consultant is recorded within a Directorate-maintained workbook. This local rostering and recording process is intended to provide assurance that core service requirements are met and that duties do not clash.

However, the reliance on informal or flexible arrangements, in the absence of an actively used and documented Job Plan, represents a limitation to assurance and reduces the ability to independently verify the separation between substantive commitments and additional paid work. In addition, it severely impacts upon the ability to effectively investigate any Fraud or Financial irregularity related issues.

Consultant No.8

Specialty	Trauma & Orthopaedics		
Main Base	Royal Gwent Hospital		
Division	Surgery		
Job Plan – 12.25 (Rounded) sessions p/w – Signed Off	DCC	SPA	Other
	9.24	2.93	0.00
Extra Duties M01-M07 - 2025/2026	£64582.60		
Claiming Method	Backfill – Patchwork Rota WLI – Local Workbook		
D.O.I.	NO		
Private Practice	St. Josephs Hospital, Newport. Nuffield Hospital, Cardiff.		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – The Department utilises Medi Rota as the primary system for recording all clinical activity, including core contractual duties and Extra Duties. The Trauma & Orthopaedics (T&O) rota operates on a four-week cycle, which is designed to align directly with the approved Job Plan.

Supporting Professional Activity (SPA) time within the Job Plan is a mixture of scheduled and non-scheduled. The non-scheduled SPA activity may be undertaken flexibly. It is not clear how flexible SPA is accounted for, however the ABUHB Job Planning procedure states that core SPA need not be evidenced.

Based on the evidence reviewed, no instances of overlapping duties between core and additional activity were identified. The structure of the rota and centralised recording of activity provides assurance that work is appropriately scheduled and that the majority of core contractual hours are clearly delineated from Extra Duties.

Consultant no.9

Specialty	Trauma & Orthopaedics		
Main Base	Nevill Hall Hospital		
Division	Surgery		
Job Plan – Not in Place	DCC	SPA	Other
	0.00	0.00	0.00
Extra Duties M01-M07 - 2025/2026	£67364.43		
Claiming Method	Backfill – Patchwork Rota WLI – Local Workbook		
D.O.I.	*********		
Private Practice	*********		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – The Department utilises Medi Rota as the primary system for recording all clinical activity, including core contractual duties and Extra Duties. The Trauma & Orthopaedics (T&O) rota operates on a four-week cycle, which is designed to align directly with approved Consultant Job Plans.

For the period relevant to this review, Consultant No. 9 did not have an active, signed-off Job Plan in place. A Job Plan exists for a period subsequent to the audit scope; however, this had not been formally approved at the time of review.

As a result, it has not been possible to audit Extra Duties activity directly against an agreed Job Plan. The absence of an approved Job Plan for the relevant period represents a governance and control weakness, as it restricts full verification of contractual compliance and diminishes the strength of assurance that can be provided over the appropriateness of Extra Duties undertaken.

Notwithstanding this limitation, the consistent use of Medi Rota within the Department provides a degree of operational assurance that duties are scheduled centrally and that clashes between core activity and Extra Duties are unlikely. The structured nature of the rota and the centralised recording of all activity support visibility of working patterns and assist in distinguishing core contractual hours from additional work.

Consultant no. 10

Specialty	General Surgery		
Main Base	Royal Gwent Hospital		
Division	Surgery		
Job Plan – 12 (Rounded) sessions p/w –	DCC	SPA	Other
Signed Off	9.10	3.00	0.00
Extra Duties M01-M07 - 2025/2026	£60,114.76		
Claiming Method	Backfill – Patchwork Rota WLI – Local Workbook		
D.O.I.	*********		
Private Practice	*********		
Directorate / Divisional General Manager	*********		
Divisional Director	*********		
Finance Partner Accountant	*********		
NFI	NO		
Rostering	Medi Rota		
Fraud related issues arising	NO		

- Properly authorised in advance – Yes.
- Delivered as rostered – Yes.
- Accurately recorded and remunerated – Yes.
- Compliant with contractual, policy, and job-planning requirements – Consultant No. 3 holds a full-time contractual Job Plan, which, due to the nature of their role, is condensed during the working week. The Job Plan operates on an annualised basis and, when reviewed on a weekly profile, identifies a proportion of time that is not contractually

allocated to Direct Clinical Care (DCC). Extra Duties have therefore been undertaken during periods where the Consultant is not contracted to DCC activity.

Supporting Professional Activities (SPA) time within the Job Plan is not formally scheduled and may therefore be undertaken flexibly. However, the audit was unable to identify recorded evidence demonstrating when SPA activity was undertaken. An annual, outcomes-based appraisal is undertaken for each Consultant, which includes a review of SPA activity. The underlying assumption is that a satisfactory appraisal outcome provides retrospective assurance that SPA commitments are being fulfilled.

While these mechanisms provide a level of retrospective assurance, the absence of a formal record evidencing the timing and delivery of displaced SPA activity represents a control weakness. This limits transparency and reduces the ability to independently verify that SPA obligations are consistently met when SPA time is substituted with remunerated WLI activity.

Appendix 2 – Project Document

Fraud Risk Investigation Project
Ref: CLUE LPE/25/00814

Project Title

Medical Staffing Extra Duties – Fraud and Financial Risk associated with working in ABUHB contracted time.

Project Overview

This project will deliver a structured investigation into potential fraud and financial loss incurred by Aneurin Bevan University Health Board (ABUHB), specifically relating to medical staff undertaking private or Health Board duties during contracted hours. Extra duties can take a number of forms inclusive of Locum, WLI and Backfill work. This list is not exhaustive.

The investigation aligns with NHS Counter Fraud Authority (NHSCFA) requirements for proactive fraud detection and supports Government Functional Standard 13: Fraud, particularly Requirement 3, which mandates comprehensive local risk assessments and proportionate counter fraud measures. Risk assessments will follow the Government Counter Fraud Profession (GCFP) methodology and be managed in accordance with ABUHB' s risk management policy, with outcomes reported to the Audit Committee.

The investigation is prompted by both recent and historical allegations that have led to formal inquiries, indicating a pattern of concern. The project aims to:

- Assess the nature, scale, and impact of suspected fraud or financial loss
- Ensure appropriate remedial action is taken
- Implement controls to prevent recurrence
- Gain a fuller understanding of how extra duties are allocated and used by the HB

Key Activities

- Conduct a formal fraud risk assessment focusing on:
  - Job planning
  - Private practice
  - Allocation and rostering of extra duties (e.g., WLI initiatives)

- Collect and analyse evidence regarding:
  - Payments for additional shifts to medical staff
  - Instances of overlap with contracted hours
- Identify medical staff engaged in private work and verify:
  - Submission of Declaration of Interest forms
  - Compliance with internal policies

Objectives

- Establish facts and gather evidence in line with NHS Counter Fraud Authority (NHSCFA)/Cabinet Office standards.
- Minimise financial and reputational risk to the Health Board.
- Support disciplinary, civil, or criminal proceedings where appropriate.
- Recommend and implement control improvements.

Scope

- Review of relevant control measures in place via comprehensive Fraud Risk Assessment.
- Interviews with staff and stakeholders where appropriate.
- Liaison with Medical directorate and Finance Directorate throughout.
- Reporting and recommendations.
- Formal investigation if fraudulent activity is identified.

Stakeholders

- Project Sponsor: Robert Jones – Asst Director Corporate Finance/ABUHB Fraud Champion
- Project Manager: Gareth Lavington – Head of Counter Fraud
- Lead Project Investigator: Beverley Jones - LCFS
- Investigators: Sara Morris, Nicola Tillings - LCFS
- Supporting Teams: Medical Directorate, HR, Finance Directorate.
- External Bodies (if applicable): NHSCFA, Police, Crown Prosecution Service

Timeline

- Project Development – Q3
- Formal Assessment – Q3/Q4
- Review of findings – Q4
- Final Report- Target Date end Q4

- Recommendations Implemented – Ongoing review

Resources Required

- Access to relevant systems and records
- Interview facilities
- Expert Advisory Support e.g., Medical Staffing, Job Planning, WLI allocation
- Investigation software/tools

Risks and Mitigations

- Non-cooperation from staff - Ensure confidentiality and clear communication
- Data access delays - Early engagement with data holders
- Reputational damage - Manage communications carefully and factually

Success Criteria

- Investigation completed within agreed timeframe.
- Evidence supports clear conclusions and actions.
- Recommendations accepted and implemented.
- Lessons learned shared with relevant departments.

Legal Considerations

Where instances of fraud or irregularity are identified, ensure the investigation complies with relevant legislation, including:

- - Fraud Act 2006
- - Theft Act 1968
- - Data Protection Act 2018 / UK GDPR
- - Employment Law (for disciplinary proceedings)
- - Maintain accurate records to support potential disclosure in legal proceedings
- - Criminal Procedure and Investigations Act 1996
- - Police and Criminal Evidence Act 1984

Fraud Local Proactive Exercise

LPE/25/00597

Impersonating a Medical Professional:

Agency Nursing Staff

Project Title

Impersonating a Medical Professional: Agency Nursing Staff

Project Overview

This proactive exercise assesses the risks to Aneurin Bevan University Health Board in respect of agency nurse imposter fraud - whereby an individual legitimately registers with a nursing agency and provides the required identity documents, qualifications and professional registration details to secure NHS agency work, but subsequently a different individual undertakes shifts on their behalf.

This type of fraud circumvents recruitment, onboarding and vetting controls designed to ensure that only appropriately qualified, professionally registered and suitably screened individuals are granted access to patients and permitted to provide care / undertake clinical duties - the imposter would not have been subject to the employment checks undertaken by the agency - including identity verification, professional registration validation, employment screening, occupational health clearance, Disclosure and Barring Service (DBS) checks, right-to-work verification and mandatory training requirements.

Failure to maintain robust identity verification and deployment controls can potentially result in imposters unlawfully gaining access to ABUHB premises, patients, clinical areas/systems, confidential/personal information and controlled medication, posing significant risks to:

- Patient safety
- Staff safety and security
- Service delivery
- Committal of fraud offences and financial loss

- Potential Theft of ABUHB assets and patients' belongings
- Regulatory non-compliance
- Unlawful access to confidential patient information
- Breach of GDPR/Data Protection legislation
- ABUHB reputational damage

This project aligns with NHS Counter Fraud Authority (NHSCFA) requirements for proactive fraud detection and supports Government Functional Standard 13: Fraud, particularly Requirement 3, which mandates comprehensive local risk assessments and proportionate counter fraud measures. Risk assessments will follow the Government Counter Fraud Profession (GCFP) methodology and be managed in accordance with ABUHB's risk management policy, with outcomes reported to the Audit Committee.

Key Activities

- Review of relevant control measures in place via comprehensive Counter Fraud Risk Assessment
- Engagement with Ward Managers to establish/confirm local verification process
- Assess / test whether adequate ward-level controls are in place to mitigate the risk of imposter fraud by engaging with Senior Nurse Ward Managers to establish whether appropriate identity and verification checks are undertaken when agency staff present for duty
- Identify agency staff on-duty and conduct unannounced drop in spot checks to verify:
    - The individual on-duty matches the agency booking
    - Agency photo ID badge
    - PIN/registration are valid/in date
    - Individual has presented in agency supplied uniform
- Reporting and recommendations
- Formal investigation if fraudulent activity is identified.

Findings

A total of 39 agency staff spot checks and 27 Ward Managers were engaged with at the following hospital sites:

- Grange University Hospital
- Royal Gwent Hospital
- Nevill Hall Hospital
- Ysbyty Ystrad Fawr
- Monnow Vale, Monmouth
- St Cradoc's Hospital

The wards covered are set out in Appendix 1

- No instances of imposter fraud were identified

- A high proportion of agency workers are long-term workers known to ABUHB ward staff – evidence suggests that controls become less robust where workers are considered "known" increasing the risk that expired professional registration expiry or other assurance issues may go unchecked.

- Variation was identified in the checks undertaken by Ward Managers when agency staff presented for duty, with some managers completing identity and induction checks on first attendance (historically), while others relied on familiarity with the worker and undertook no routine verification

- A number of agency staff were found to have missing, expired ID badges

- Uniform compliance was inconsistent with many agency workers wearing self-supplied workwear, uniforms from other agencies, or clothing not identifiable as agency staff.

- One identity-related concern (gender) was escalated by the LCFS for immediate investigation with the supplying agency via the Resource Bank Manager. The circumstances highlighted potential weaknesses in local assurance processes, whereby the individual had previously been allowed to complete a shift while concerns remained unresolved - appropriate challenge/verification measures had not been applied when the individual first presented on duty.

Recommendations

As per those provided within the Fraud Risk Assessment previously disseminated

Stakeholders

- Project Sponsor: Robert Jones – Asst Director Corporate Finance/ABUHB Fraud Champion
- Project Manager: Gareth Lavington – Head of Counter Fraud
- Investigators: Beverley Jones, Sara Morris, Nicola Tillings - LCFS
- Supporting Teams: Nursing Directorate, HR, Finance

Appendix 1

Date	Location	Ward	Agency	Induction	Agency ID Badge	Agency Uniform	Comments
21/11/2025	Ysbyty Ystrad Fawr	Risca COTE	Swiiis	Yes	Yes	Yes	Long term worker, induction undertaken by nurse manager on first presentation (historical)
21/11/2002	Ysbyty Ystrad Fawr	Risca COTE	Swiis	No	Yes	No	Long term worker - own supplied workwear
21/11/2025	Ysbyty Ystrad Fawr	Oakdale	Medics Pro	Yes	Yes	No	Long term worker - no induction/ID badge never checked
21/11/2025	Ysbyty Ystrad Fawr	Penallta	Enform	No	No - Lost	No	Different agency uniform
21/11/2025	Nevill Hall	Ward 4/4	Next Step	No	Yes	No	Own supplied workwear / long term worker - induction on first presentation
21/11/2025	Nevill Hall	Ward 4/4	Ability	No	Yes	Yes	Long term worker, induction undertaken by nurse manager on first presentation
21/11/2025	Nevill Hall	Ward 3/3	Medics Pro	Yes	No - Lost		Awaiting replacement Agency ID badge
11/03/2026	Grange University	A&E	Connect	No	Yes	No	Long term worker
11/03/2026	Grange University	A&E	MPS	Yes	No / expired	No	Long term worker. Awaiting replacement ID badge
11/03/2026	Grange University	General Surgery 0C	Zentar	No	No	No	Not in receipt of agency ID badge, not supplied with agency uniform
11/03/2026	Grange University	T&O A0	Your World	No	Yes	No	Agency has not provided uniform. Long-term worker
11/03/2026	Grange University	General Surgery B0	PRN Blue	Yes	Yes	No	Long term worker. Induction/ID checks not since 2020
11/03/2026	Grange University	Respiratory C4	Connect	No	Yes	No	Own supplied workwear
17/03/2026	Monnow Vale	Monnow	Medics Pro	No	Expired Oct 2025	No	Long term worker, induction/checks undertaken when started
17/03/2026	Monnow	Monnow	Connect	No	No	No	No ID / own supplied workwear
17/03/2026	Monnow Vale	Monnow	Connect	No	Expired	No	Expired ID badge
19/03/2026	Ysbyty Ystrad Fawr	3/1 Risca	Connect	No	Not checked	Not checked	Noted by staff nurse is long term worker.
19/03/2026	Ysbyty Ystrad Fawr	2/1 Oakdale	MPS	Yes	Digital	No	Long term worker
19/03/2026	Ysbyty Ystrad Fawr	2/1 Oakdale	Swiis	No	Yes	No	Long term worker

19/03/2026	Ysbyty Ystrad Fawr	MAU	Richmond	Yes	Yes	No	Commenced with ABUHB end Jan/early Feb 2026.
19/03/2026	Ysbyty Ystrad Fawr	MAU	Connect	No	Expired	No	Expired ID badge / self-supplied workwear
19/03/2026	Ysbyty Ystrad Fawr	Ty Cyfannol MHU	Ability	No	Yes	No	Own supply workwear, 1 x uniform supplied by agency - too small. ABUHB Nov 2025, covers YYF/NHH/RGH/St Cradoc's
19/03/2026	Ysbyty Ystrad Fawr	Ty Cyfannol MHU	Total Health	No	Yes	No	In own supplied workwear, 1 x uniform provided by agency. Mainly ABUHB, also occasionally SBUHB.
31/03/2026	St Cradoc's	Adferiad	Medics Pro	Yes	Expired	No	Long term Worker, ID card expired. Different agency uniform
31/03/2026	St Cradoc's	Adferiad	Medics Pro	Yes	Yes	No	Long term worker, also works shifts at GUH and RGH
31/03/2026	St Cradoc's	Adferiad	Pro Nursing	Yes	Yes		Started AB Jan or Feb 2026
31/03/2026	St Cradoc's	Adferiad	Pro Nursing		Yes	No	Self supplied workwear,
31/03/2026	St Cradoc's	PICU/Beechwood	Total Assist	No	Expired 28/03/26	No	Long term worker, NHS supplied tabard
31/03/2026	St Cradoc's	PICU/Beechwood	Pro Nursing	Yes	Yes	No	Long term worker, also works SBUHB,
31/03/2026	St Cradoc's	PICU/Beechwood	Medics Pro	No	Yes	Yes	No issues
07/04/2026	Royal Gwent	C5 East Penhow	PRN Blue	Yes	Yes	Yes	No issues
07/04/2026	Royal Gwent	C5 East Penhow	Swiss	Yes	Expired	No	Expired ID badge - awaiting replacement from agency
07/04/2026	Royal Gwent	C4 Respiratory	Connect	No	Yes	No	Own provided workwear. Previous C&V/BCUHB/SBUHB - covers YYF and Monnow Vale
07/04/2026	Royal Gwent	D7 West	Total Assist	No	Yes	No	Own provided workwear.
07/04/2026	Royal Gwent	D4 East	Careprov	No	Yes	No	Own provided workwear
20/05/2026	Grange University	B4 stroke	Connect	Yes	Yes, in order	Yes	Long term worker, also shifts at RGH, more at GUH
20/05/2026	Grange University	AO T&O	Connect	No	Yes, in order	No	Also shifts at RGH, previously worked in London, stated ABUHB March 2026. Own provided workwear
20/05/2026	Grange University	B0 Gen surgery	Connect	No	Yes, in order	No	Different agency uniform
20/05/2026	Grange University	Assessment Ward (0)	Connect	No	Yes, in order	No	Different agency uniform

Action Plan - Impersonating a Nursing Professional

No.	Action	Lead/Owner	Key deliverables	Timescale	Assurance/Outcome	Status
1	Issue concise local guidance	Head of Nursing Workforce, Education & Regulation, supported by Temporary Staffing Lead	Develop and circulate a one-page manager guidance note or crib sheet setting out the minimum checks required when an agency worker arrives on site, including photo ID comparison, confirmation of assignment/booking, uniform/name badge expectations, professional registration/PIN checks where relevant, and immediate escalation route.	Deadline: 15 September 2026	Guidance issued to ward managers and senior staff.	To commence
2	Standardise the arrival checklist	Temporary Staffing Lead and Head of Nursing Workforce Education & Regulation	Introduce a short agency worker arrival checklist for ward managers or senior staff to complete for each agency worker attending a Health Board site, aligned to the existing induction process. Checklist to	Deadline: 15 September 2026; implementation deadline: 29 September 2026	Standard checklist approved and implemented across relevant areas.	To commence

			include confirmation of identity, role, booking, induction, uniform/ID badge and registration check where applicable.			
3	Strengthen induction compliance	Ward Managers, overseen by Divisional Senior Nurses	Reinforce the requirement for local induction completion for all agency workers new to a ward, department or section, and clarify where completed records should be retained for audit purposes.	Deadline: 15 September 2026	Local induction records retained and available for audit.	To commence
4	Confirm escalation process	Head of Nursing Workforce, Education & Regulation; supported by Temporary Staffing Lead and Local Counter Fraud Specialist	Agree and communicate a clear process for managers to follow if an agency worker cannot be verified or if concerns arise regarding identity, conduct, capability, registration, safeguarding or patient safety. This should include pausing deployment where appropriate and contacting the senior nurse/site manager, Temporary	Deadline: 29 September 2026	Escalation route communicated and embedded in local guidance.	To commence

			Staffing/Bank and Counter Fraud.			
5	Review registration visibility and checking	Temporary Staffing Lead, supported by Bank Office and HealthRoster Lead	Confirm the most reliable route for managers to verify PIN and registration information where required, including whether any system interface or process improvement is feasible.	Deadline: 29 September 2026	Agreed process for registration verification documented.	To commence
6	Consider ID badge scanning or photocopying	Information Governance Lead, supported by Head of Nursing Workforce Education & Regulation and Local Counter Fraud Specialist	Explore the feasibility, information governance implications and proportionality of scanning or photocopying agency worker ID badges as an additional assurance measure. If not implemented, include an alternative auditable confirmation step within the checklist.	Deadline: 29 September 2026	Decision documented, with alternative auditable process agreed if required.	To commence
7	Audit and assurance	Head of Nursing Workforce Education & Regulation; supported by Local Counter	Include targeted compliance checks as part of nursing audit programme, supported by Counter Fraud spot checks where appropriate. Findings	First audit deadline: 31 December 2026; second audit deadline: 31 March 2027; review frequency	Compliance findings reported through governance route, with actions tracked.	To commence

		Fraud Specialist	and themes to be reported through the relevant operational nursing governance route and used to refresh guidance or training.	thereafter		
8	Awareness and communication	Head of Nursing Workforce, Divisional Nurses and Local Counter Fraud Specialist	Use senior nursing forums, ward manager communications and relevant operational briefings to raise awareness of the fraud risk and required checking process. Promote Counter Fraud awareness sessions to relevant cohorts of staff.	Communication launch deadline: 15 September 2026; ongoing through routine governance communications	Key messages communicated through intranet, strategic nursing workforce group, divisional nursing professional forums	To commence

Internal Audit Progress Report

Audit, Risk and Assurance Committee

September 2026

Aneurin Bevan University Health Board

NWSSP Audit and Assurance Services

Contents

1. Introduction

The purpose of this report is to:

- confirm the status of the audit work for the 2026/27 Internal Audit Plan; and
- note briefs issued in the period for information.

2. Progress against the 2026/27 Internal Audit Plan

The current progress is summarised below, with further detail within Appendix B.

Audit Status	Number
Final reports	3
Draft reports	3
Work in progress	6
Planning	6
Pre-planning	16
Total number of audits planned	34

The following final reports have been issued since the meeting of the Audit, Risk and Assurance Committee on 23rd June 2026:

AUDIT ASSIGNMENT	ASSURANCE RATING
Falls Management	Reasonable
Shadow IT	Reasonable
Satellite Radiotherapy - NHH	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 23rd June 2026.

Falls Management (reasonable)

The audit concluded that the Health Board has effective arrangements in place to manage inpatient falls, supported by a robust policy framework and strong monitoring and oversight processes. However, improvements are required to ensure supporting policies are updated, falls training is standardised, reporting and documentation are completed consistently, and investigations are undertaken in a timely manner to strengthen patient safety and organisational learning

Shadow IT (reasonable)

We found that the Health Board has appropriate governance, procurement and cyber security arrangements to manage Shadow IT, with enhanced monitoring significantly improving visibility of previously unknown systems and devices.

However, several weaknesses remain, including delays in approving key policies, limited oversight of lower-value digital purchases, the absence of a fully operational DDaT governance group, shadow IT not being reflected in the Corporate Risk Register, and the lack of a complete inventory of digital systems and suppliers.

Satellite Radiotherapy – NHH (reasonable)

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. On the whole the project has been successfully delivered i.e. within the agreed budget allocation, albeit with a six-month delay from the original completion date. We raised findings over the lack of a signed service level agreement, unresolved defects / actions to be completed and discrepancies in the recording of financial costs.

4. Summary of Audit Briefs Recently issued

A summary of the briefs issued since the last Audit, Risk and Assurance Committee is provided within Appendix C, with copies of the final audit briefs included for information.

5. Recommendation

The Audit, Risk and Assurance Committee is invited to **note** the above points within the report.

Appendix A: Progress against 2026/27 Internal Audit Plan

Reviews	Assurance Rating	Status
1. Divisional Budgetary Control		Draft Report
2. Benefits Realisation (excluding digital)	Reasonable	Draft Report
3. Falls Management	Reasonable	Final Report
4. Professional Staff Registration		Work in progress
5. Shadow IT	Reasonable	Final Report
6. NHH Regional Satellite Centre	Reasonable	Final Report
7. Policy Management		Planning
8. Governance of Escalation Level		Pre-planning
9. Sustainable Funding		Planning
10. Charitable Funds		Work in progress
11. Stakeholder Engagement		Pre-planning
12. Duty of Quality		Pre-planning
13. Value and Sustainability		Work in progress
14. Welsh Risk Pool Lessons		Planning
15. Hospital Sterilisation and Disinfection Unit (HSDU)		Planning
16. Patient Experience		Planning
17. Dementia Care		Pre-planning
18. Mental Capacity Act - Deprivation of Liberty Safeguards		Pre-planning
19. Cancer Referrals		Pre-planning
20. Discharge Planning		Pre-planning
21. Primary Care and Community Services Divisional Review		Pre-planning
22. Clinical Audit		Pre-planning
23. Job Planning		Planning
24. Rostering & Operational Workforce Management		Pre-planning
25. Vaccination Programme		Work in progress
26. Job Evaluation	Reasonable	Draft Report
27. Follow-up of Agreed Actions		Pre-planning
28. Electronic Prescribing and Medicines Administration		Pre-planning
29. Project Management Office		Pre-planning
30. Procurement of Digital Services		Pre-planning
31. Networks		Work in progress
32. Capital Systems		Pre-planning
33. Estates Assurance		Pre-planning
34. Ophthalmology Review (2025/26)		Work in progress

Appendix B: Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Appendix C: Audit / Review Briefs Issued

Audit Title	Status	Outline Scope
Vaccination Programme	Brief issued	Evaluate the processes in place to monitor and promote the uptake of vaccinations and immunisations amongst the public.
Policy Management	Brief issued	To ensure the policy management arrangements at the Health Board are effective and consistently applied to support compliance and governance – reflecting on previous recommendations raised.
Value and Sustainability	Brief issued	To review the activity of the Value & Sustainability Board (and supporting workstreams) and the approach to savings identification, reporting, monitoring and delivery.
Patient Experience	Brief issued	To review the arrangements and processes in place within the Health Board for capturing and utilising patient experience.
Welsh Risk Pool Lessons	Draft brief issued	The overall objective is to determine if lessons learnt and associated actions from Welsh Risk Pool claims are fully implemented, to prevent a re-occurrence.
Job Planning	Draft brief issued	The audit will provide assurance that arrangements are in place and operating effectively for consultant job planning.
Sustainable Funding	Draft brief issued	The audit will assess the adequacy and effectiveness of the Health Board's financial grip and control arrangements, focusing on budget management, forecasting, decision making governance, and compliance with NHS Wales financial policies. It will also review the completeness, accuracy, and reliability of the self-assessment completed.
Ophthalmology Review	Draft brief issued	To determine if the Ophthalmology and ENT service areas have effective processes embedded for the management of resources, service delivery (including capacity planning) and budgetary responsibilities.

Falls Management (Inpatient)

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

Reasonable Assurance

Contents

Review Reference	ABU-2526-08
Fieldwork	February – March 2026
Executive Sign Off	July 2026
Audit, Risk and Assurance Committee	September 2026
Executive Lead	Peter Carr, Executive Director of Allied Health Professionals & Health Science
Audit Team	Stephen Chaney, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To provide assurance that the Falls Policy for Hospital Adult Inpatients is adequate and being adhered to by staff, with focus on and sample testing taken from reported hospital inpatient falls only.

Overview

Aneurin Bevan University Health Board (the 'Health Board') recognises that the reduction of inpatient falls, together with the effective management of patients following a fall, constitutes a significant patient safety priority. A fall is defined as "an event which results in a person coming to rest inadvertently on the ground or other lower level" (WHO, 2018).

Guidance from the National Institute for Health and Care Excellence (NICE) identifies falls and fall-related injuries as a common and serious concern for older people, with inpatient falls representing the most frequently reported patient safety incidents. The impact of a fall can be considerable, encompassing distress, pain, injury, reduced confidence, loss of independence and, in some cases, mortality. These consequences extend beyond the individual, affecting families, carers and healthcare staff.

Preventing falls and ensuring timely, robust and compassionate management following a fall are essential components of high-quality care for individuals at risk. Such measures are fundamental to safeguarding patient wellbeing, promoting safety and improving clinical outcomes.

This audit was undertaken to evaluate whether the Health Board has effective and timely processes in place for the management of inpatient falls, and to assess the extent to which staff are adhering to these processes to ensure patient safety.

We have concluded reasonable assurance on this area based on the framework in place and general compliance observed. The matters requiring management attention include:

- There is a clear Falls Policy for Hospital Adult Inpatients; however, several supporting policies require updating and alignment to ensure full consistency. Additionally, adding a flow diagram outlining the falls reporting process would improve accessibility and provide a quick reference point for clinical staff.
- Falls awareness training exists throughout the Health Board, but inconsistent delivery across divisions highlights a need for standardisation.
- Some variances between Datix and weekly falls reports for the sampled periods of October 2025 and January 2026 were attributed to falls recoded after the initial weekly data reports were generated, meaning they were not recorded as falls at the time but were later amended to meet those criteria. There is a risk that recoded falls are not brought to the attention of the staff overseeing falls. It is important to note that, although the review of falls is within their remit, it is not their primary area of responsibility.
- Falls documentation across the Welsh Nursing Care Record (WNCR), Clinical Workstation (CWS), and Concise Review Documents for Falls Strategic Oversight Panel (FSOP) was not consistently completed with the required level of detail, and in some cases was not completed at all.
- The falls process was not consistently completed in a timely manner, resulting in incomplete documentation and delays in establishing a full account of events, which in turn hindered the timely progression of necessary investigations.

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 the Health Board's Falls Policy (and any other supporting policies) for hospital adult inpatients is up to date, evidence-based, and aligned with current national guidelines and best practice standards.	1	**Reasonable**
2	The Health Board is proactive in reducing the risk of adult inpatient falls through the development of falls guidance and raising awareness.	2	**Reasonable**
3	Falls incidents involving adult inpatients are investigated and scrutinised to identify any common themes and trends and appropriate corrective action is determined.	3,4,5,6	**Limited**
4	There is regular monitoring and reporting of Falls for adult inpatients data at an appropriate forum to provide assurance to the Board as well as share learning and good practice.	-	**Substantial**

Management Actions

1 High Priority

5 Medium Priority

Themes

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Assess whether the Health Board's Falls Policy (and any other supporting policies) for hospital adult inpatients is up to date, evidence-based, and aligned with current national guidelines and best practice standards.	**Reasonable**

Overview / Summary of Observations

The Health Board's *Falls Policy for Hospital Adult Inpatients* (the 'Policy') is well aligned with current national guidance and recognised best-practice standards for minimising and preventing where possible inpatient falls. It incorporates the core elements recommended by NICE and NHS Wales, including multifactorial risk assessment (MFRA), personalised care planning, environmental risk reduction, medication review and structured post-fall evaluation and is therefore, appropriate. To enhance usability, the Policy would benefit from a summary page or flow diagram outlining the falls reporting process, enabling staff to access key steps quickly within clinical settings.

Relevant supporting policies were also reviewed as part of the audit, and the following was observed:

- Incident Reporting Policy – review date December 2022
- The Use of Bedrails and Bedrail Covers Policy – review date August 2025
- The RIDDOR SOP, while listed on the Falls resource page and relevant to reporting laws, is not mentioned in the Policy and should be added.

Management also identified that there was no reference to the National Policy on Patient Safety Incident Reporting and Management in Wales (updated May 2023). Ensuring these documents are current and clearly linked strengthens the overall governance framework for reporting and learning from patient safety incidents. The Policy is further supported by the Health and Care Quality Standards, the ABUHB Quality Strategy and the Patient Quality & Safety Person-Centred Enhanced Observations Framework. Collectively, these documents reinforce the Health Board's commitment to patient safety and continuous improvement.

During the audit it was advised that the Incident Reporting Policy and the Use of Bedrails and Bedrail Covers Policy are going through the review stage ready for approval, which should be in June 26.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Policies and Procedures** Whilst the main *Falls Policy for Hospital Adult Inpatients* was in date, the following policies / procedural documents should be reviewed, updated and incorporated accordingly to ensure completeness: • Incident Reporting Policy • The Use of Bedrails and Bedrail Coves Policy – review date August 2025. • RIDDOR SOP – not referenced within the Inpatient Falls Policy. • The National Policy on Patient Safety Incident Reporting and Management in Wales – not referenced within the Inpatient Falls Policy.	Risk to patient harm if information is not correct. Legal and regulatory non-compliance resulting in reputational damage.	**Agreed Action:** **1.1 Review and update of associated Policies:** Obtain final approval for and publish the revised Use of Bedrails and Bedrail Covers Policy on the intranet. The publication of the revised Incident Reporting and Management Policy on 12 February 2026 will be provided as evidence that this element has already been completed. **1.2 Make updates to the Falls Policy for Hospital Adult Inpatients** Approve and publish the revised Falls Policy for Hospital Adult Inpatients, incorporating references to the RIDDOR SOP and the National Policy on Patient Safety Incident Reporting and Management in Wales, together with a concise falls-reporting flow diagram covering immediate post-fall actions, clinical review and escalation timescales, and RLDatix reporting.

	The *Falls Policy for Hospital Adult Inpatients* could also benefit from a summary page or flow diagram outlining the falls reporting process, enabling staff to access key steps quickly within clinical settings - as detailed in Finding 5.		**Expected Evidence of Implementation:** **Action 1.1** - Approved versions of the Incident Reporting and Management Policy and the Use of Bedrails and Bedrail Covers Policy published on the intranet, supported by the relevant approval records. **Action 1.2** - Approved revised Falls Policy for Hospital Adult Inpatients published on the intranet, including references to the RIDDOR SOP and the National Policy on Patient Safety Incident Reporting and Management in Wales, together with the falls-reporting flow diagram.
		Medium Priority	**Action 1.1 Officer:** Head of Health & Safety **Target Implementation Date:** 30/09/2026
	Theme: Policies & Procedures	Control Design	**Action 1.2 Officer:** Assistant Director of AHPs and Health Science **Target Implementation Date:** 30/09/2026

Objective 2: The Health Board is proactive in reducing the risk of adult inpatient falls through the development of falls guidance and raising awareness.	**Reasonable**

Overview / Summary of Observations

The audit observed that staff primarily follow the Health Board's *Falls Policy for Hospital Adult Inpatients* for guidance, and many wards display falls related posters to support risk assessment and intervention. It was noted that an annual 'Falls Week' takes place in September and this assists in raising awareness on falls guidance and awareness. Training materials, including presentations used within divisions, are currently being reviewed for adequacy. At the Falls and Bone Health Group it was noted that while nurses and medical staff already receive core patient safety training, falls training should function as an enhancement or refresher rather than a standalone competency.

Quality Patient Safety (QPS) leads continue to deliver focused training across divisions, and recent initiatives include the establishment of Falls Champions, with 19 wards represented at the inaugural meeting in January 2026. Following the departure of a temporarily assigned trainer, work is underway to review all ESR modules relating to falls, supported by QPS leads who are assessing content and providing feedback. Recommendations will be submitted to the Falls and Bone Health Strategic Group to inform a revised, standardised training package.

A key risk identified is the use of multiple training presentations across the Health Board. Work is underway to consolidate these into a single corporate training resource to ensure consistency. The falls intranet page also requires updating to ensure accurate training information and contacts. While training is being delivered, a unified Health Board wide approach is essential to support staff competence and compliance

	Key Findings	Risk & Impact	Agreed Management Action
2	**Falls Awareness and Training** The Health Board's intranet page should be updated to ensure it has all the correct training information and contact details relating to falls management. A standardised approach to training is required to ensure consistency in approach and improve compliance, based on a common message and expectations, reducing variations across teams. This will assist in the full completion of Falls documentation as detailed in Finding 5.	Without a consistent training approach, lessons learned from incidents cannot be embedded effectively, limiting the organisation's ability to improve outcomes.	**Agreed Action:** **2.1 Update the ABUHB Intranet Falls Page:** Update and publish the falls intranet page with current corporate contact details, approved falls-training information and links to the relevant policies, guidance and training materials. **2.2 Develop and implement a single, corporate Falls Training Curriculum:** Approve and publish a single corporate Falls Training Curriculum covering MFRA completion, falls prevention, post-fall management and escalation, RLDatix reporting and documentation standards. The curriculum will identify the relevant staff groups and divisional delivery arrangements. The first report on divisional delivery and staff compliance will be presented to the Falls and Bone Health Strategic Group by an agreed specific date.

			Expected Evidence of Implementation: **Action 2.1** – Updated Falls and Bone Health Management intranet page showing current contact details, approved training information and links to the relevant policies, guidance and training materials. **Action 2.2** – Approved corporate Falls Training Curriculum published on the intranet and formally issued to Divisions, together with the first report to the Falls and Bone Health Strategic Group.
		Medium Priority	**Action 2.1 Officer:** Assistant Director AHPs & Health Science **Target Implementation Date:** 30/09/2026
	Theme: Training & Development	Control Design	**Action 2.2 Officer**: Assistant Director AHPs & Health Science **Target Implementation Date:** 30/11/2026

Objective 3: Falls incidents involving adult inpatients are investigated and scrutinised to identify any common themes and trends and appropriate corrective action is determined.	**Limited**

Overview / Summary of Observations

A review of Datix incident reports weekly and falls data for October 2025 and January 2026, identified several incidents appearing in weekly falls reports but not in Datix due to timing differences; these exceptions were either raised in error or later rejected as duplicates. A further 11 incidents were recorded in Datix but not included in weekly falls data. Ten were initially categorised under alternative incident types and only later recoded as falls, whilst the remaining one incident was not coded as a fall, as the patient was assisted to the floor by a nurse to prevent a fall. Through Datix, the incident would have been escalated to the relevant managers. As a result, the incident may not have been discussed under the falls process.

Testing of 15 fall incidents (September 2025–February 2026) highlighted Datix records were not closed promptly, documentation was inconsistent, and multi factorial risk assessments (MFRAs) and post-fall updates were frequently incomplete or not completed. Concise review documents were often late, incomplete, or outstanding well beyond the required although not mandated 72-hour timeframe, delaying Falls Strategic Oversight Panel (FSOP) reviews and their effectiveness. These delays and inconsistencies weaken patient safety oversight and expose the organisation to regulatory, legal, and reputational risk due to failures in timely incident closure and assurance processes.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Falls Reporting** From a review of Datix reports and weekly falls data reports for October 2025 and January 2026, there were a total of 379 and 327 falls reported at Datix, respectively. It was identified that 10 incidents that appeared on Datix were not included in the weekly falls data reports for these time frames. These incidents were corrected by the Health and Safety Team after the initial weekly data reports were run, where they were not recorded as falls at the time, but later amended to meet those criteria. A change in code would prompt a notification to those who receives falls RL Datix messages. This presents a risk that falls may fall outside of the scrutiny of the staff who review falls. Our sample testing of 15 falls also identified two falls that were not included on the falls weekly data reports, but were recorded on Datix as inpatient falls (118351) and (129883).	Risk of mis reporting inpatient falls as a result of miscoding due to multiple options for fall being available on the system e.g. fall, slip, trip or injury. This may result in reduced or inflated numbers of recorded falls.	**Agreed Action:** **Action 3.1:** Approve and publish guidance defining the standard coding of inpatient falls on RLDatix and the process for notifying the relevant falls-review staff when an incident is subsequently recoded as a fall. A baseline audit of compliance will be completed and reported to the Datix Strategic Group on 3 December 2026, with the frequency of subsequent monitoring agreed at that meeting. **Expected Evidence of Implementation:** Approved Reporting and Management of Patient Falls Guidance published on the intranet, including the standard coding requirements and the process for notifying relevant staff when an incident is recoded as a fall. Baseline audit results presented to the Datix Strategic Group on 3 December 2026, supported by the meeting minutes.

		Medium Priority	**Officer:** Head of Health, Safety and Fire **Target Implementation Date:** 01/10/2026 publish document Baseline audit data to be presented at 03/12/2026 Datix Strategic Group Meeting.
	Theme: Reporting	Control Operation	
4	**Falls Process** Multi-factorial risk assessments (MFRA) are completed at every admission and if a patient transfers between wards or hospitals. The standard within the Hospital Falls Policy recommends that a MFRA is undertaken within 6 hours of admission and is repeated weekly or upon any change in clinical condition thereafter for the duration of their inpatient stay. Also following any fall, the MFRA and the inpatient notes within the patient clinical records are updated. A post-fall assessment document is also completed and added to the patient's care plan and file. Mental health and learning disabilities wards and the accident and emergency department are not utilising WNCR as a patient clinical record, so MFRA Documentation should be held within their patient record system e.g. digitally in WCCIS for mental health patients and as a paper record within the emergency department. Within our sample testing of 15 falls, we identified that two related to mental health wards and thus, MFRAs were not completed on WNCR. It was noted on Datix that in one of the incidents, an assessment of the patient was not completed post fall before the patient was moved (118351)	Risk of incomplete reporting data set if completion of MFRA is only measured within WNCR. MFRA also need to be reviewed within the other patient record systems.	**Agreed Action:** **Action 4.1:** Implement a standard annual snapshot-audit methodology for adult inpatient MFRAs, covering WNCR, WCCIS and relevant paper-based patient records. The first audit cycle will be completed and reported to the Falls and Bone Health Strategic Group, with progress against resulting improvement actions monitored quarterly.
			Expected Evidence of Implementation: Approved MFRA audit methodology demonstrating coverage of WNCR, WCCIS and relevant paper-based patient records; completed results from the first Divisional audit cycle; and minutes of the Falls and Bone Health Strategic Group evidencing consideration of the findings and monitoring of any required improvement actions.
		Medium Priority	**Action 4.1 Officer**: Assistant Director AHPs & Health Science **Target Implementation Date:** 30/06/2027
	Theme: Information, Data Quality & Data Accuracy	Control Design	

5	**Falls Investigation** We reviewed WNCR and CWS for completeness but did not review the patient files. The testing of 15 falls identified: • Nine MFRAs were completed satisfactorily. • One MFRA was not completed on admission of the patient, this was missed by an agency nurse (128676). • Three were not completed fully as there were gaps where further detail should have been provided e.g., blood pressure checks and narrative on the patient. • Two of the MFRAs related to mental health wards. It was noted on Datix that in one of the incidents, an assessment of the patient was not completed post fall before the patient was moved (118351) (see **finding 4**). Seven MFRAs were updated on WNCR following falls. The remaining six were not fully updated: • 5 were not updated with the fall details or recorded that the patient had one or more falls in the last 12 months, despite our testing confirming they had. • 1 MFRA was not updated after the fall, but inpatient notes on WNCR recorded information concerning the fall. The completeness of falls documentation is essential to support thorough investigations, safeguard patient safety, and ensure lessons are learned.	Poor records delay investigations and reduce the organisation's ability to identify patterns and prevent recurrence. Duty of Candour notifications may be delayed or missed, exposing the organisation to regulatory challenge.	**Agreed Action:** **Action 5.1:** Ensure the corporate Falls Training Curriculum includes the requirements to complete the MFRA within six hours of admission, complete all required fields and update the MFRA following a fall or material change in clinical condition. **Action 5.2:** Following each ward-accreditation or divisional MFRA audit, Ward Managers will produce time-bound improvement actions for identified non-compliance. Divisional leads will report the initial findings, agreed actions and accountable owners to the Falls and Bone Health Strategic Group **Expected Evidence of Implementation:** **Action 5.1** - Approved corporate Falls Training Curriculum demonstrating that MFRA completion, completion within the required admission timeframe and post-fall updating requirements are included within the training content. **Action 5.2** - Ward-based audit results identifying instances of non-compliance, together with documented local improvement actions, accountable owners and completion dates. Divisional or Falls and Bone Health Strategic Group reports and minutes should evidence subsequent monitoring and closure.
		High Priority	**Action 5.1 Officer**: Assistant Director AHPs & Health Science. Target Implementation Date: 30/11/2026 (same as Action 2.2) **Action 5.2 Officer**: Assistant Director AHPs & Health Science **Target Implementation date:** 30/05/2027
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

6	**Time Delays** As part of an investigation, a concise review document is completed, which should be completed within 72 hours, although this is not mandated. Testing of 15 reported falls found: • Three concise review documents were not completed in a timely manner. Two were requested in October and November 2025 (120200 & 125106) and have still not been received, the remaining document was requested in September 2025 and was received January 2026 (118113). • Two were not sufficiently complete and there was a request made for more information. The testing of the same 15 reported falls showed delays to the process in five instances, as follows: • A Falls Strategic Oversight Panels (FSOP) continues to be deferred in one instance for a fall that took place in September 2025, the reason for the delay is because further information is required (118351). • One fall remains under investigation since December 2025 and is still not closed on Datix (128239) • One fall from December 2025 was awaiting closure on Datix (128676). • Two falls remained under management review, one since January 2026 (129620) and one since February 2026 (134567).	Escalation pathways may not be triggered, meaning serious patient harm could go unnoticed. Investigations and learning are delayed, increasing the likelihood of recurrence.	**Agreed Action:** **Action 6.1:** Approve and implement a revised process for managing injurious inpatient falls. The process will specify responsibility for completing concise reviews, mandate the required completion timescale, define escalation arrangements for overdue reviews and establish routine reporting of completion and outstanding cases to the Falls and Bone Health Strategic Group. **Expected Evidence of Implementation:** Approved and published revised process setting out responsibilities, required timescales for concise reviews, escalation arrangements for overdue cases and the retained senior oversight arrangements. The first performance report should demonstrate compliance with the revised process and identify the number and age of any outstanding reviews.
		Medium Priority	**Action 6.1 Officer**: Executive Director of AHPs & Health Science **Target Implementation Date**: 31/12/26
	Theme: Planning, Delivery & Deadline Management	Control Operation	

Objective 4: There is regular monitoring and reporting of Falls for adult inpatients data at an appropriate forum to provide assurance to the Board as well as share learning and good practice.	**Substantial**

Overview / Summary of Observations

All falls reported on Datix are reviewed by the staff reviewing falls (note **finding 3**), ensuring consistent monitoring and oversight. Trend analysis is undertaken routinely through Quality, Patient Safety (QPS) work and monthly Divisional reports. Executive scrutiny is maintained through Executive Huddles and weekly Executive Management Team meetings, where patient safety issues, including falls, are regularly considered. In addition, monthly Divisional Quality Management Group meetings review overall performance with a focus on key patient safety domains such as falls and infection prevention. Alongside this, a Falls and Bone Strategic Group is in operation which meet on a three-monthly basis to provide corporate level, strategic steer and oversight.

QPS leads maintain a proactive approach by engaging directly with wards to provide feedback and implement improvement actions following reported falls. Formal learning is disseminated to clinical areas when required, ensuring that lessons are embedded into practice. The Health Board has introduced several initiatives to reduce inpatient falls, including a revised process for reviewing incidents resulting in severe injury to facilitate timely learning, the publication of an updated Falls Policy for Hospital Adult Inpatients supported by awareness and training, and the implementation of ward-level quality improvement projects such as ward accreditations targeting falls reduction. Wards also complete deep dives every six months along with regular spot checks on patient records to see if the falls process is adhered to.

Evidence demonstrates strong monitoring, reporting and shared learning across multiple forums. Feedback following Falls Strategic Oversight Panels (FSOPs) ensures learning is reinforced and communicated effectively. Committee documentation accurately reflects the activity observed during this audit.

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.

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.

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

Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital

Final Internal Audit Report

2025/26

Aneurin Bevan University Health Board

Reasonable Assurance

Contents

Review Reference	ABU-SSU-2526-28
Fieldwork	July - October 2025
Executive Sign Off	25th August 2026
Audit Committee	15th September 2026
Executive Lead	Hannah Evans, Director of Strategy, Planning & Partnerships ABUHB
	Carl James, Executive Director of Strategic Transformation, Planning and Digital/Deputy Chief Executive Officer VUNHST
Audit Team	Huw Richards, Head of Internal Audit
	Paul Stocker, Audit Manager

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Shared Services Partnership
Audit and Assurance Services

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

Executive Summary

Purpose

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 and (and associated fee) provided within the approved Full Business Case (FBC) for the project. The previous audit undertaken in 2023/24 determined reasonable assurance.

Overview

At a project audit, levels of assurance are determined on whether the project achieves its original key delivery objectives, and that governance, risk management and internal control are effectively designed and applied.

The facility is now open and fully operational, with patients benefiting from the scanning and treatments that are available. On the whole the project has been successfully delivered i.e. within the agreed budget allocation, albeit with a six-month delay from the original completion date.

The UHB had addressed all the Management actions from the previous year's audits.

We have concluded **reasonable assurance** at this final review of the project.

The following issues have been identified, and the findings have been recorded for Management consideration:

- At the point of project completion and handover there were a number of defects which had been identified but remained to be resolved.
- A Service Level Agreement (SLA) between the UHB and the Trust was developed over the preceding several months prior to project handover but remained in draft and unsigned at the point of project completion.
- Unresolved water quality issues delayed the opening of the facility post official handover
- Lack of clarity of causality of water issue and any potential contractual obligations.

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

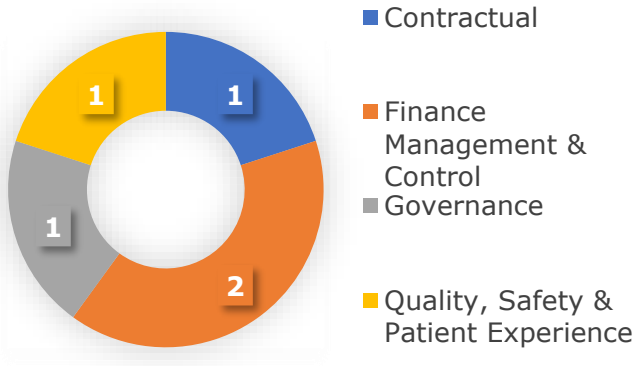
Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	**Project Performance:** Consideration of performance against key project objectives (e.g., time, cost, quality, etc.) and an assessment of any variances to the achievement of the same.	1,2	**Limited**
2	**Project Governance**: Assurance that appropriate governance arrangements were in place for the current project phase. Particular consideration was given to the stakeholder engagement and effectiveness of the collaborative working arrangements established between ABU and VNHST, recognising the joint delivery objectives for this project.	3	**Limited**
3	**Project Financial System**: Adequate cost control and reporting systems were operated, both internally and by the External Cost Adviser. Validation of costs to date as contributing to the final account including an assessment of contract changes and the calculation of pain/gain as appropriate.		**Reasonable**
4	**User/Technical Commissioning:** Assurance that appropriate arrangements were in place to co-ordinate the technical commissioning by the contractor and the user commissioning by the Health Board/Trust.	4,5	**Reasonable**
5	**Equipping:** To ensure that the equipping process was aligned with the key construction delivery timetable, and that there were appropriate management and reporting arrangements in place to ensure its satisfactory co-ordination.		**Substantial**
6	**Validation of Management Action:** Assurance that previously agreed actions have been appropriately actioned by management.		**Substantial**

Management Actions

1	4
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Financial Loss

Findings & Agreed Action Plan

Objective 1: Project Performance	**Limited**

The development of the Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital was designed to expand the Velindre University NHS Trust's radiotherapy treatment capacity by approximately 20%. Functioning as an extension of the Velindre Cancer Centre in Whitchurch, Cardiff, the RSC was strategically located to enhance regional cancer services, improving access to care and significantly reducing travel time for those patients living in the Gwent area.
Welsh Government (WG) capital funding for the development of £37.185m was approved in December 2022, of which £1.356m inc of VAT was classified as QRA-Exceptional risk (to be held by WG). A further £11.412m of Capital funding was agreed within the FBC submission for Velindre Integrated Radiotherapy Solutions (IRS) and equipment to be managed directly by VUNHST. WG additionally provided a further £0.401m for RAAC related works.

Time

At the time of reporting, the Project had been certified as complete, with handover taking place on the 6th May 2025. This was approximately six months later than the originally planned contract date, primarily due to several compensation events resulting in an agreed extension of six months. Post-completion, issues relating to water quality delayed the commencement of treatments, with the first patients received on the 16th June 2025. Operations initially proceeded at reduced capacity until the matter was resolved. It is understood that the facility is now fully operational, with its official opening having taken place on the 16th October 2025.

The contract extension of 23 weeks was primarily due to delays in relation to the asbestos found within the under croft, burst water pipes and temperature controls linked to the linear acceleration installation.

Start date	Original contract completion date	Revised contract completion date	Contract extension (weeks)	Handover date
16/01/2023	25/11/2024	04/05/2025	23	01/05/2025

Table 1

Cost

The UHB received its final monthly cost report in April 2025, table (2) below notes the variance between the expected outturn and FBC allowance i.e.

	FBC Allowance (including additional RAAC funding)	Expected Outturn as per Cost Report (Nr.28 April 2025)
Works (All Works Summary)	£23,349,361	£25,546,296
Fees (All Fees Summary)	£3,091,000	£3,185,420
Non-Works Costs	£2,324,500	£2,001,186
Equipment – ABUHB only	£25,500	£103,277
Contingencies	£1,413,000	-
VAT	**£6,064,247**	**£6,167,236**
VAT Recovery (Provisional)	(£156,200)	(£750,255)
Total	£36,111,408	£36,253,158

Table 2

However, at the time of the current review, the UHB's Cost Advisers confirmed that the final account process was ongoing and was expected to reach completion within the following few weeks. Discussions with the Supply Chain Partner (SCP) were continuing to finalise outstanding matters. In contrast to the above, a preliminary gain-share calculation had been prepared, indicating a favourable forecast gain of £647,288**,** to be apportioned equally between the UHB and the SCP in accordance with the terms of the contract.

This gain share figure is a result of the actual billed costs (PWDD) coming in lower than the tendered (agreed) total of prices.

Preliminary Share Calculation as at 27th May 2025	
Tendered Total of Prices - Implemented	£26,133,196
Total of Prices yet to be implemented (Forecast)	£165,203
Total	**£26,298,399**
Total for Price of Work Done to Date (PWDD)	£25,501,862
Final Total forecast PWDD	£149,250
Total	**£25,651,511**

Difference between forecast and PWDD (Gain share)	£647,288
SCP Share as per clause 53.1 (50%)	**£323,644**

Table 3

Formal assurance over the final position will only be available once the account is fully agreed and approved through the UHB's governance processes. At the time of reporting, the final cost had yet to be determined and the uncertainty of when this will be known and a lack of continued reporting is raised as a finding below.

Quality

The appointed Supervisor had provided monthly reports detailing site progress and issues/defects raised and attended the monthly progress meetings. The reports reviewed in the period of the audit had not raised any significant concerns regarding the quality of works. The latest report from the Supervisor dated 15th October 2025 produced to coincide with the end of defects period on the 21st October 2025, recorded six outstanding defects from the handover period along with twenty-three further defects that had arisen/been noted.

None of the defects noted were highlighted as high risk or detrimental to the operation of the facility, mostly being associated with final finish of trunking and cladding.

Conclusion

The Project was completed following an authorised six-month extension of time arising from unforeseen circumstances and related compensation events and is now operational for patient treatment. The latest reported final financial position shows a cost gain under the NEC3 Option C contract, shared between the Client and the Supply Chain Partner through the contractual pain/gain mechanism.

Key Findings		Risk & Impact	Agreed Management Action
1	**Reporting of project cost position** The last monthly project cost report was produced in April 2025 and presented at the May Project Board meeting. As the project handover was achieved in May 2025 no further monthly cost reports/updates were provided by the UHB's advisers. A preliminary interim assessment noting forecast gain share was produced on the 27th May 2025. However, at the time of reporting (December 2025), this had not been finalised, and a report provided to the ABU Capital and Estates Board Meeting of the 10th December, recorded that 'The final account needs to be agreed and final gain share payment confirmed. The scheme is expected to be within budget'. The continuing lack of clarity over the final cost position should be addressed by provision of continued quantified reporting/updates. Similarly, the UHB should formally confirm the retention of any gain share sums, ensuring Welsh Government are fully appraised on any fluctuations in the potential gain share amounts, (recognising the last Project Progress Report (PPR) return to WG in June 2025). Subsequent to the issuing of the draft audit report the UHB were provided with a Final Account valuation prepared by the SCP and reviewed by the UHB's Cost Advisers.	Uncertainty of final financial position with potential issues in respect of CRL.	**Agreed Action:** Final Account received. **Expected Evidence of Implementation:** • Final account documentation (valuation 029) • Report to Capital / Estates or relevant governance board confirming final cost position.
	Theme: Finance Management & Control	**Medium Priority** Control Operation	Officer: N/A Target Implementation Date: Completed - Actioned since the issue of the draft report.

Key Findings		Risk & Impact	Agreed Management Action
2	**Unresolved Defects** At the point of project completion and handover there were a number of defects which had been identified but not yet resolved. This was highlighted in July 2025 and again in an email dated 16th October 2025 when the UHB's advisers contacted the SCP commenting that they required *a programme highlighting when these works will be completed and how they intend to*	Minor snagging items covered by a 12-month rectification period, may lead to some inefficiencies if not addressed promptly. Delays	**Agreed Action:** The Defects Tracker to continue to be managed by the Supervisor as per the NEC Contract. Progress monitored on a weekly basis Escalation meetings to be held between Assistant Director for Health Board and Regional Director for Kier if actions are not being resolved.

	close out with the Project Supervisor. A Defect status summary dated 16th October 2025 recorded 23 outstanding items.	and limited communication from the contractor could require additional follow-up to ensure timely completion.	**Expected Evidence of Implementation:** • Updated defects tracker showing status and closure of items • Correspondence or escalation records with contractor • Supervisor confirmation at end of defects period that all issues are resolved (or evidence of retention use if applicable)
		Medium Priority	**Officer:** Assistant Director Strategic Capital **Target Implementation Date:** 30th September 2026
	Theme: Contractual	Control Operation	

Objective 2: Project Governance	**Limited**

Overview / Summary of Observations

Oversight of the project was structured through three principal governance forums. Two of these operated as joint groups (Board & Team) between Aneurin Bevan UHB and Velindre University NHS Trust. The Trust also maintained a separate Project Board, which reported into the joint governance structure. Examination of agendas and minutes for these forums confirmed that meetings were consistently well-attended, with quoracy maintained. Documentation reviewed provided clear evidence of active discussion, appropriate challenge and scrutiny of both verbal updates and written reports.

Overall the joint governance arrangements demonstrated effective cross-organisational communication and collaboration between the UHB and the Trust. This coordinated approach supported decision-making and contributed positively to the effective delivery and oversight of the Project.

Whilst noting the above, the finding as raised below highlights an area of concern.

Key Findings		Risk & Impact	Agreed Management Action
3	**Service Level Agreement** A Service Level Agreement (SLA) between the UHB and the Trust was developed over the preceding several months prior to Project handover but remained in draft and unsigned at the point of project completion. Operating a new healthcare facility without a signed SLA between the managing and service providers poses significant governance and safety risks. The lack of formal agreement on statutory compliance, maintenance, and clinical safety responsibilities increases the likelihood of operational failure, legal liability, and potential harm to patients or staff. The SLA should be considered a critical prerequisite for building occupation and service commencement.	Operating without a signed SLA risks unclear accountability, potential service failure, legal exposure, and compromised patient safety.	**Agreed Action:** Final signed SLA document to be produced by Velindre, once received it will be signed by the Health Board. **Expected Evidence of Implementation:** • Completed Signed SLA
		High Priority	**Officer:** Assistant Director of Strategic Capital, ABUHB. **Target Implementation Date:** 30th September 2026
	Theme: Governance	Control Operation	

Objective 3: Project Financial System	**Reasonable**

Overview / Summary of Observations

Monthly Project Cost Reports were provided by the UHB's Cost Adviser throughout the duration of the project up to completion in May 2025. Interim payment assessments were also undertaken by the Cost Adviser based on appropriate reconciliation and scrutiny of cost information submitted by the Supply Chain Partner (SCP).

The project was delivered under an NEC3 Option C contract, whereby any savings achieved against the Target Cost are shared between the parties. The UHB's Cost Advisers had calculated the final cost outcome as being between 97.5% and 100% of the Target Cost. In accordance with the contract this results in a 50:50 gainshare allocation, with the SCP/UHB both entitled to £323,644.93.

At the time of reporting, the final account had not yet been formally agreed. However, supporting documentation provided by the UHB's Cost Advisers demonstrated that appropriate due diligence and verification processes were ongoing in relation to the final account settlement.

Objective 4: User/Technical Commissioning	**Reasonable**

Overview / Summary of Observations

Commissioning is one of the most critical phases in the delivery of a new build healthcare facility.

Technical Commissioning involved verifying that the building services and systems performed correctly and efficiently, e.g. Heating, ventilation & air conditioning (HVAC), water, electrical, fire safety, IT, medical gases, security, and nurse call systems**.** The minutes of the Project Board meeting dated 3rd June 2025 confirmed that all required paperwork and documentation for building compliance had been signed off.

User commissioning (also called operational or clinical commissioning) ensures the facility meets the needs of healthcare users including staff, and patients. The UHB/Trust maintained an SRO Project Plan detailing key tasks, including operational and clinical commissioning and staff training, with the latest version (September 2025) confirming 100% completion.

The project handover was governed by defined "go/no-go" criteria, documented within a project-specific template and regularly reviewed at Project Board meetings to support assurance and decision-making. At the Regional Project Board meeting on 3rd June 2025, these criteria were applied to assess readiness for service commencement. The Board determined that one criterion - the quality of the unit's water supply - had not yet been satisfactorily met with a Total Viable Count (TVC)>3000.

TVC itself isn't a pathogen - but it is an important indicator that the system now supports microbial life. That creates ideal conditions for: Legionella, Pseudomonas aeruginosa and other opportunistic organisms. In hospitals, this is critical because these systems serve immunocompromised patients, so TVC >3,000 is treated as a water safety red flag, even if specific pathogens haven't been found yet.

Consequently, the decision was taken to delay the opening of the facility until the water quality issue was resolved and full compliance with the go/no-go criteria could be confirmed.

Commissioning did, however, involve an issue that delayed the opening of the facility and that is detailed in findings 4 and 5 as set out below.

	Key Findings	**Risk & Impact**	**Agreed Management Action**
4	**Promptness of identification and resolution of water quality issues** Best practice guidance (i.e. HTM 04-01, BS 8680) emphasises that once a system is wetted, it must be either brought into full operational use promptly or maintained through rigorous flushing and monitoring regimes to prevent deterioration in water quality. The system was first wetted in January 2025, yet the first remedial measures were not initiated until May 2025 - a delay of approximately four months. This represents a significant gap in proactive control measures, particularly given the well-documented risks associated with	Delay to opening of facility and ability to deliver planned care. With greater risk to patients being treated at the facility, many of whom are more susceptible to water borne pathogens.	**Agreed Action:** Water issue resolved. The compliance team have an agreed testing plan in place. This issue will form part of the Post Project Evaluation within any lessons learnt to be incorporated within Management Procedures.

	stagnation and microbial proliferation in newly commissioned water systems. The four-month lag suggests either a breakdown in governance oversight or a lack of clarity over responsibility for maintaining the water system during the pre-occupancy phase.		**Expected Evidence of Implementation:** • Health Board Management Procedure to be implemented • Review at Post Project Evaluation/ Lessons Learnt
		Medium Priority	**Officer:** Divisional Director of Facilities and Estates/ Assistant Director of Strategic Capital
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 30th September 2026
Key Findings		**Risk & Impact**	**Agreed Management Action**
5	**Root cause analysis – water issue** During the review of the new health facility capital build project, it was noted that water quality issues delayed the commencement of patient treatment by several weeks**.** The UHB/Trust could not determine whether this issue was attributable to the main contractor's work or to external factors (e.g., design, commissioning, utilities). Consequently, no compensation event or contractual remedy has been pursued. It was reported by ABUHB Management that the issue may have been the result of flux. In new builds, most pipe joints (especially copper) are soldered using flux — a chemical paste that helps metal bond properly. If commissioning and flushing aren't thorough, flux residue is left inside the pipes. That residue: • Is organic and nutrient-rich • Coats internal pipe surfaces • Acts as a starter food source for bacteria • Makes it much easier for biofilm to establish Management should consider undertaking a root cause analysis of the water quality issue to determine whether it originated from contractor works, design defects, or external factors.	Delay in service commencement affected patient care and service delivery timelines. Potential costs (e.g., delay costs, remedial works, or lost operational time) may remain unclaimed if the cause lies within contractor scope.	**Agreed Action:** This issue will form part of the Post Project Evaluation within any lessons learnt to be incorporated within Management Procedures. **Expected Evidence of Implementation:** • Post-project evaluation report including lessons learned
		Medium Priority	**Officer:** Divisional Director for Estates and Facilities Assistant Director for Strategic Capital
	Theme: Finance Management & Control	Control Operation	**Target Implementation Date:** 30th September 2026

Objective 5: Equipping	**Substantial**

Overview / Summary of Observations

Issues were encountered during 2024/25 in relation to the ordering and delivery of equipment. These were primarily attributable to delays within the overall project timeline, which affected the Project's ability to receive and appropriately store equipment as originally planned.

This matter was subsequently resolved through the submission and approval of a capital slippage request, enabling the carry forward of associated funding into 2025/26. As a result, all required equipment was successfully delivered and installed in advance of the facility becoming operational.

The Project was initially approved with a total budget of £48.597m. Funding responsibility was split between the two project sponsors/clients, with ABUHB responsible for the construction of the facility, and VUNHST responsible for operational management and the procurement of specialist equipment required to furnish the facility.

The budget was allocated as follows:

- ABUHB: £35.829m (excluding market volatility funding of £1.356m)
- VUNHST: £11.412m, largely attributable to equipment procurement (primarily Linear Accelerator machines)

Within the ABUHB allocation, a comparatively small provision was made for equipment purchases, with the Full Business Case (FBC) including an allowance of £25.5k. In contrast, VUNHST's procurement of Linear Accelerator machines formed part of the wider Integrated Radiotherapy Solutions (IRS) Programme, the procurement element of which was subject to a separate Internal Audit review in 2024.

The most recent project cost report prepared by the UHB's Cost Adviser identified an anticipated outturn of £103k for equipment. The audit review confirmed that this figure includes both IT and equipment-related expenditure. The resulting variance against the original budget provision of £25.5k has been funded from the Project's contingency allocation.

Objective 6: Validation of Previous Management Actions	**Substantial**

Overview / Summary of Observations

Six Medium Priority actions from the 2022/23 and 2023/24 audit reports were identified as applicable for validation (noting that other actions had either been closed in prior reports or were scheduled for future projects). All six actions were recorded as completed at the UHB Audit Tracker, and the position has been verified at the current review that appropriate action had been taken by the UHB.

See **Appendix A** for the supporting detail.

Appendix A – Validation of Management Action

Recommendations agreed at the 2023/24 audit

Development of a RSC at Nevill Hall Hospital (September 2024)				Previously providing 	
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
3.1	Invoice Approvals	Authorisations are always carried out in line with the scheme of delegation. Further authorisation measures have now been put in place to ensure a physical signature is provided on Authorisation Forms prior to the invoice payment. This will also be rolled out to all Capital Projects.	Actioned	N/A	**Medium**
4.1	Supervisor Role – Site Progress	The Health Board has access to RDRIVE which is the site where all details of the Snags, defects, etc are uploaded by the Supervisor and updated by the Contractor once they have been completed. The Health Board receives a weekly report from this site so that it can track progress against issues raised. Additionally, the Kier Aftercare produce a tracker with all snags/defects for formal review by the Health Board. Monthly meetings will be undertaken to review and sign off.	Actioned	N/A	**Medium**
6.1	Financial Monitoring/Reporting	Agreed – a Risk Register Review will be undertaken and will ensure that it is updated to reflect the remaining contingency requirements.	Actioned	N/A	**Medium**
6.2	Financial Monitoring/Reporting	Agreed -once reviewed this will discussed and scrutinised at the relevant Project Board.	Actioned	N/A	**Medium**

Development of a RSC at Nevill Hall Hospital (September 2024) Previously providing					
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
6.3	Financial Monitoring/Reporting	Agreed - Project Cash Flow to be discussed at Project Board, ensuring that any potential risks are highlighted.	Actioned	N/A	**Medium**

Recommendations agreed at the 2022/23 audit

Development of a Regional Radiotherapy Satellite Centre (RSC) (March 2023) Previously providing					
Ref	**Area**	**Previously agreed Action**	**Current Status**	**Revised Responsibility & Timescale**	**Priority Rating**
7.1	Design Development	UHB commented as follows in the audit Tracker as maintained: November 2023: there are numerous collateral warranties that occur at numerous points in the contract therefore this would not be completed until the end of the contract, i.e. February 2025. At this point in time the process for the provision of collateral warranties had not been required to be actioned as the relevant works had not been completed.	Actioned	N/A	**Medium**

Appendix B

Assurance Opinion

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

Prioritisation of Findings

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

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

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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.

Archwilio Cymru
Audit Wales

Aneurin Bevan University Health Board – Audit Committee Update

Date issued: September 2026

Contents

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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 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**: Planning due to start in October.
- **Expected Board date:** January 2027

Audit of the 2026-27 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 2026-27 Annual Report and Accounts.
- **Status:** Not started.
- **Expected committee date:** 22 June 2027

Performance audit update

Review of cancer services

- **Executive Lead:** Chief Operating Officer
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. The work considered:
  - The local plans to recover cancer waiting lists and longer-term plans to meet growing demand.
  - The work that the Health Board is doing to prevent cancers.
  - The progress NHS bodies are making and actions they are taking to achieve the Welsh Government targets and quality standards for cancer services.
- **Status:** Final report issued
- **Expected committee date:** September 2026

Deep dive review of the arrangements to manage estates

- **Executive Lead**: Chief Operating Officer
- **Focus of the work:** This work examined the effectiveness of corporate arrangements to manage the Health Board's estate. It had 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:** November 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:** Fieldwork
- **Expected committee date:** March 2027

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 not published other relevant outputs which have relevance to the NHS.

Audit Wales is current consulting on proposals for fee rates and other aspects of the statutory fee regime for audit work. The closing date for this consultation is the 18th September 2026.

Consultation on Fee Scales 2027-28	August 2026

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

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Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

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Are cancer services improving?

Aneurin Bevan University Health Board

August 2026

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Contents

Audit snapshot

What we looked at

1 We looked at Aneurin Bevan University Health Board's (the Health Board)'s approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.

2 We also reviewed trends in cancer service performance. Our 2025 national report on cancer services highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review.

Why this is important

3 Demand for cancer services is increasing, driven by factors such as:

- an ageing population;
- rising levels of obesity and alcohol use;
- better survival rates, meaning patients need ongoing follow-up and monitoring; and
- the ongoing introduction of new tests and treatments.

4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.

5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

6 The Health Board has worked well to manage increasing service demand without a corresponding significant worsening of waiting times performance. However, actions to improve cancer services have not yet led to lasting improvement. Performance is still well below the 75% target. In 2025–26, only 61% of patients started treatment within 62 days. The overall average performance also hides wide differences between services. In particular, urology and gastrointestinal pathways are underperforming.

7 The Health Board has taken steps to manage immediate pressures. These include running extra clinics, filling staff vacancies, and changing care pathways. These actions have helped to steady demand in the short term. Whilst they have improved capacity for treating breast and skin cancer, they have not dealt with deeper capacity problems. As a result, overall performance has not improved. The Health Board expects to meet national targets by late 2026–27, but current progress suggests it is not on track.

8 The Health Board has strengthened its cancer service leadership and operational oversight. This has helped to increase focus on cancer care. However, gaps in reporting, limited use of intelligence, and weak Board and committee scrutiny means that progress is slow. The Health Board is proactively taking steps to improve cancer prevention and screening, but we are concerned that scale of these initiatives might not be sufficient to have the required impact.

9 The Health Board understands the challenges it faces. However, its approach is mainly reactive rather than planned ahead. Whilst its working on updating its cancer strategy, it does not have a clear, detailed improvement plan. This makes it harder to respond to rising demand and to meet treatment targets. This is a growing concern, as cancer service costs are rising faster than inflation and there is no clear long-term financial plan.

What we recommend

10 We have made seven recommendations to the Health Board in the following areas:

- approving a new Cancer Strategy;
- monitoring the delivery of the plan;
- developing a costed cancer improvement plan to deliver the strategy;
- developing a long-term cancer workforce plan;
- improving the tracking of cancer improvement actions;
- working with partners to improve analysis of cancer screening data; and
- including a wider range of data in monitoring reports.

Key facts and figures

The number of new suspected cancer referrals rose by 11% between 2022–23 and 2025–26.

Spending on cancer services rose from £90 million to £138 million between 2019–20 and 2023–24. This is £31 million more than if spending had kept pace with inflation over the same period.

In March 2026, most referrals were for suspected lower gastrointestinal (748), breast (392) and upper gastrointestinal (373) cancers.

In March 2026, 63.1% of patients started treatment within 62 days compared with the 75% target.

In March 2026, there was wide variation in treatment waiting times. Performance ranged from 91% for skin cancer to just 36% for gynaecological cancer, against a 75% target.

Between 2002 and 2024 one-year cancer mortality rates have fallen by 15.9%.

Our findings

Cancer service improvement planning

Cancer planning is not joined up leading to fragmented, reactive cancer improvement, rather than longer-term sustainability

Cancer improvement plans

11 The Board approved a Cancer Strategy for 2020–25 that aligned with national policy, national targets and person-centred care. However, the strategy is now out of date and, although a refresh is in progress, the Health Board does not yet have clear reporting mechanisms in place to routinely monitor delivery of the strategy and provide assurance to the Board and its committees that implementation is on track.

12 The Annual Plan 2026–27 sets out high-level priorities for the year. These include redesigning pathways, addressing underperformance, and improving Multi-disciplinary Team governance. While these priorities broadly align with national expectations, the links to the All-Wales Cancer Improvement Plan 2023–26 are unclear. The Annual Plan 2026–27 understandably does not provide detail on the enabling workforce, finances, systems or estate to meet cancer demand in the short- or longer-term. This is a clear gap which a stand-alone cancer plan would need to address.

13 There is no clear approach setting out how the Health Board will meet the Suspected Cancer Pathway (SCP) standard or strengthen services to meet growing demand and growing costs for diagnosis or treatment. Actions to address cancer inequalities are underway, but again these are not yet clearly built into service planning.

14 The Health Board does assess adherence to National Optimal Pathways[1], but planning assumptions appear too optimistic. Recovery actions remain high-level and lack clear timescales, ownership, measurable impact, and clear links to performance recovery. As a result, responses to pressures are often short-term and rely on measures such as overtime and backlog initiatives.

15 The Health Board does not expect to meet national SCP targets until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that it will meet this aim.

Cancer intelligence and data

16 The Health Board needs to better use data analysis and intelligence to inform service planning. The Health Board uses referral data and projections to support day-to-day scheduling of services. However, this approach is generally reactive and not used to inform medium-to longer-term planning. Intelligence shows a clear increase in cancer demand. However, this has not led to a matching increase in workforce capacity. This could make it harder to achieve the SCP targets and directly affect patient outcomes.

17 The Health Board regularly reports cancer demand and performance data[2]. Operational teams and Executives clearly understand the differing performance and risks for different cancers. This helps the Health Board to identify services that are under pressure and supports occasional detailed reviews.

[1] Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

[2] Cancer demand and performance data includes referral volumes, backlogs, waiting times, conversion rates and SCP compliance.

18 The Health Board collects data on different stages of the pathway, which it primarily uses for operational management. This includes time to first outpatient appointment, compliance with diagnosis within 28-days targets, and the time from decision to treat to treatment start. However, the Health Board does not routinely report this information to committees or the Board. This data would help the Board understand where pressures exist along the pathway to inform medium- to long-term investment prioritisation.

19 The Health Board is not making the best use of outcomes data to inform decision making and targeted action. As a result, focus is on meeting cancer targets rather than whether the Health Board is improving patient outcomes. We understand that the Health Board is planning to introduce a set of outcomes-based metrics. This includes information on survival, stage at diagnosis and longer-term outcomes.

Supporting fragile services

20 The timeliness of cancer treatment depends on the type of cancer a patient has. Most of the patients waiting longer than 62 days on the suspected cancer pathway are in the lower gastrointestinal, upper gastrointestinal and urology pathways.

21 The main causes of pressure are well known and regularly discussed. These include limited diagnostic capacity, shortages of staff and reliance on specialist (tertiary) providers[3]. The challenge using tertiary providers is ensuring timely radiotherapy, chemotherapy and/or specialist procedures. The Health Board has set up Gynaecological, Urology and Colorectal services recovery groups to help address underperformance. This shows a strong understanding of where risks to delivery are highest, and a commitment to address the issues.

[3] Tertiary providers for the Health Board include Velindre University NHS Trust, Swansea Bay University Health Board, Cardiff & Vale University Health Board and NHS England.

22 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with their partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services and joint multidisciplinary team working. However, these arrangements are still developing, and it is not yet clear how or if they will improve service capacity and efficiency.

Financial and resource planning

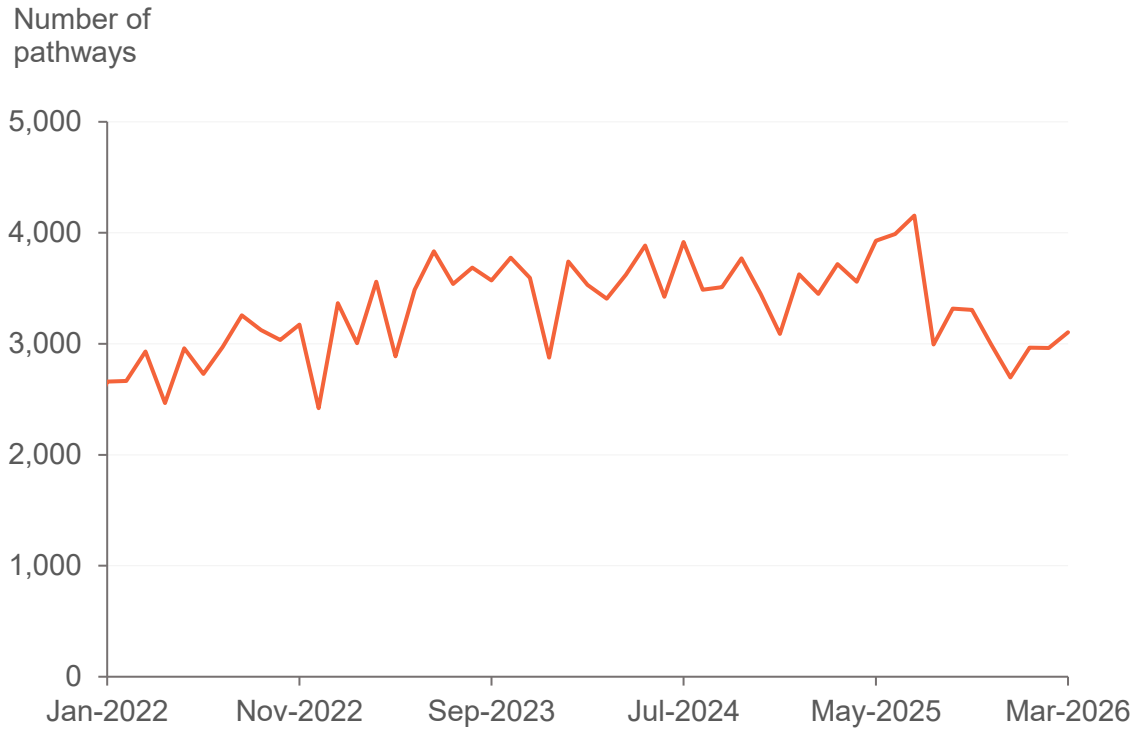
The absence of comprehensive financial and resource plans for cancer services, limit assurance that resources can meet rising demand and national targets

Funding plans

23 The Health Board has not sufficiently costed the total investment required to fund its cancer service improvement actions. Instead, it relies on ad-hoc business cases and short-term funding for local developments. This makes it hard to see the full investment needed to drive service improvements to meet cancer standards and targets. It also does not provide the assurance that the totality of planned improvements needed to meet targets are affordable.

24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows an ongoing increase until mid-2025, then a reduction. There has been a notable increase in referrals between 2022–23 and 2025–26 in head and neck (+26%), gynaecological (+16%) and breast (+15%) tumour sites. While new referrals are currently lower than a couple of years ago, the costs have risen faster than inflation (**Exhibit 2**).

Exhibit 1: newly opened suspected cancer pathways, Aneurin Bevan University Health Board, January 2022 to March 2026 (number)

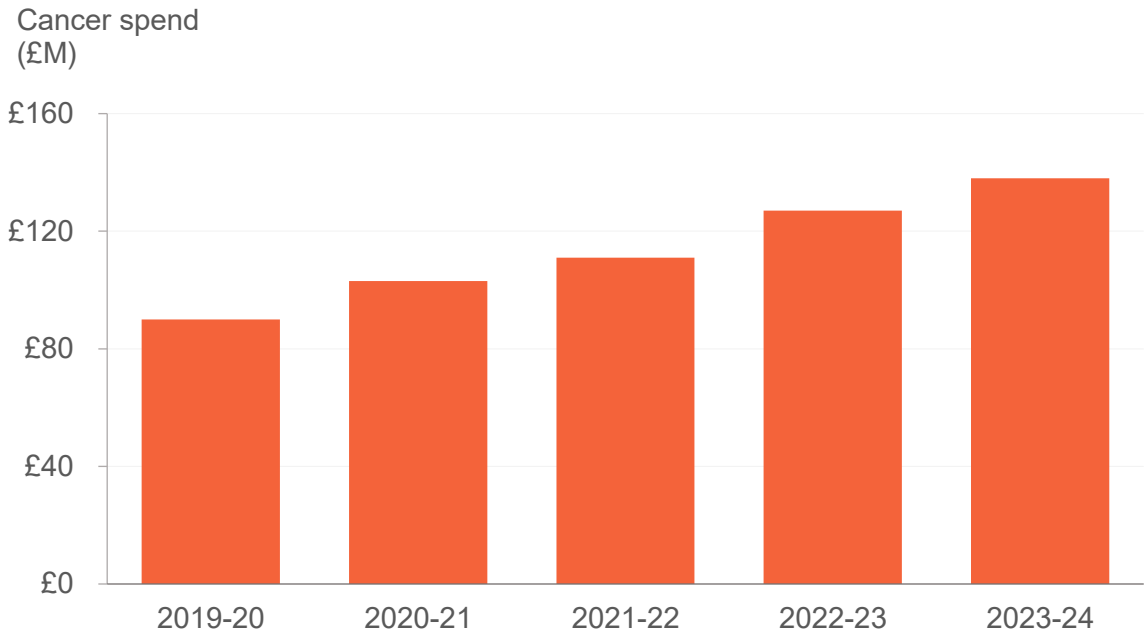


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway

25 **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board's cancer spending rose by around 29% above inflation[4]. Hospital cancer medicines spending has also risen. Between 2019–20 and 2024–25, spending on cancer medicines increased from £10 million to around £15.4 million[5,6]. This is about £3.1 million more than if costs had increased in line with inflation (2024–25 prices).

Exhibit 2: actual cancer services spend, Aneurin Bevan University Health Board, 2019–20 to 2023–24, (£million)



Source: Audit Wales analysis of Health Board data, sourced from the Welsh Government

[4] Inflation is calculated using 2023-24 as a baseline and HM Treasury inflation data.

[5] Some speciality medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

[6] Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

26 Cancer service costs are not set out in the Annual Plan 2026–27. While the Health Board has set out costs in divisional budgets, it is difficult to identify the totality of the planned cancer spend. This is a significant weakness given the scale of cancer services, rising demand, and ongoing cost pressures, including high-cost drugs. **Exhibits 1** and **2** broadly show that increases in cost align to increased demand. However, cost growth is exceeding inflation and needs to be effectively planned for.

27 The Health Board does not have a single costed delivery programme for cancer services. There is evidence of finance reporting to inform planning at individual service level, including forecasts, pay and non-pay costs, savings schemes, and known financial risks and pressures. However, this information is not used to inform a consolidated, costed plan for cancer.

Wider resourcing requirements

28 The Health Board clearly understands its workforce pressures. This includes vacancies, skills shortages, and limited capacity. These challenges are particularly evident in breast, gynaecology, and urology. It has taken action to manage current risks. This includes recruiting specialist staff and redeploying staff.

29 Workforce challenges are not confined to cancer services, with many staff contributing across both cancer and planned care pathways. While recognising these interdependencies, the Health Board does not have a clear workforce plan that sets out how it will develop and sustain the workforce needed to meet future demand. As a result, workforce planning remains focused largely on addressing immediate pressures rather than building longer-term capacity and resilience.

30 The Health Board includes cancer estates plans in its corporate estates strategy. Major developments, such as cancer centre designations and the Satellite Radiotherapy Unit[7], show that cancer is a priority for estates investments.

[7] The Radiotherapy Satellite Centre at Nevill Hall Hospital in Abergavenny is funded by the Welsh Government. This investment is part of a wider package announced in 2023 to upgrade

31 The Health Board has an established five-year diagnostic equipment replacement programme, including processes to prioritise additional capacity and replacement needs. However, equipment planning is managed separately from cancer service delivery planning and is not brought together within a single cancer delivery plan. As a result, there is limited assurance that future equipment requirements are systematically aligned to anticipated growth in cancer demand.

32 The Health Board recognises that digital capability is important. Live cancer tracking dashboards support day-to-day oversight. However, digital in the main supports day-to-day tracking, rather than service transformation.

radiotherapy services in Southeast Wales, with the facility designed to bring care closer to patients' homes. It is staffed by Velindre University NHS Trust.

Cancer prevention and population screening

While taking positive and innovative action, the Health Board is not maximising the benefits of cancer prevention

33 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. To give this context, if the Health Board prevented 20% of cancers, it could have saved £2.3 million in bed day costs in 2024–25, based on the most recent available financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

Exhibit 3: potential capacity gains from cancer prevention, Aneurin Bevan University Health Board, based on 2024–25 activity

	2024–25 actual	-10% reduction	-20% reduction	-38% reduction
Finished consultant episodes	**16,755**	**15,080** (1,676 reduction)	**13,404** (3,351 reduction)	**10,388** (6,367 reduction)
Admission episodes	**14,842**	**13,358** (1,484 reduction)	**11,874** (2,968 reduction)	**9,202** (5,640 reduction)
Bed days	**22,947**	**20,652** (2,295 reduction)	**18,358** (4,589 reduction)	**14,227** (8,720 reduction)
Bed day cost savings		(**£1.2** million)	(**£2.3** million)	(**£4.4** million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Note:

1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.

2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our 2025 National Cancer Services Report.

Public health risk assessment

34 Population health intelligence is strong and well understood but this isn't yet driving large-scale cancer prevention initiatives. The Health Board has developed a Population Health Cancer Dashboard, which has received national recognition. The dashboard brings together data on cancer rates and key risk factors, such as smoking, alcohol use, and body mass index. It also shows differences by age, gender, deprivation, and location. This helps the Health Board understand cancer risk, variation, and inequalities across the population. It also provides assurance that there is understanding of where targeted prevention work would be beneficial.

35 The Health Board has set up a Cancer Board as a strategic forum for overseeing cancer service delivery. The Cancer Board uses the intelligence to inform discussions and decisions. However, beyond the Cancer Board, the Health Board does not sufficiently use population health data to inform cancer prevention planning, priorities and delivery plans.

Approaches to improving population lifestyles

36 The Health Board is delivering a range of programmes to promote healthy lifestyles that reduces cancer risk. However, the long-term impact of local cancer prevention initiatives is limited due to insufficient funding and prioritisation. The Health Board's Annual Plan 2026-27 clearly sets prevention and population health as priorities. However, interviewees indicated that spending on prevention is a small part of overall Health Board funding and more could be invested to improve overall impact.

37 Ongoing funding supports key programmes such as smoking cessation, healthy weight services, vaccination, and screening uptake. Programme uptake and outcomes are monitored by Public Health team, and some metrics at Finance & Performance Committee. This shows that the Health Board manages and evaluates prevention programmes.

38 The Public Health team also develop local prevention initiatives, along with targeted campaigns in areas of low uptake. These business cases go to the Executive Team for approval and are tested for alignment with priorities. Initiatives such as Alcohol “Try Dry” take an evidence-based approach to address lifestyle risks linked to cancer. However, some activities, such as the community-based skin cancer prevention initiative, depend on short-term funding or have limited staff capacity. This makes it harder to manage and may limit the positive impact that the schemes were designed to achieve.

39 The Health Board also participate in National public health programmes, including Help Me Quit and Healthy Weight Healthy You, strongly shape how prevention funding is used. These programmes support cancer prevention and focus on high-risk groups.

Targeted prevention and population screening

40 There are clear referral routes to diagnosis and treatment for patients whose cancer is detected through each of the national screening programmes. The Health Board has limited access to timely screening data. Screening data is not available in real time, which restricts the Health Board’s ability to monitor and plan to meet demand resulting from screening. Performance data also shows that screening is not consistently leading to timely diagnosis and consequently starting treatment, particularly for colorectal cancer, due to limited colonoscopy capacity.

41 The Health Board has some understanding of inequalities of screening uptake. The Health Board’s Public Health team analyses uptake by deprivation, geography, age and sex. They consider barriers such as access and health literacy to identify targeted actions. These actions include predicting non-attendance, active patient follow-up and the use of patient stories to address fear and disengagement.

42 Human papillomavirus vaccination (HPV) rates are below the Health Board's national target of 90%, last reported at around 77% in September 2025. The Health Board has introduced school-based delivery, community outreach, and other actions set out in the Vaccine Inequity Strategy. Despite this, these actions have not yet led to sustained improvement.

Cancer leadership and oversight

While leadership are supporting operational improvements, there is a need for better oversight of the strategic direction of cancer services

Managerial leadership

43 There is now clear leadership for cancer services, after a period of instability. The Chief Operating Officer has overall responsibility, supported by a Senior Responsible Owner and a Clinical Lead. This provides a clear and more joined-up approach to leadership. Prior to this, the COVID pandemic, changes in senior staff, service changes and regional tensions disrupted leadership stability and continuity. While recent appointments and executive focus aim to address this, the effects are still visible in cancer performance and progress.

44 Senior managers make decisions on priorities and spending within agreed limits. The Health Board's Divisional Management Team meetings are supporting timely decision making, when needed. In the past, this has included approving funding for extra clinics and other short-term actions to meet demand.

45 The Health Board's Cancer Board includes staff, primary care, third-sector partners, and patient representatives. This helps to promote openness and joint working to solve problems. This collaborative approach is also evident at operational level. Structured forums, including assurance meetings and tumour-specific recovery groups help teams keep track of performance and waiting lists and take shared action where needed.

46 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In south-east Wales whilst health boards plan and deliver many parts of the cancer diagnosis and treatment pathway, they commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services[8] for most patients. It is imperative that joint working ensures effective planning, referral, and continuity of cancer care across organisational boundaries.

Oversight and scrutiny

47 The Board and the Finance and Performance Committee regularly review cancer performance information. Reports include performance against the target for 75 per cent of patients to start treatment within 62-days of suspicion. The reports also include, waiting list backlog levels, performance trajectories, key risks, and key actions. This gives a good high-level view. However, reports are missing measures such as average waiting times, tumour-specific performance and cancer outcomes. This is important because the average performance can mask significant variation across tumour sites. This may limit the Board and Finance and Performance Committee's ability to seek targeted assurance on services that have the greatest impact on patient outcomes.

48 Finance and Performance Committee minutes suggest that there has been limited scrutiny when cancer performance targets are missed. Equally, Board and committee minutes show that challenge on the proposed actions needed is weak. This is a greater concern because reported improvement actions are often high-level and lack detail.

[8] including radiotherapy, chemotherapy, and other systemic anti-cancer treatments (SACTs).

49 The Health Board has an established Cancer Board, chaired at Executive level (Chief Operating Officer), which has met bi-monthly since 2020 with consistent clinical engagement. Furthermore, they produce a comprehensive and well-structured Annual Cancer Report that provides assurance that improvement work is ongoing. However, it lacks detail on whether those activities are translating into sustainable improvements in performance and outcomes.

Cancer performance

Some patients are facing unacceptably long waits, and the actions to improve are not enabling the Health Board to meet its targets

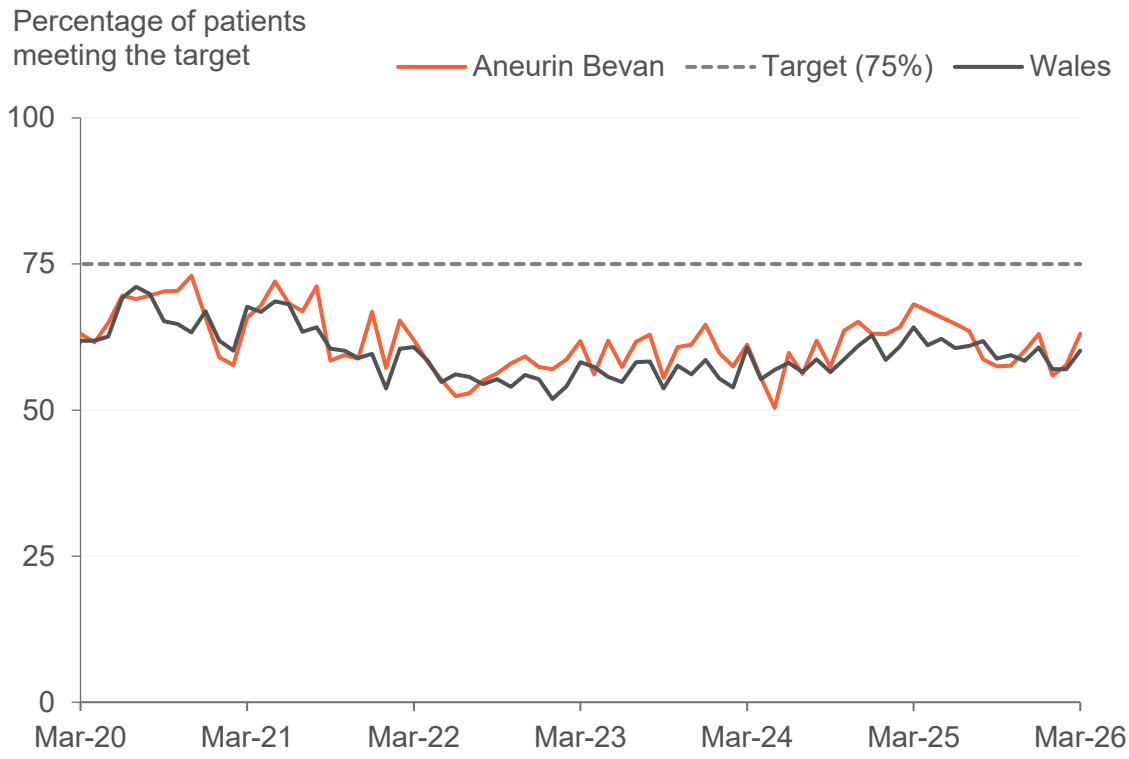
62-day cancer performance

50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days from the first point where cancer is suspected.

51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.

52 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance, although reflecting the average achieved in Wales, is falling well short of meeting the national cancer target (**Exhibit 4**). It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Aneurin Bevan University Health Board, March 2020 to March 2026, (percentage)



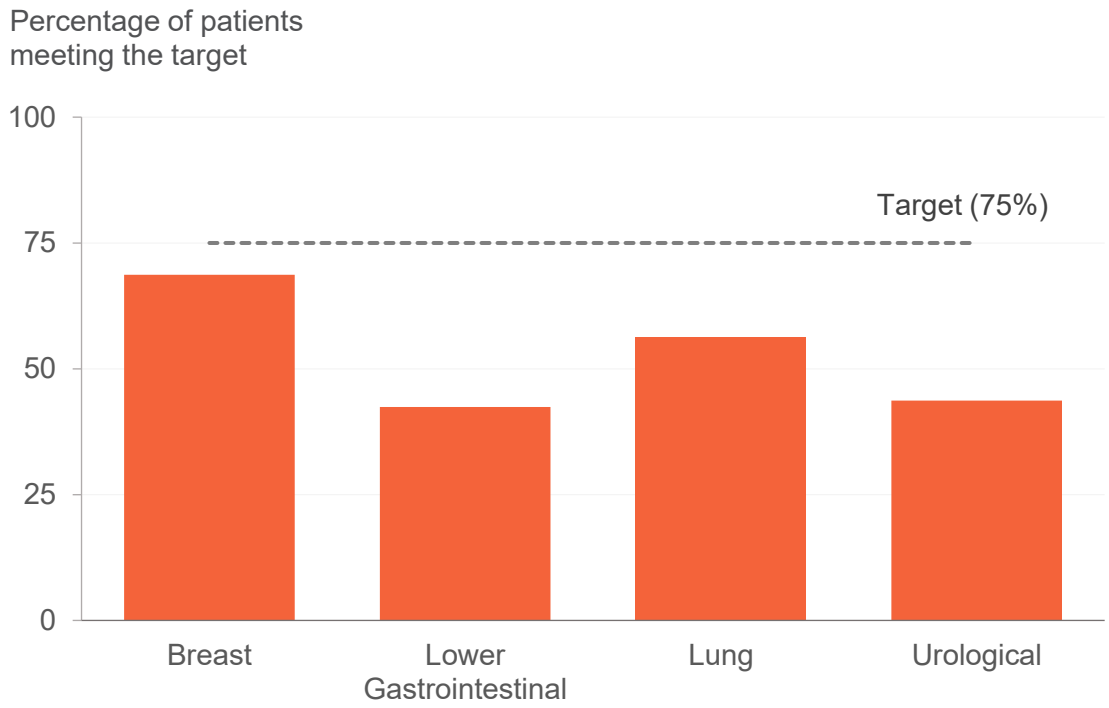
Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

53 The Health Board is not meeting the 62–day Welsh Government target. However, overall performance also hides large differences between sex and tumour types. For example, between December 2025 and March 2026, between 8% and 14% more men than women waited beyond the target.

54 Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target with 88.3% of patients starting their treatment within 62 days. **Exhibit 5** shows performance across four common cancer tumour sites. It raises significant concerns about urological and lower gastrointestinal cancer case timeliness.

Exhibit 5: patients meeting the 62–day cancer treatment target by tumour site, Aneurin Bevan Health Board, 12-month average during 2025–26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer

Impact of action to improve cancer services

55 The action taken by the Health Board is helping to manage short-term risks. But this is not significantly improving performance overall or addressing significant underperformance for some tumour sites. This is likely to be affecting the outcomes for some groups of patients.

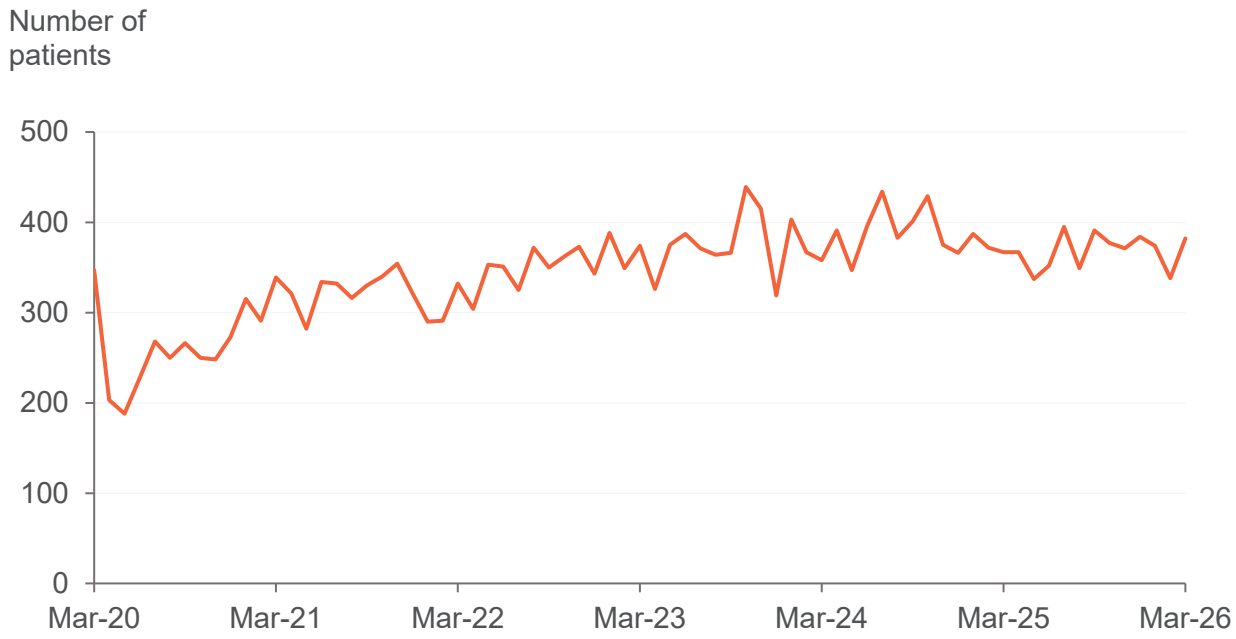
56 Workforce pressures are a major challenge for cancer services. Managers have reactively responded to immediate risks. These include recruiting consultants and cancer nurse specialists, using locums and changing clinic scheduling. However, these actions do not close underlying capacity gaps or sustainably match capacity to demand.

57 The Health Board is trying to address diagnostic and treatment capacity shortfalls. Its actions include redesigning care pathways, speeding up pathology results and waiting list initiatives. If there are issues that teams cannot solve locally, they develop business cases to seek extra funding. This has supported investment in specialist equipment, such as surgical robots, new endoscopy solutions and specialist testing[9].

58 Performance against the 62-day target suggest that the actions taken have not had sufficient impact to improve capacity. The number of new patients starting treatment each month has not notably increased since 2023 (**Exhibit 6**). However, the Health Board has indicated that wider overall treatment activity throughout the pathway have increased.

[9] HER2 testing identifies if breast or stomach cancers have high levels of the HER2 protein or gene, which drives cancer growth. Testing helps determine eligibility for targeted therapies.

Exhibit 6: cancer patients starting treatment each month, Aneurin Bevan Health Board, March 2020 to March 2026 (number)



Source: Audit Wales analysis of Digital Health and Care Wales data

59 The Health Board needs to do more to reflect on the impact of the actions that it is taking. Improvement actions are not clearly prioritised and do not have realistic improvement targets. There is no routine evaluation of the impact of action taken and the resulting impacts. There is little evidence that learning from previous initiatives, including 'Lean systems' training, is consistently applied through formal improvement methods such as PDSA cycles[10].

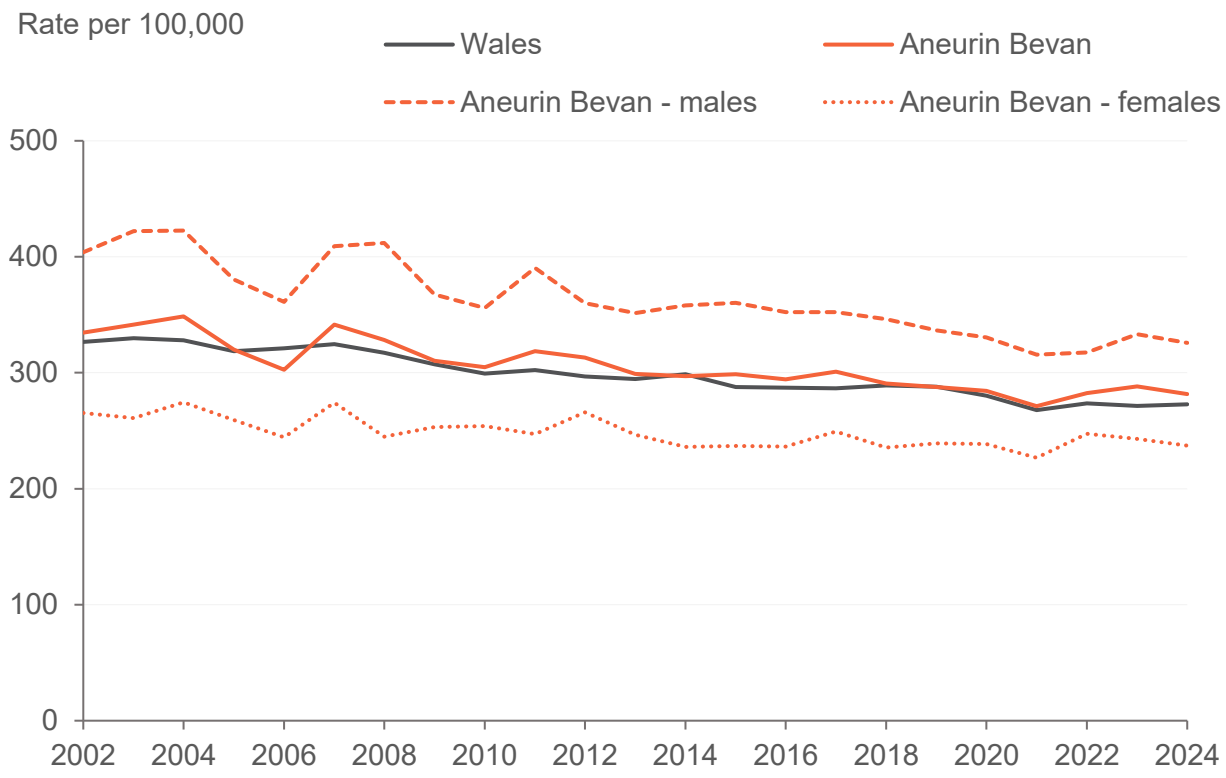
[10] PDSA cycles (Plan-Do-Study-Act) are a four-stage, iterative problem-solving model used to test, implement, and refine changes for process improvement.

Improving cancer outcomes

60 Mortality, stage at diagnosis, PROMs and PREMs data are reviewed in specialty clinical effectiveness meetings. However, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement.

61 **Exhibit 7** shows the one-year mortality rate for the Health Board.

Exhibit 7: one-year cancer mortality, Aneurin Bevan University Health Board 2002 – 2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

62 Analysis of one-year cancer mortality data from 2002 to 2024 in **Exhibit 7** shows a consistent reduction in one-year mortality over the last 20 years. This represents a positive long-term trend and suggests that improvements in cancer prevention, early detection and treatment are having a beneficial impact. The Health Board's cancer mortality rate is also lower than the Wales average. However, outcomes for males remain worse than for females.

Recommendations

Cancer services planning

R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy **(paragraph 11)**.

R2 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track **(paragraph 11)**.

R3 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases **(paragraph 12)**.

R4 The Health Board should ensure that the cancer improvement plan includes SMART[11] cancer improvement actions with defined responsibilities for delivery **(paragraph 14)**.

[11] Specific, Measurable, Achievable, Relevant, and Time-Bound

R5 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce provision tailored to future demand **(paragraph 29)**.

R6 Health boards should work collectively with Public Health Wales NHS Trust to agree as soon as possible a comprehensive set of data analysis on screening services, including:

- Timeliness across each part of the current three cancer screening pathways and lung screening once it is fully rolled out.
- Information on uptake screening rates and variations by population groups (including age, location, sex (where applicable), and ethnicity.

(paragraph 40).

Cancer progress reporting

R7 The Health Board should improve cancer reporting by including average waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance **(paragraphs 47 - 49)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience. We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Cancer Services Manager;
- Chief Operating Officer;
- Clinical Lead for Cancer;
- Division Director for Clinical Support Services;
- Head of Public Health; and
- Strategic Lead Cancer Nurse.

We also held a focus group with the operational specialty management leads.

2 Key terms in this report

Term	Description
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Multidisciplinary Team	Multidisciplinary Team working is where health and care professionals from different specialisms work together to agree a patient's care.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.

Term	Description
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

Term	Description
Waiting list initiatives	Waiting list initiatives are targeted actions or interventions designed to reduce patient waiting times and manage waiting list backlogs (e.g. additional clinics, extra sessions, outsourcing or insourcing).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy.	The Health Board has completed an evaluation of the 2020–2025 Cancer Strategy, which will be considered by the Executive Committee in July 2026. Development of a new Gwent Cancer Plan, aligned to the Gwent 2035 Strategy, is underway. Engagement workshops are being undertaken to inform the six strategic pillars of the plan, which will be submitted to the Executive Committee for approval. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Gwent Cancer Plan will be reviewed and, where necessary, updated to ensure alignment with the national strategic direction, priorities and implementation requirements.	31 March 2027	Chief Operating Officer Supported by: Assistant Medical Director for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases.	The Health Board accepts this recommendation and will develop a fully costed Cancer Improvement Plan aligned to the current Welsh Government Quality Statement for Cancer, Single Cancer Pathway requirements, National Optimal Pathways and the Gwent Cancer Plan. The plan will identify the workforce, digital, infrastructure, service redesign and investment requirements necessary to support sustainable improvement in cancer services. It will include clear priorities, delivery milestones, affordability assessments, expected benefits and defined governance arrangements for implementation and monitoring. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Improvement Plan will be reviewed and updated, where necessary, to ensure alignment with the national strategic direction and implementation requirements.	31 March 2027	Chief Operating Officer **Supported by:** Senior Responsible Officer & Senior Programme Manager for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R3 The Health Board should ensure that the cancer improvement plan includes SMART[12] cancer improvement actions with defined responsibilities for delivery.	Cancer Improvement Plans will include defined actions, measurable outputs, named responsible leads and delivery timescales. Action logs will be developed for each tumour site and approved by tumour site leads and divisional teams to support implementation. Progress and delivery against actions will be monitored and reported through Cancer Board governance arrangements.	31 October 2026	Chief Operating Officer Supported by: Cancer Services Manager
R4 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce	Directorates will develop integrated workforce plans to support sustainable service delivery and future cancer demand. Plans will include workforce baselines, capacity gap assessments, demand modelling, skills mix reviews and recruitment and retention actions.	31 March 2027	Chief Operating Officer Supported by: Deputy Director of Workforce

[12] Specific, Measurable, Achievable, Relevant, and Time-Bound

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
provision tailored to future demand.	The workforce plan will inform the 2027/28 IMTP process.		
R5 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track.	Oversight of delivery will be provided through Cancer Board reporting to the Executive Committee, with periodic assurance reporting and annual deep dives to the Public Board. Re-established and strengthened the Health Board Cancer Board with clear terms of reference, executive leadership and multidisciplinary membership. Evidence of regular meetings and action tracking is in place. Cancer Programme formally designated as one of the Health Board's priority programmes with executive sponsorship from the COO. This will ensure regular updates into Public Board, and scrutiny via our annual plan / IMTP process.	Completed July 2026	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
	Cancer performance is now reviewed routinely through: • SRO Led performance meetings • Cancer Board • Divisional Performance Reviews • Executive oversight arrangements • Board Deep Dives and Board reporting. A dedicated Cancer Programme Deep Dive has been presented to Board setting out achievements, risks, performance and future priorities. Tumour-specific action plans and programme reporting are being developed to support delivery monitoring and accountability.		
R6 The Health Boards should work with Public Health Wales NHS Trust to	Public Health Wales now provides quarterly screening reports to Health Board representatives. The Health Board will continue to work with Public Health Wales to	Ongoing	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
agree as soon as possible a comprehensive set of data on screening services, including: • Timeliness across each part of the three cancer screening pathways; and • Information on uptake rates and variations by population groups (e.g. age, location, sex (where applicable), and ethnicity.	develop an agreed dataset covering screening timeliness, uptake rates and variation across population groups. Opportunities to enhance reporting through more accessible and interactive platforms will also be explored. Progress is monitored through screening pathway improvement meetings and reported through established cancer governance arrangements.		Supported by: Head of Public Health team ABUHB
R7 The Health Board should improve cancer reporting by including average	Existing cancer reporting will be enhanced to include average waiting times, tumour-specific performance	31 March 2027	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance.	measures and conversion-to-cancer rates by tumour site. Following approval of the Cancer Plan, a revised performance framework will be developed which includes a broader range of outcome measures aligned to the plan's strategic priorities.		Supported by: Cancer Services Manager & Senior Responsible Officer for Cancer

About us

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

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

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Archwilio Cymru
Audit Wales

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 September 2026
CYFARFOD O: **MEETING OF:**	Audit, Risk and Assurance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Financial Grip and Control Assurance Review**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Robert Holcombe – Director of Finance, Procurement and Value
SWYDDOG ADRODD: **REPORTING OFFICER:**	Robert Jones – Assistant Finance Director

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of the self-assessment exercise completed, by the Health Board, against Welsh Government's Grip and Control themes and criteria.

It highlights the three stage approach taken; summary assessment; overall conclusion and recommendations identified.

A detailed report can be found in Appendix 1 – Financial Grip and Control Assurance Report

Cefndir / Background

The Grip and Control self-review was undertaken in response to Welsh Government's request for NHS Wales organisations to assess the strength and consistency of their financial control arrangements during a period of significant financial pressure across the system. The Welsh Government guidance set out a series of practical control measures intended to support organisations in strengthening expenditure control, improving grip over workforce and non-pay cost drivers, and demonstrating that core financial governance disciplines are operating effectively.

For ABUHB, the review was used as a structured opportunity to test the extent to which the Health Board's existing policies, procedures, reporting arrangements and accountability mechanisms aligned to the national Grip and Control expectations. It also provided a means of moving beyond previous, higher-level self-assessments by gathering more detailed evidence across the eight framework areas and, where required, testing how controls are applied at divisional and operational level.

The Grip and Control framework should therefore be viewed as supplementary to, rather than a replacement for, the Health Board's established governance framework, Standing Financial Instructions, internal control procedures and existing audit and assurance arrangements. Its value is in providing an additional lens through which the Health Board can evidence financial discipline,

identify areas where control evidence or consistency can be strengthened, and support wider assurance to the Board, Welsh Government and external review bodies.

Asesiad / Assessment

Assurance Process and Assessment Approach

A three-phase assurance approach was applied. Phase 1 was a desktop review of all controls, undertaken as central assurance. This considered whether a policy, procedure or control framework existed and whether central evidence indicated delivery/compliance. Each control was given a central assurance RAG based on the existence of documented arrangements and evidence of operational application.

Phase 2 provided detailed divisional assurance for a targeted 49 of the controls. The subset focused on controls where divisional ownership, local application or local management evidence was necessary to validate whether the control was operating effectively in practice. Divisional responses were assessed as fully compliant, partly compliant or not compliant and translated into a divisional RAG. Phase 2 completion at divisional level resulted in the return of 19 Divisional Summaries, supported by 125 delegated budget holders, with each return supported by Finance and Workforce Business Partners:

Division	**Volume** of budget holder assessments
Workforce & Organisational Development	1
Medical Director	1
External Commissioning	1
Estates and Facilities	7
Digital, Data & Technology	1
Director of Public Health	1
Finance Director	1
Nurse Director	1
Urgent Care	6
Medicine	15
Clinical Support Services	8
Division of Surgery	14
Regional Partnership Board	2
Family & Therapies	25
Primary Care & Continuing Health Care	32
Mental Health & Learning Disabilities Division	6
Director of Corporate Governance	1
Director of Planning	1
Chief Executive	1
	125

The requirement of having detailed reviews with 125 budget holders had two primary aims:

1. **Reiterate the organisational expectation and the Tone from the top**
   By requiring detailed reviews re-iterated the importance of scrutiny and control

2. **Provide support to budget holders and opportunity to share best practice**
   Through collaboration with Finance and Workforce Business Partners budget holders were able to share best practice, or identify and raise concerns with how systems and processes are best applied to meet the aims of the Governance and Control framework. This should further support ongoing adherence and strengthening of consistency across and between Divisions.

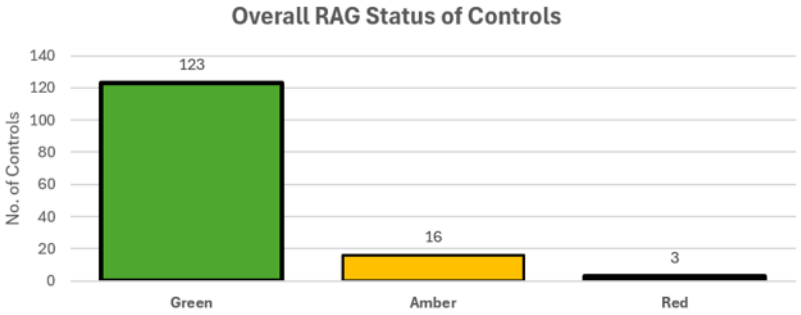
Phase 3 then considered whether additional desktop or executive lead assurance was required, or corroborative evidence where operational practice varied.

The final Overall RAG was determined by considering both assurance stages together. Where either central assurance or divisional assurance indicated a material gap, the final rating was moderated to reflect the highest residual control risk.

Assessment Summary

The review provides positive overall assurance that ABUHB has a generally strong grip and control environment, with 123 of 142 controls assessed as Green, representing 87% of the framework.

The principal weakness identified is concentrated in Theme 4: Rostering, Rotas and Job Planning, which accounts for all three Red-rated controls and represents the weakest of the eight review areas. The key issue is consultant job planning compliance and the related inability, until current improvement work is completed, to fully evidence the alignment of medical capacity, rotas, patient demand, planned activity and productivity.



Overall RAG summary by framework area

Framework area	Green	Amber	Red	Total
1. Framework and Guidance	14	1	0	15
2. People Costs – Establishment and Vacancies	15	2	0	17
3. People Costs – Sickness and Leave Management	8	1	0	9
4. Rostering, Rotas and Job Planning	7	7	3	17
5. People Costs – Temporary staffing including Bank and Agency & Locum	24	1	0	25
6. People Costs – Other Staff Payments	8	1	0	9
7. Procurement	26	1	0	27
8. Other Items	21	2	0	23
Total	123 (87%)	16 (11%)	3 (2%)	142

Overall Conclusion

The overall conclusion is one of significant assurance. ABUHB has a strong core financial control framework, with most controls established, supported by policy and governance arrangements, and assessed as operating effectively. The review also aligns with assurance received through ordinary review routes, including Internal Audit and Audit Wales, which have not identified systemic weaknesses in the Health Board's financial governance environment.

The main residual weakness is concentrated in medical workforce planning, particularly consultant job planning compliance, rota alignment and the ability to demonstrate medical productivity and utilisation. This is a known improvement area and is already subject to Executive, Medical Director and ARAC scrutiny, with system roll-out and focused management action expected to strengthen assurance by December 2026.

The review provides a useful baseline and demonstrates that the Health Board has many of the necessary controls in place. The focus should now be on targeted strengthening where required, particularly in evidencing operational review at budget-holder level, improving consistency of workforce policy application, and delivering the medical job planning and e-rostering improvement plan.

Recommendations endorsed by the Executive Committee 6th August 2026

Control Improvements identified by theme

Where Amber and Red-rated controls were identified within the thematic sections of the report, control improvements have been identified and highlighted.
Improvements are documented, per theme and detailed control, in Appendix 1.

Evidencing controls at lower layers of accountability

ABUHB has invested significantly in real-time reporting and data visualisation, including the use of national Qlik Sense dashboards and local reporting tools. These provide strong visibility of financial and workforce performance and are routinely used within senior governance forums such as Executive and Divisional Management Team meetings.

However, the move towards more agile, real-time review means that evidence of historical control review is not always retained consistently at lower levels of accountability. In some cases, assurance that review has taken place relies on meeting discussion, verbal confirmation or locally held evidence rather than a consistent retained audit trail.

To strengthen future audit compliance and reinforce accountability, it is recommended that a standard Grip and Control budget holder report or attestation process is introduced. This would require budget holders to confirm that their budgets are being actively reviewed and managed, identify key risks or exceptions, and record mitigating actions. This would provide a retained evidence base that review and challenge is taking place across all layers of budget accountability.

Signposting and operational understanding of workforce policies

The review confirmed that ABUHB has a comprehensive workforce policy framework supporting many of the controls within the Grip and Control framework. However, divisional responses highlighted that operational understanding of these policies is not always consistent, particularly where controls are applied infrequently or only in specific circumstances. Further the implementation of the SMA app has strengthened compliance by simplifying the process for staff and managers, providing a clearer and more consistent route for accessing and applying workforce processes. However, the review still identified an opportunity to improve wider signposting, practical guidance and management awareness for workforce policies that sit outside, or are not fully embedded within, the SMA workflow.

This does not indicate an absence of policy, but it does highlight an opportunity to improve signposting, practical guidance and management awareness. Repeated communication of relevant policies, supported by clear guidance on how controls should be applied in practice, would help

ensure more consistent operational application and improve the quality of evidence available for future assurance reviews.

Argymhelliad / Recommendation

That the committee receives the update and continues to support the aims of adhering to a strong grip and control framework within ABUHB.

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

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

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

Financial Grip and Control Assurance Review

Prepared By: Robert Jones, Assistant Finance Director

Fieldwork Lead: Heulwen Griffiths, Head of Business Systems and Governance

Executive Sponsors: Rob Holcombe, Finance Director, Nicola Prygodzicz, Chief Executive

1. Background

The Grip and Control self-review was undertaken in response to Welsh Government's request for NHS Wales organisations to assess the strength and consistency of their financial control arrangements during a period of significant financial pressure across the system. The Welsh Government guidance set out a series of practical control measures intended to support organisations in strengthening expenditure control, improving grip over workforce and non-pay cost drivers, and demonstrating that core financial governance disciplines are operating effectively.

For ABUHB, the review was used as a structured opportunity to test the extent to which the Health Board's existing policies, procedures, reporting arrangements and accountability mechanisms aligned to the national Grip and Control expectations. It also provided a means of moving beyond previous, higher-level self-assessments by gathering more detailed evidence across the eight framework areas and, where required, testing how controls are applied at divisional and operational level.

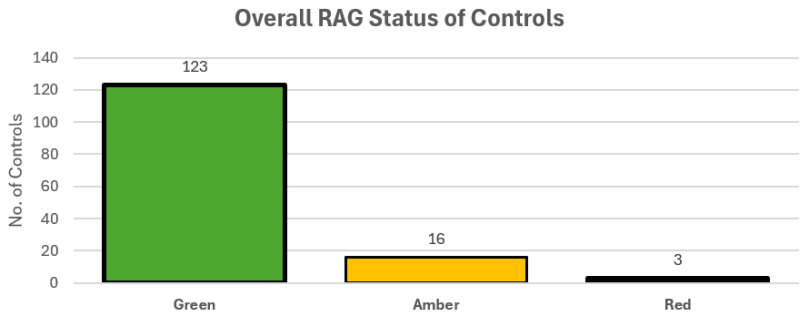
The Grip and Control framework should therefore be viewed as supplementary to, rather than a replacement for, the Health Board's established governance framework, Standing Financial Instructions, internal control procedures and existing audit and assurance arrangements. Its value is in providing an additional lens through which the Health Board can evidence financial discipline, identify areas where control evidence or consistency can be strengthened, and support wider assurance to the Board, Welsh Government and external review bodies.

2. Executive summary

The review provides positive overall assurance that ABUHB has a generally strong grip and control environment, with 123 of 142 controls assessed as Green, representing 87% of the framework. **This is consistent with assurance received through ordinary review channels, including Internal Audit and Audit Wales, which have not identified systemic weaknesses in the Health Board's core financial governance arrangements.**

The principal weakness identified is concentrated in Theme 4: Rostering, Rotas and Job Planning, which accounts for all three Red-rated controls and represents the weakest of the eight review areas. The key issue is consultant job planning compliance and the related inability, until current improvement work is completed, to fully evidence the alignment of medical capacity, rotas, patient demand, planned activity and productivity.

This is a known improvement area for ABUHB and is already subject to significant ARAC and Executive scrutiny. A plan is in place, led through Medical Director focus and supported by system roll-out and enhanced reporting, to improve job planning compliance and strengthen assurance over rota alignment and medical workforce utilisation by December 2026. Overall, the review supports a conclusion of substantial assurance, with targeted improvement required in medical workforce planning and the evidencing of operational controls.



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3. Assurance process and assessment approach

A three-phase assurance approach was applied. Phase 1 was a desktop review of all controls, undertaken as central assurance. This considered whether a policy, procedure or control framework existed and whether central evidence indicated delivery/compliance. Each control was given a central assurance RAG based on the existence of documented arrangements and evidence of operational application.

Phase 2 provided detailed divisional assurance for a targeted 49 of the controls. The subset focused on controls where divisional ownership, local application or local management evidence was necessary to validate whether the control was operating effectively in practice. Divisional responses were assessed as fully compliant, partly compliant or not compliant and translated into a divisional RAG. Phase 2 completion at divisional level resulted in the return of 19 Divisional Summaries, supported by 125 delegated budget holders, with each return supported by Finance and Workforce Business Partners:

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The requirement of having detailed reviews with 125 budget holders had two primary aims:

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   By requiring detailed reviews re-iterated the importance of scrutiny and control

2. **Provide support to budget holders and opportunity to share best practice**

   Through collaboration with Finance and Workforce Business Partners budget holders were able to share best practice, or identify and raise concerns with how systems and processes are best applied to meet the aims of the Governance and Control framework. This should further support ongoing adherence and strengthening of consistency across and between Divisions.

Phase 3 then considered whether additional desktop or executive lead assurance was required, or corroborative evidence where operational practice varied.

The final Overall RAG was determined by considering both assurance stages together. Where either central assurance or divisional assurance indicated a material gap, the final rating was moderated to reflect the highest residual control risk.

4. Additional opportunities for improvement identified through the review

The Grip and Control review confirmed that the Health Board has a broad and generally effective control framework in place across the key areas of financial management. Most controls were assessed as compliant, supported by established policies, procedures, reporting mechanisms and governance arrangements.

In addition to the Amber and Red-rated controls set out within the thematic sections of this report, the review identified two cross-cutting improvement opportunities. These do not materially change the overall assurance conclusion, but would strengthen the consistency, transparency and evidencing of controls across the organisation.

Evidencing controls at lower layers of accountability

ABUHB has invested significantly in real-time reporting and data visualisation, including the use of national Qlik Sense dashboards and local reporting tools. These provide strong visibility of financial and workforce performance and are routinely used within senior governance forums such as Executive and Divisional Management Team meetings.

However, the move towards more agile, real-time review means that evidence of historical control review is not always retained consistently at lower levels of accountability. In some cases, assurance that review has taken place relies on meeting discussion, verbal confirmation or locally held evidence rather than a consistent retained audit trail.

To strengthen future audit compliance and reinforce accountability, it is recommended that a standard Grip and Control budget holder report or attestation process is introduced. This would require budget holders to confirm that their budgets are being actively reviewed and managed, identify key risks or exceptions, and record mitigating actions. This would provide a retained evidence base that review and challenge is taking place across all layers of budget accountability.

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This does not indicate an absence of policy, but it does highlight an opportunity to improve signposting, practical guidance and management awareness. Repeated communication of relevant policies, supported by clear guidance on how controls should be applied in practice, would help ensure more consistent operational application and improve the quality of evidence available for future assurance reviews.

5. Controls assessed as compliant with local variation from Welsh Government wording

The review identified a small number of controls where ABUHB was assessed as compliant, but where the Health Board's local approach does not strictly mirror the wording or frequency set out in the Welsh Government Grip and Control framework. In these cases, management judgement was applied to determine whether the local control provided equivalent or more proportionate assurance.

Where the Health Board has an established alternative control, supported by appropriate approval, monitoring or governance arrangements, the control has been assessed as Green. This approach recognises that the Welsh Government framework is intended to strengthen financial grip and control, but that local application should remain proportionate, operationally deliverable and aligned to existing governance arrangements.

Weekly WTE tracker

The Welsh Government framework refers to an automated weekly headcount tracker covering temporary and substantive workforce. ABUHB currently operates establishment and workforce monitoring arrangements through the Trac recruitment process, budget establishment controls and monthly workforce reporting.

The Health Board considers that monthly retrospective review provides sufficient assurance where recruitment controls are operating effectively, posts are authorised within budget, and establishment movements are subject to existing approval routes. A weekly review may be appropriate where recruitment controls are weaker or where real-time establishment drift is a significant risk, but this is not considered necessary in the current ABUHB control environment.

Roster approval timescales

The framework refers to rosters being approved 12 weeks in advance. ABUHB's current requirement is for rosters to be approved six weeks in advance. This has been assessed as compliant because the six-week timescale is considered a more practical and

proportionate balance between forward planning, staff notice periods, leave requests and the need to maintain flexibility where service requirements change.

A 12-week requirement may provide earlier visibility, but could also lead to more subsequent roster changes where operational circumstances, vacancies, leave or service pressures evolve. The six-week standard is therefore considered to provide a reasonable level of control while remaining deliverable in practice.

Conversion of temporary staff to substantive employment

The framework suggests considering contract terms that enable the organisation to offer a substantive role after a defined period of temporary or locum use. ABUHB has considered this principle, but has not adopted an automatic conversion policy.

This is because automatic conversion from temporary to substantive employment would not always represent the most appropriate or cost-effective control response. In some cases, temporary staffing may relate to time-limited demand, fixed-term service pressures, cover for absence, or activity with a foreseeable end date. In such circumstances, retaining a temporary arrangement may be more appropriate than creating fixed workforce capacity.

ABUHB's position is therefore that conversion to substantive employment should be considered on a case-by-case basis, informed by service demand, affordability, workforce planning and value-for-money considerations. This provides a more balanced control than an automatic trigger based solely on length of engagement.

6. Overall Conclusion

The overall conclusion is one of significant assurance. ABUHB has a strong core financial control framework, with most controls established, supported by policy and governance arrangements, and assessed as operating effectively. The review also aligns with assurance received through ordinary review routes, including Internal Audit and Audit Wales, which have not identified systemic weaknesses in the Health Board's financial governance environment.

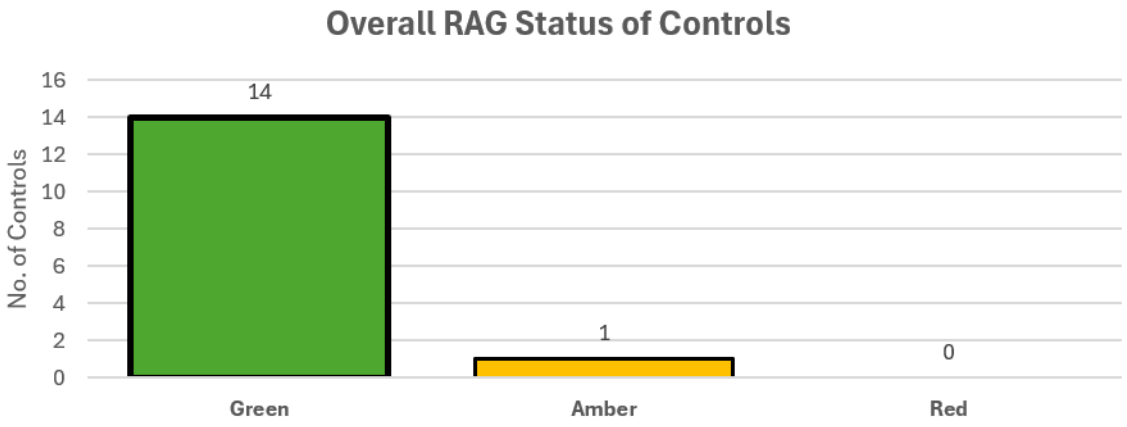
The main residual weakness is concentrated in medical workforce planning, particularly consultant job planning compliance, rota alignment and the ability to demonstrate medical productivity and utilisation. This is a known improvement area and is already subject to Executive, Medical Director and ARAC scrutiny, with system roll-out and focused management action expected to strengthen assurance by December 2026.

The review provides a useful baseline and demonstrates that the Health Board has many of the necessary controls in place. The focus should now be on targeted strengthening where required, particularly in evidencing operational review at budget-holder level, improving consistency of workforce policy application, and delivering the medical job planning and e-rostering improvement plan.

Theme 1 - Framework and Guidance

ABUHB has a well-established financial governance framework supported by up-to-date Standing Financial Instructions, documented financial control procedures and clearly defined governance arrangements. Financial control processes are accessible to staff, supported by training and awareness activity, and underpinned by clear accountability through budget delegation arrangements. The Health Board also operates established business case approval processes and committee structures which provide scrutiny and challenge over significant investments and service developments.

The review identified strong evidence of organisational oversight through formal escalation routes, performance management arrangements and accountability mechanisms. The introduction of the Performance Management & Accountability Framework 2025 further strengthens the governance environment by establishing clear expectations, escalation processes and routine assurance reviews across finance, performance, quality and workforce domains.



This framework area contains 15 controls: 14 Green, 1 Amber and 0 Red.

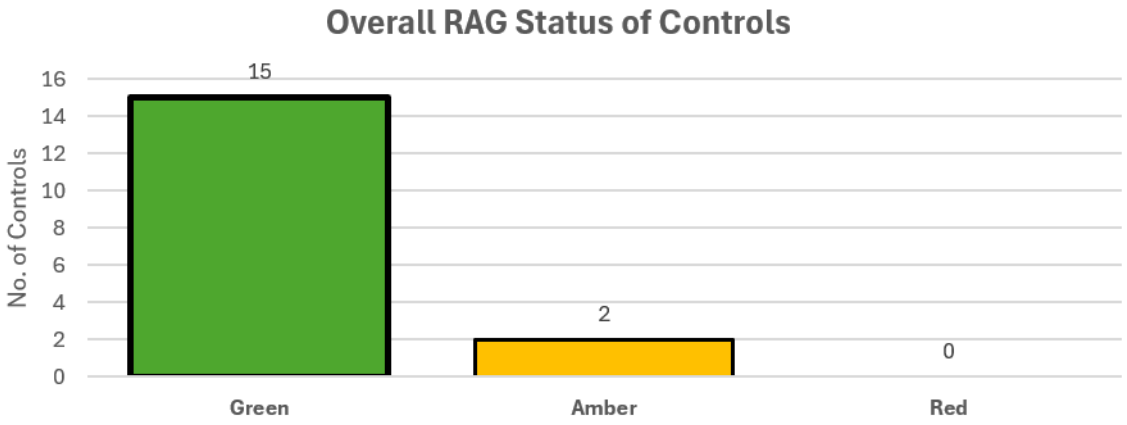
Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
1.4.4 Review previous 12 months of business cases to ensure savings/benefits realisation	1.4 Investments and Business Cases	Amber	Recent Internal Audits provide assurance of strong controls. However the Health Boards processes are segmented (for example Capital/Digital/schemes through PIP/Schemes under £75k) and as such the Health Board does not have a consistent tracking approach or framework. This prevents holistic views of realization success being established.	The organisation should consider how benefits across all projects are consistently captured, managed, reviewed and reported.

Theme 2 - People Costs – Establishment and Vacancies

The Health Board has robust processes for vacancy management. Workforce planning arrangements are embedded through divisional management structures and are linked to approved establishments and financial planning processes. Recruitment decisions are subject to challenge and scrutiny, ensuring workforce growth is aligned to service need and affordability.

Good practice is evident through routine workforce monitoring, divisional performance reviews and the application of accountability arrangements which require leaders to actively manage workforce resources. The Health Board has established mechanisms to review workforce trends, vacancy positions and workforce affordability, supporting proactive management of staffing costs while maintaining service delivery.



This framework area contains 17 controls: 15 Green, 2 Amber and 0 Red. The improvements identified focus on medical staffing whom do not have full e-rostering and is the focus of an ongoing project expected to be completed by the end of 2026.

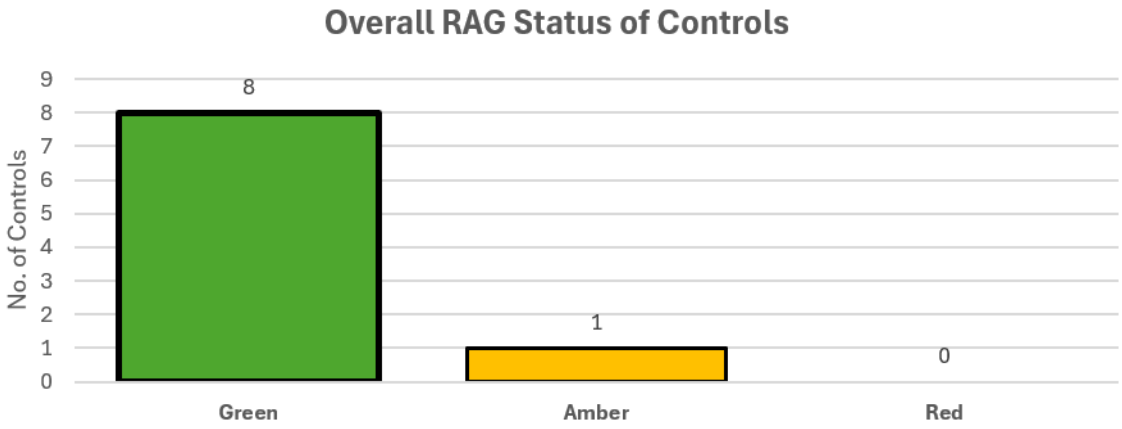
Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
2.2.1 Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget	2.2 Establishment (Establishment)	Amber	Establishments are in place for all services and staff groups with the exception of medical staff – this will be completed when e-rostering is implemented.	Completion of the e-rostering project to bring medical establishment in line.
2.2.2 Workforce plans are regularly reviewed by service and divisional leads to ensure compliance with or action to move to compliance against both establishment and budget	2.2 Establishment (Establishment)	Amber	Returns do not provide consistent evidence of an agreed review cycle for workforce plans by service and divisional leads, or documented action to move services back into compliance with establishment and budget.	Implement an automated budget report where budget holder attests that mitigating actions are identified and followed up.

Theme 3 - People Costs – Sickness and Leave Management

ABUHB benefits from a comprehensive policy framework governing sickness absence and leave management, supported by established divisional review processes and management oversight. The expectation that managers actively monitor attendance, undertake return-to-work activity and escalate concerns through normal management arrangements demonstrates a mature control environment.

The wider performance and accountability framework reinforces these controls by embedding workforce metrics within routine review meetings and escalation arrangements. This creates clear accountability for workforce performance and provides opportunities for early intervention where trends emerge, helping to minimise the operational and financial impact of sickness absence.



This framework area contains 9 controls: 8 Green, 1 Amber and 0 Red.

Amber/Red/Pending controls requiring action

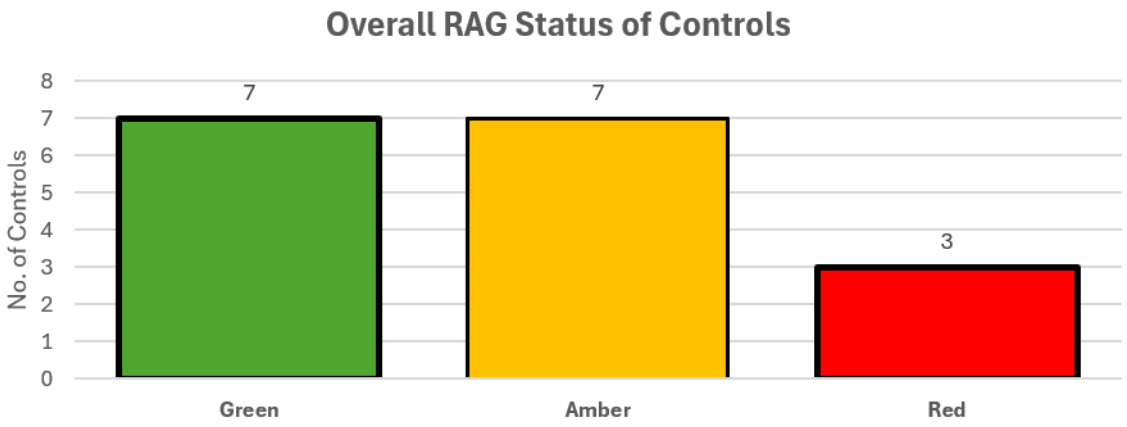
Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
3.1.5 There is a set % target for staff on **leave** at any time and performance is measured against this target	3.1 Monitoring and Reporting	Amber	Returns indicate annual leave is reviewed at DMT level, but do not consistently evidenced a defined leave utilisation target or routine performance measurement against ability to deliver the service.	Implement a KPI which considers the value of variable pay paid to cover annual leave, with monitoring of additional pay route cause criteria.

Theme 4 - Rostering, Rotas and Job Planning

Theme 4 represents the weakest area of assurance across the Grip and Control review. While ABUHB has established rostering arrangements in some staff groups, particularly within nursing services, the overall assurance position is limited by incomplete medical e-rostering implementation and low compliance with agreed consultant job planning requirements. These gaps restrict the Health Board's ability to demonstrate that planned staffing capacity is consistently aligned to patient demand, service activity and financial control expectations.

The most significant issue is the absence of agreed and current job plans for a substantial proportion of consultants. As at March 2026, only 55% of consultants had approved job plans against an expected compliance level of 90%. This creates a material assurance gap because job plans are the foundation for confirming the contracted clinical capacity available, aligning rotas to planned activity, assessing productivity, understanding variation in programmed activities, and identifying underutilisation or excess capacity. Until job planning compliance improves and is routinely linked to rota and activity data, the Health Board cannot provide full assurance that medical staffing resources are being deployed optimally to meet patient demand.

The review also identified that planned-versus-actual reporting, transparent medical leave planning, on-call utilisation analysis and routine productivity reporting are either not yet fully embedded or dependent on future implementation of Patchwork and related reporting developments. This limits the ability of Medical Director leadership, divisions and finance teams to triangulate workforce capacity, roster design, service demand and cost drivers. The agreed improvement plan, including targeted divisional deep dives, job planning compliance actions, restrictions linked to vacancy approvals and implementation of medical rostering functionality, is therefore critical to strengthening control in this area.



This framework area contains 17 controls: 7 Green, 7 Amber and 3 Red.

Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
4.1.1 E-rostering is fully deployed	4.1 General rostering and rotas	Amber	Returns indicate that Agenda for Change e-rostering is deployed, but medical rostering remains incomplete due to delays with Patchwork rota implementation.	Draft revised implementation plan for review incorporating the new resident doctor contract
4.2.5 Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning)	4.2 Robust Nursing Rota Management	Amber	There is no systematic review required post school holiday period to validate that roster management was robust. However, roster approval 6 weeks in advance would	Inclusion of the "booking Reason" for agency and locum within the monthly grip and control report in development, considering if the current list of booking reasons remains complete

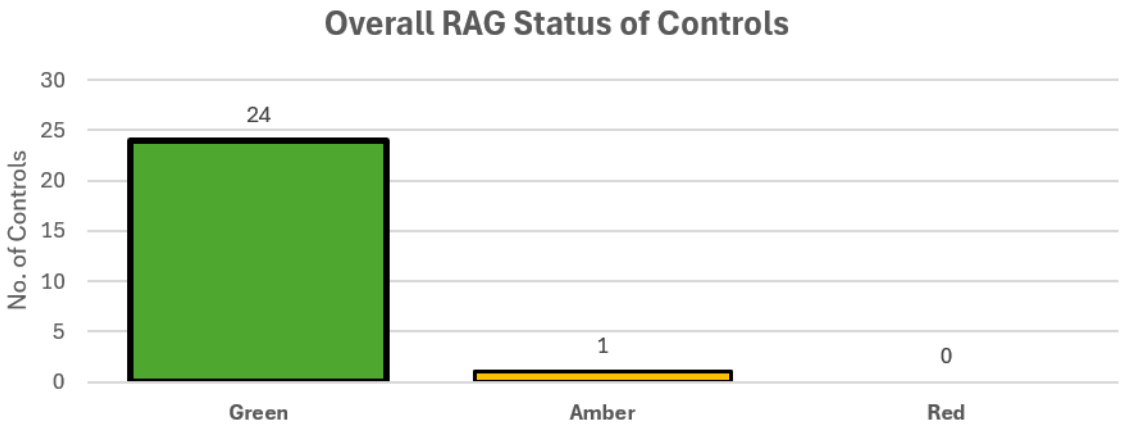
			consider seasonality and sickness/leave rates.	(including whether “Annual Leave Cover” would be better worded than “Facilities Annual Leave”:  Booking Reason 1 Carers leave Estab Vacancies Estab Vacancies ~ Estab Vacancies Estab Vacancies ~ Special Leave Extra Capacity/Occupancy Extra Capacity/Occupancy ~ Extra Capacity/Occupancy Extra Sessions/Waiting List Initiative Facilities Annual Leave Parental Leave Parental Leave ~ Estab Vacancies Phased Return Sickness Sickness ~ Estab Vacancies Sickness ~ Sickness Special Leave Staffing Shortages Supervision
4.2.6 Review options for: • reduced handover periods; • back-to the ward for nursing management staff for a number of shifts per week; and • specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation	4.2 Robust Nursing Rota Management	Amber	There is clear evidence to support consideration of reduced handover periods, and back to ward for nursing management. The review of policy identified that consideration of how Specialist Nurses can be utilised to support Rotas was not as explicit, but recent evidence in the heatwave clearly demonstrated that operationally this was considered and utilised.	Amend the current policy and roll out guidelines of what options can be considered when filling rota gaps, including the use of Specialist nurses in non specialist roles.
4.3.1 Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times	4.3 Robust Medical Job Planning Management	Red	As at March 2026 55% of Consultants had approved job plans, below the target expectation of 90% Deep dives with divisional management were undertaken in January 2026 to review compliance levels, action plans and support required. Together with an agreed action plan which is already in place.	To support the targeted job planning compliance, key actions include • progress updates into Divisional Performance Reviews, conducting targeted deep dives; • withholding vacancy approvals until up-to-date consultant job plans are in place; and • Pay impacting changes and study leave funding will also be restricted unless job plans are current or under appeal.
4.3.2 Process in place to ensure alignment of rota to job plans	4.3 Robust Medical Job Planning Management	Red	Returns indicate that planned-versus-actual reporting will become available following rostering implementation (4.3.1), but current evidence does not yet demonstrate routine alignment between rotas and job plans.	Implementing a KPI performance metric of job plan alignment.

4.3.3 Monitoring in place to support Medical Director leadership track medical productivity for example:- • job plan delivery (individual and then team job plans); • PAs over 12; • % Direct Clinical Care; and • theatre/clinic throughput	4.3 Robust Medical Job Planning Management	Red	Returns confirm a procedure exists for job plans over 12 PAs and approval by the Deputy Medical Director is required, but there is no current routine process for supplying Medical Director leadership with job plan activity and productivity data.	The Medical Workforce E-System team to provide job planning data for individual and team capacity for all activities which includes DCC's theatre and clinic PA's.
4.3.4 Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity “PA” staff)	4.3 Robust Medical Job Planning Management	Amber	There is no current routine process for providing Medical Director leadership with compliance and productivity analysis to identify low or high PA variation. Job planning data can be extracted from the L2P system currently being deployed and will result in greater transparency.	Data from the L2P job planning system to be utilised when fully implemented.
4.3.5 Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning	4.3 Robust Medical Job Planning Management	Amber	The implementation of Patchwork Rota is expected to improve visibility of medical annual leave and shift cover gaps, but current arrangements do not yet provide full transparency to planning teams.	Implementation of rostering will provide visibility of annual leave by service
4.3.6 Review on-call run rate for utilisation trends (which AB understands to mean that where home on calls regularly result in attendance, that rota patterns are amended accordingly to make core shifts).	4.3 Robust Medical Job Planning Management	Amber	Workforce reporting could support on-call activity review, but do not yet evidence a routine process for analysing on-call utilisation trends and escalating findings.	Workforce to implement a regular report for on call activity to Medical Director office to review
4.4.1 Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity	4.4 Other Clinical Staff	Amber	86% of returns were deemed only partially compliance due to failure to evidence checks that are completed.	Productivity planning review for CNS and AHPs be undertaken.

Theme 5 - People Costs – Temporary staffing including Bank and Agency & Locum

ABUHB has a highly developed framework governing the use of bank and agency staffing. Detailed protocols, booking rules, approval requirements and segregation of duties create strong financial and operational controls over temporary staffing expenditure. Agency usage is subject to formal authorisation processes, with clear expectations that all alternative workforce options are exhausted before agency staffing is approved.

The review identified particularly strong controls surrounding authorisation, booking, timesheet verification and reporting. Monthly monitoring of retrospective shifts, agency spend and breaches of control processes provides ongoing assurance, while divisional management teams play an active role in scrutinising temporary staffing utilisation. These arrangements represent a mature control environment and demonstrate a clear commitment to minimising avoidable agency expenditure.



This framework area contains 25 controls: 24 Green, 1 Amber and 0 Red.

Within action 5.6.2. there is a suggestion that organisations should “Consider options for contract terms that enables the organisation to offer substantive role after x months use:- e.g. offer locums a suitable package to convert from locum to substantive contracts”. This option has been considered however no distinct “policy” was agreed as suitable. This is because it may be beneficial to retain a temporary contract as a least cost versus increasing fixed WTE. Especially in cases where demand has a foreseeable end date aligning with the fixed contract.

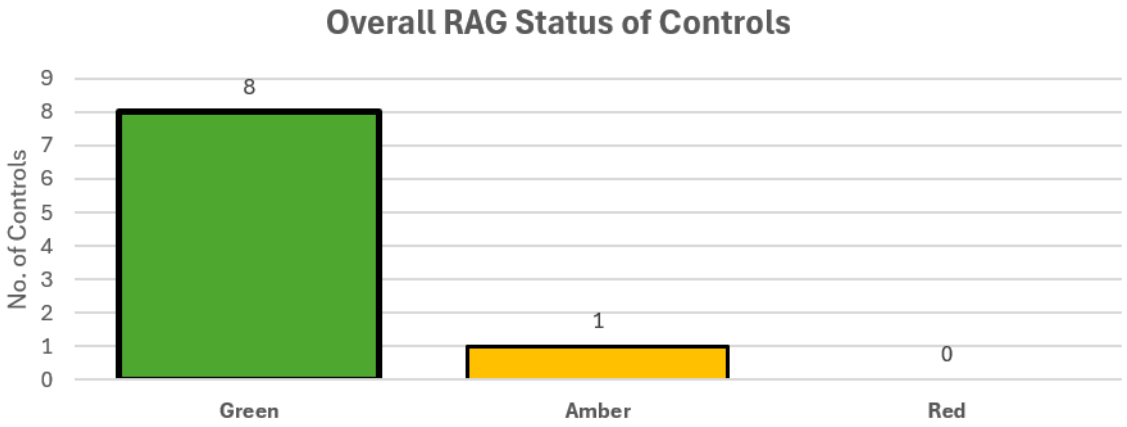
Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
5.6.2 Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use:- e.g. offer locums a suitable package to convert from locum to substantive contracts	5.6 Effective monitoring	Amber	ABUHB QlikSense provides Agency and Bank information costs. But does not yet give insight into key metrics such as length of contract or daily rate/cost per hour. This could be improved therefore.	Include Agency and Bank analysis in the monthly Grip and Control report. Implement amendments to data within QlikSense to allow greater scrutiny of Agency and Bank costs.

Theme 6 - People Costs – Other Staff Payments

The Health Board has established arrangements governing overtime, additional sessions, enhanced payments and other workforce-related expenditure. Financial governance controls provide clear authorisation requirements and support scrutiny of expenditure outside normal payroll arrangements. Workforce and financial performance monitoring arrangements ensure that significant cost drivers are visible and subject to challenge.

A significant strength is the Health Board's use of performance reporting, Qlik-based analytics and management review processes which provide visibility of key workforce expenditure categories. This enables leaders to identify emerging trends, challenge outlier expenditure and maintain oversight of workforce affordability across services.



This framework area contains 9 controls: 8 Green, 1 Amber and 0 Red.

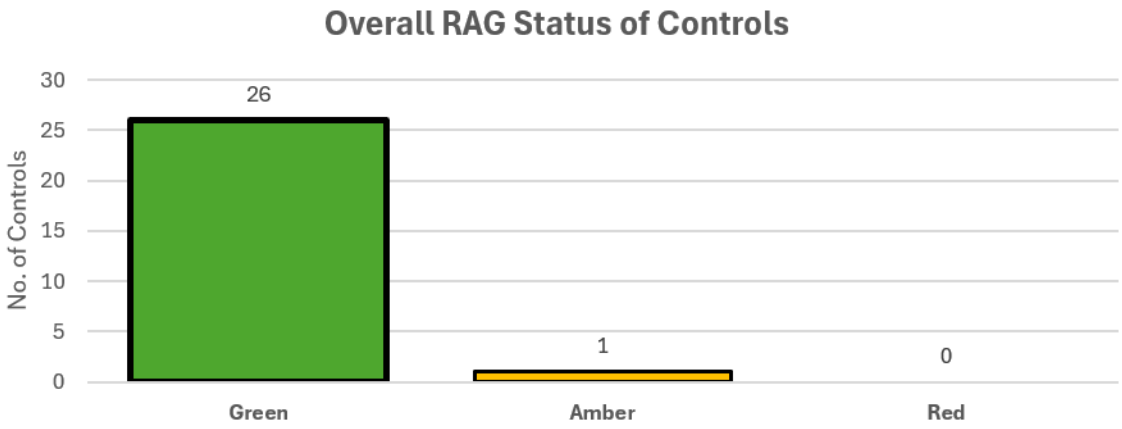
Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
6.2.1 Monthly monitoring of the highest mileage and expenses claimants	6.2 Expenses Monitoring	Amber	Returns indicate that monthly monitoring of the highest mileage and expenses claimants is not currently in place.	Monthly monitoring will be put in place.

Theme 7 - Procurement

The procurement review demonstrated a strong overall control environment with extensive evidence of compliance with procurement regulations, governance requirements and best practice contract management arrangements. Roles and responsibilities are clearly communicated through training and awareness programmes, while Single Tender Actions are subject to formal scrutiny and reporting. Procurement activity is supported by contract registers, tendering procedures, standard terms and conditions and formal contract management processes.

The evidence base demonstrated good practice across the procurement lifecycle, including use of whole-life costing, annual contract reviews, monitoring of expiring contracts, contract management plans and benchmarking activity. Independent assurance is also provided through internal and external audit review, with the AB Local Procurement Internal Audit Report identifying a good level of compliance and no significant control weaknesses.



This framework area contains 27 controls: 26 Green, 1 Amber and 0 Red. It was identified through the review that in the past 12 months a revised VNSB workstream focusing on SLAs has supported the achievement of a number of these controls.

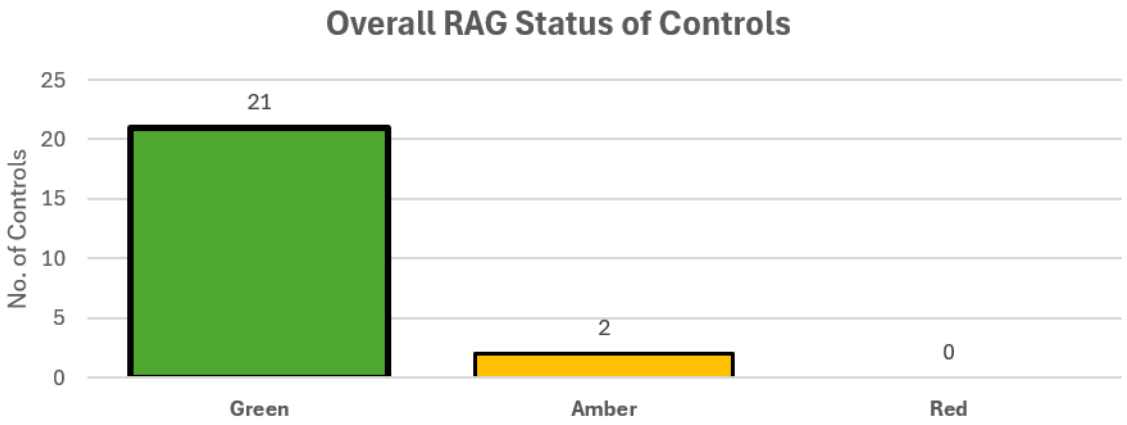
Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
7.6.2 Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale	7.6 Procurement - Other	Amber	ABUHB has established a new FCP (Financial Control Procedure) to specifically target the monitoring of Contract tendering. However Returns indicate limited forward visibility of new contract requirements, with approximately 41% of activity described as unplanned (99 contracts awarded where procurement were engaged post setting the work programme for the year in April). This limits the ability to share a complete pipeline with NWSSP, aggregate demand, plan procurement routes early and secure economies of scale.	Establish a formal rolling contract pipeline process, maintained jointly by Procurement and divisions, to capture upcoming contract renewals, new requirements and likely procurement routes at least 6–9 months in advance. The pipeline should be reviewed routinely with NWSSP and through the relevant internal procurement / financial governance forum, with exceptions reported where requirements emerge late or outside the planned cycle. This should support earlier market engagement, aggregation of demand, improved route-to-market planning and clearer evidence that opportunities for economies of scale have been considered.

Theme 8 - Other Items

The “Other Items” theme demonstrates strong financial stewardship across a diverse range of areas including VAT recovery, debtor management, stock control, estates management, journals, capital and balance sheet governance. Established review mechanisms exist for balance sheet reconciliations, provisions, fixed assets and capital investment decisions, providing assurance over the accuracy and integrity of the Health Board’s financial records.

Evidence also demonstrates mature operational controls in specialist areas. For example, pharmacy procurement arrangements utilise stock holding thresholds, monthly KPI monitoring and supplier verification processes to minimise wastage and secure value for money. Capital governance arrangements include formal business case processes, asset reviews and investment appraisal requirements, ensuring resources are directed to priority areas and aligned with organisational objectives.



This framework area contains 23 controls: 21 Green, 2 Amber and 0 Red.

Amber/Red/Pending controls requiring action

Control	Theme	Overall RAG	Rationale / finding	Next step / control improvement
8.2.1 A NHS visitor and migrant cost recovery programme in place	8.2 Income and Debt management	Amber	An NHS visitor and migrant FCP is in place. During 2025/26 the Health Board raised invoices for Overseas Visitors for £213,591. Of this only £18,540 has been subsequently paid. Therefore whilst there is a policy in place, its effectiveness to ensure robust cost recovery can be challenged.	Review the implementation of the Overseas Patient Policy, including training of outpatients and ward staff to maximise recovery.
8.3.1 Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf life items or use consignment	8.3 Stock Management	Amber	Returns indicate that central assurance is fully compliant. With FCPs clearly requiring: • **"Checks should be carried out on a regular basis to ensure that there is**	Consider stock rotation evidencing within clinical duties at an appropriate frequency.

			no ‘out of date’ stock on the shelves." • **"Where stock has a shelf life the stock should be rotated when restocking."** However, some returns indicating that assurance over this process was incomplete with Divisional, local and ward level stock rotation is 67% fully complaint, 33% partially compliant. Zero not compliant.	

Appendix: RAG definitions

Red: no procedure and not compliant, or a significant control gap requiring priority action.
Amber: procedure or compliance gap requiring strengthening and/or further evidence.
Green: procedure in place and operating with sufficient evidence of compliance.

Archwilio Cymru
Audit Wales

Audit Brief – Structured Assessment

Aneurin Bevan University Health Board

Audit year: 2026

Date issued: August 2026

This document has been prepared for the internal use of Aneurin Bevan University Health Board (the Health Board) as part of work to be performed in accordance with the Auditor General's statutory functions under section 61(3)(b) of the Public Audit (Wales) Act 2004.

No liability is accepted by the Auditor General or the staff of the Wales Audit Office in relation to any member, director, officer or other employee in their individual capacity, or to any third party in respect of this report.

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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.

Contents

Why this is important

1 Our 2026 structured assessment approach has been revised to place a stronger emphasis on effectiveness and impact, recognising the importance of understanding not only what organisations do, but also the difference it makes.

2 Accordingly, our work will focus on the Health Board's 2025-28 Integrated Medium-Term Plan (IMTP). We will consider not only what has been planned and delivered, but also the impact those actions are having on organisational finances, performance and outcomes.

3 This is important because IMTPs and Annual Plans are the main means by which NHS organisations set out how they will deliver their objectives, respond to national priorities and meet their statutory responsibilities. When used effectively, they help organisations translate strategy into action, drive improvement, support financial sustainability and strengthen organisational resilience.

What we will look at

Objective

4 Our objective for this audit is to assess the effectiveness and impact of the organisation's arrangements for planning, delivering and overseeing its 2025-28 IMTP.

Questions

5 This audit will address the overall question: **Is the organisation's 2025-28 IMTP Annual Plan effectively planned, delivered, and achieving its intended outcomes?**

6 **Appendix 1** contains the detailed audit questions.

Scope

7 We are conducting this audit under section 61(3)(b) of the Public Audit (Wales) Act 2004, which requires the Auditor General to satisfy themselves that the organisation has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

8 The Auditor General for Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

9 This audit will cover the following:

- the effectiveness of the organisation's arrangements for planning, delivering and overseeing its 2025-28 IMTP, including whether those arrangements are supporting improvements in financial sustainability, performance, and risk management; and
- progress in implementing outstanding structured assessment recommendations from previous years.

10 The audit will not include the broader assessment of corporate governance arrangements undertaken in previous structured assessments. Instead, governance arrangements will be considered through the lens of how effectively they support the development, delivery, monitoring and achievement of the organisation's 2025-28 IMTP.

11 As part of our fieldwork, we will also gather high-level intelligence on the Board's oversight of hosted bodies and joint committees (where relevant) to inform our broader understanding of these arrangements. No formal assurance or reporting will be provided on this work.

Criteria

12 Our audit criteria set out what good looks like and provide the basis for assessing the effectiveness and impact of the organisation's arrangements for planning, delivering and overseeing its 2025-28 IMTP.

13 The criteria are drawn from the NHS Wales Planning Framework 2025-2028 and related Welsh Government planning guidance and directions, alongside relevant statutory requirements, national policy, previous Auditor General review findings, and recognised good practice in planning, delivery, oversight and governance.

14 **Appendix 1** shows how the criteria relate to the audit questions.

How we will do our work

Methods

15 The audit will use the following methods:

- **Document review** - including the plan and supporting strategies, planning assumptions and modelling, Board and committee papers, risk management documents, integrated performance and financial reporting, and delivery monitoring information. We will seek to use documents available in the public domain wherever possible and will agree any additional document requirements as part of setting up the fieldwork.
- **Interviews** - with relevant Board members and officers. We will agree participants as part of setting up the fieldwork and arrange interviews at dates and times that are convenient for those participants. Interviews will normally be conducted virtually, although we may hold them in person where there is a particular need to do so.
- **Observation** - of relevant Board and committee meetings falling within the fieldwork period.
- **Data analysis** - of relevant performance, workforce and financial data associated with the planning, delivery and monitoring of the 2025-28 IMTP.

Language

16 Please let us know the language preferences (Welsh or English) of those involved in the audit. We will try our best to accommodate these preferences if informed when setting up fieldwork.

Reporting our findings

17 The audit will produce the following output:

- report (evaluative)

18 When we issue our final audit output, we will ask you to respond to our findings and recommendations. We will provide you with a Management Response Form (MRF) where you can set out your organisation's intended response to each recommendation.

19 To comply with our Code of Audit Practice, audit teams must:

- review your organisation's response; and
- state to the relevant oversight committee[1] whether they are satisfied that the audit findings and recommendations have been properly considered.

20 If we are not satisfied, we will make officers aware of our concerns. This will allow you to consider what changes might be needed.

21 If, following this, we are still not satisfied that the findings and recommendations have been properly considered, the Code of Audit Practice requires us to make that known to the relevant committee when it meets to receive the audit output and MRF.

[1] For example, Governance and Audit Committee, Audit and Risk Committee.

Timetable

22 **Exhibit 1** shows the high-level timetable of the main audit stages.

Exhibit 1: audit timetable

Stage	Date
Issue final audit brief	September 2026
Issue draft output	November 2026
Issue final output	December 2026

Audit Wales contacts

23 **Exhibit 2** sets out the Audit Wales team that will be working on this audit.

Exhibit 2: Audit Wales contacts

Name	Contact details
Audit Director	Tom Haslam
Audit Manager	Andrew Doughton
Audit Lead	Sara Utley
Senior Auditor	David Murphy

Appendices

1 Audit questions and criteria

Is the organisation's 2025-28 Integrated Medium-Term Plan (IMTP) Annual Plan effectively planned, delivered, and achieving its intended outcomes?

1.1 Is the plan realistic, focused, and well-founded?
1.1.1 Does the plan set out a clear, realistic and prioritised ambition? • The plan is based on a clear assessment of key challenges and opportunities facing the organisation, aligned to relevant Welsh Government priorities and frameworks (e.g. A Healthier Wales, the NHS Wales Planning Framework), and to the organisation's long-term strategy (including clinical services plan, where relevant), and well-being objectives. • Plan priorities are focused and supported by clear trade-offs and decisions that align resources to priority outcomes and deliverable commitments, with measurable success indicators that show whether the desired outcomes are being achieved. • Plan priorities, assumptions, resource allocation decisions, and / or delivery approaches were influenced by stakeholder input and feedback.
1.1.2 Is the plan to deliver the ambition coherent, evidence-based and realistic? • Key assumptions and forecasts (e.g. financial, workforce, activity) are explicit, realistic, based on robust data and trend analysis, and tested against prior delivery performance where relevant. • Actions are specific, measurable, achievable, assigned to accountable owners, time-bound, and linked to root causes and intended outcomes. • Dependencies and drivers outside the organisation's direct control (including reliance on local, regional and national partners) are explicitly identified, assessed for likelihood and impact, and supported by realistic mitigation, escalation, or influence arrangements that are reflected within delivery arrangements. • Financial, workforce, service and risk plans are internally consistent, based on common assumptions and support a coherent planning narrative.

1.1.3 Has the organisation demonstrated that it has the capacity, capability and resources to deliver the plan?

- The organisation has demonstrated that sufficient capacity, capability and delivery arrangements are available to deliver planned change alongside business-as-usual activities.
- Sufficient financial, workforce, operational and programme-management capacity is available and aligned to delivery requirements, with funding identified and secured.
- Financial, workforce and other delivery gaps are quantified and supported by defined mitigation or contingency arrangements.
- Accountability and escalation arrangements are clearly defined at strategic, programme, and operational levels, with named accountable owners for key actions and programmes and arrangements to drive delivery at operational level.

1.1.4 Was the plan properly scrutinised, challenged, and shaped by learning prior to approval?

- The Board provided robust, documented challenge of assumptions, realism, trade-offs, deliverability and strategic alignment prior to approval.
- The approval trail demonstrates that Board challenge and external feedback, including Welsh Government feedback, resulted in substantive changes to priorities, assumptions, trajectories or resource allocation.
- The organisation can demonstrate how learning from prior plan delivery, external reviews (e.g. GIRFT and commissioned reviews) and audit findings resulted in specific changes to priorities, assumptions, trajectories, resource allocation, or delivery approaches.

1.2 Is the organisation delivering its plan at the pace and scale required?

1.2.1 Are planned actions and milestones being delivered?

- Progress is systematically tracked against clearly defined actions and milestones, using agreed delivery measures and timescales.
- Delivery status is clear, consistent and transparent, including actions and milestones that are at risk, delayed or not expected to be achieved.
- Slippage is identified promptly, with clear root causes and quantified impact on delivery plans, timescales and dependencies.

1.2.2 Are delivery risks, dependencies and underperformance identified and actively managed?

- Delivery risks, interdependencies (including partners), emerging issues and significant in-year pressures or unexpected events are actively monitored, escalated and managed, with evidence that management action has reduced risk exposure or improved delivery confidence.

- Variances against planned delivery, performance or financial trajectories trigger timely and proportionate corrective action with clear accountability.
- Ineffective actions are reprioritised, redesigned or stopped where necessary, with a focus on addressing the underlying delivery issue.
- Accountability for delivery operates consistently across executive and operational levels, not only at Board level.

1.2.3 Is delivery achieving planned outputs, outcomes and trajectories?

- Delivery is assessed against achievement of planned outputs, outcomes and trajectories, rather than solely completion of activities and milestones, with a clear distinction between deliverables produced and the improvements they are intended to achieve.
- Pace and scale of implementation are sufficient to achieve planned outputs, intended performance improvements and financial recovery trajectories.
- Delivery reporting demonstrates whether management actions are achieving their intended outputs and outcomes.
- Gaps between planned outputs, outcomes and trajectories are identified, quantified and addressed.
- Plans are actively adjusted in response to performance, risks, in-year pressures or changes in external conditions.

1.2.4 Is delivery monitored with effective oversight, assurance, and accountability?

- The Board receives integrated, timely reporting covering finance, performance, workforce, quality and risk, with monitoring applying to all key plans and priorities (including any not yet formally approved) so gaps in approval do not become gaps in oversight.
- Reporting maintains a clear golden thread from plan, through delivery, to outputs, outcomes and impact.
- Monitoring provides timely identification and escalation of delivery risks, significant variances and emerging threats to planned outcomes, including financial sustainability.
- Governance arrangements ensure timely escalation, effective scrutiny, visible accountability, appropriate use of independent assurance sources, and that agreed corrective actions are monitored through to completion.
- Reporting includes an explicit assessment of confidence in achieving planned outputs, outcomes and trajectories.
- Reporting and governance arrangements support the identification, capture and use of learning from delivery, including informing future planning, decision-making and improvement activity.

1.3 Is plan delivery achieving intended outcomes and measurable improvements?

1.3.1 Is financial sustainability improving?

- The organisation is operating within available resources, or making demonstrable progress towards recurrent financial balance, in line with planned trajectories.
- Financial reporting clearly distinguishes between underlying financial sustainability and in-year performance, with improving trends in financial control indicators (e.g. variance to plan, run-rate and forecast outturn).
- Improvements are demonstrably linked to delivery of planned actions, with a clear distinction between recurrent and non-recurrent measures and reducing reliance on the latter.
- Financial risks and cost pressures are identified, monitored and actively managed, with any shortfall against plan quantified and addressed.

1.3.2 Is performance improving in priority areas?

- There is sustained improvement in key performance indicators aligned to organisational priorities, rather than isolated or short-term gains, taking account of significant in-year pressures or unexpected events where relevant.
- Where performance is below expected levels, documented improvement plans with specific actions, named accountable owners and realistic timelines are in place, regularly monitored and reported, and demonstrating measurable improvement.
- Improvements reduce unwarranted variation across services, sites or populations where appropriate.
- Reporting clearly distinguishes between activity, outputs and outcomes, with improvements demonstrably attributable to actions taken.
- Patient, service-user and staff feedback is used alongside performance data to identify improvement priorities and inform actions.

1.3.3 Are key strategic and corporate risks reducing?

- Plan delivery is demonstrably reducing key strategic and corporate risks.
- Underlying causes of key risks are being addressed through delivery of planned actions rather than repeatedly managed through short-term mitigations.
- Risk reduction is consistent with planned trajectories and delivery expectations.
- Where planned reductions in risk have not been achieved, the reasons are understood and supported by revised delivery actions.

1.3.4 Is delivery improving financial sustainability and performance without harming quality and safety?

- Financial sustainability and performance improvements are not achieved at the expense of quality, safety or patient / service user experience.
- Quality, safety and patient experience indicators are stable or improving alongside financial sustainability and performance and are routinely reported to support oversight.
- Delivery of planned actions, including savings and service changes, has not adversely affected quality, safety or patient / service-user experience.

1.3.5 Has the organisation learned from plan delivery and used that learning to improve future planning and delivery?

- The organisation has systematically identified and evaluated lessons from plan delivery, including successes, shortfalls, stakeholder feedback, audits, reviews and other sources of assurance.
- Learning from plan delivery has informed subsequent planning and delivery arrangements, including changes to priorities, assumptions, governance, resource allocation, monitoring or delivery approaches where appropriate.
- The organisation can demonstrate that learning has resulted in tangible improvements to tangible improvements to planning, oversight, resource allocation, risk management or delivery capability.

2 Fair processing notice

This privacy notice tells you about how the Auditor General for Wales (AGW) and staff of the Wales Audit Office (WAO) process personal information collected in connection with our work.

Who we are and what we do

The AGW's work includes examining how public bodies manage and spend public money, and the WAO provides the staff and resources to enable him to carry out his work. "Audit Wales" is a trademark of the WAO and is the umbrella identity of the AGW and the WAO.

The purposes of the processing

We will use personal data when exercising our powers and duties, which chiefly concern the audit of public bodies and activities to support such work.

Data Protection Officer (DPO)

Our DPO can be contacted by telephone on 029 2032 0500 or by email at infoofficer@audit.wales.

Relevant laws

We process your personal data in accordance with data protection legislation, including the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR). Our lawful bases for processing are the powers and duties set out in the Public Audit (Wales) Acts 2004 and 2013, the Government of Wales Acts 1998 and 2006, the Local Government (Wales) Measure 2009, the Well-being of Future Generations (Wales) Act 2015, the Local Government & Elections (Wales) Act 2021 and various legislation establishing particular public bodies, such as the Care Standards Act 2000.

Further details are available in our publication, A guide to Welsh public audit legislation, which is available on our website.

Depending on the particular power or function, these statutory bases fall with Article 6(c) and (e) of the UK GDPR—processing necessary for compliance with a legal obligation, for the performance of a task carried out in the public interest or in the exercise of official authority.

Where we process special category data, the additional legal basis for processing this will ordinarily be Article 9(2)(g) of the UK GDPR (together with paragraph 6 Schedule 1 Data Protection Act 2018) relating to the exercise of a statutory function for reasons of substantial public interest.

How we obtain your personal data

The personal data that we collect and process as part of our work may be obtained from you directly (e.g. if we contact you to ask you specific questions or for further information in connection with our work), or from relevant bodies, including those that we are auditing, through the exercise of the Auditor General's access rights.

Who will see the data?

The AGW and relevant WAO staff, such as the study team, will have access to the information you provide. Your data may be shared internally within Audit Wales for the purposes described in this notice.

Our published report may include some of your information, but we will contact you before any publication of information that identifies you—see also "your rights" below.

We may share information with:

- Senior management at the audited body(ies) as far as this is necessary for exercising our powers and duties;
- Certain other public bodies/public service review bodies such as the Office of the Future Generations Commissioner, Care Inspectorate Wales (Welsh Ministers), Health Inspectorate Wales (Welsh Ministers), Estyn and the Public Services Ombudsman for Wales, where the law permits or requires this, such as under section 15 of the Well-being of Future Generations (Wales) Act 2015.

In line with initiatives to drive artificial intelligence (AI) adoption across the public sector and explore potential efficiency savings, AI may be utilised in the processing of personal data in accordance with our Artificial Intelligence and Digital Initiatives Policy. This includes note-taking and summarisation of data, but AI will not be used to make solely automated decisions.

We may produce an automated transcript of meetings and utilise M365 Copilot on the data produced. M365 Copilot is an AI-powered assistant built on large language models (LLMs) and integrated into Microsoft's suite of applications. The M365 Copilot tool follows all of Audit Wales' security policies.

How long we keep the data

We will generally keep your data for 6 years, though this may increase to 25 years if it supports a published report—we will contact you before any publication of information that identifies you—see also "your rights" below. After 25 years, the records are either transferred to the UK National Archive or securely destroyed. In practice, very little personal information is retained beyond 6 years.

Our rights

The AGW has rights to information, explanation, and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006, section 52 Public Audit (Wales) Act 2004, section 26 of the Local Government (Wales) Measure 2009 and section 98 of the Local Government & Elections (Wales) Act 2021. Further information can be found in our Access Rights leaflet available on our website. It may be a criminal offence, punishable by a fine, for a person to fail to provide information that falls within the AGW's access rights, but such an offence does not apply to surveys of the general public, which are not conducted using the statutory access rights above.

Your rights

You have rights to ask for a copy of the current personal information held about you and to object to data processing that causes unwarranted and substantial damage and distress.

To obtain a copy of the personal information we hold about you or discuss any objections or concerns, please write to the Information Officer, Wales Audit

Office, 1 Capital Quarter, Tyndall Street, Cardiff, CF10 4BZ or email infoofficer@audit.wales. You can also contact our Data Protection Officer at this address.

You may also contact the Information Commissioner's Office to obtain further information about data protection law, or to complain about how your personal data is being handled at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, or by email at casework@ico.gsi.gov.uk or by telephone 01625 545745.

Audit Wales
1 Capital Quarter, Tyndall Street
Cardiff, CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Vaccination Programme

Final Internal Audit Brief

Aneurin Bevan University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Introduction

The Welsh Government's vision for the future of immunisation programmes in Wales is the high uptake of effective, sustainably delivered vaccines administered at the right time, to reduce mortality and morbidity.

The National Immunisation Framework (NIF)[1], launched in October 2022 by the Minister for Health and Social Services, builds on lessons learned from the COVID vaccination programme. It requires health boards to develop vaccination equity strategies that clearly outline how inequities in access and uptake are being actively addressed. In May 2024 the Minister reaffirmed Welsh Government's commitment to ensuring equitable access to vaccinations for every citizen in Wales as a core priority[2].

In response, Aneurin Bevan University Health Board (the Health Board) has produced the Public Health Annual Report which focuses on vaccinations and having the conversation to build trust and confidence within Gwent Communities, providing them with the knowledge to make informed decisions about vaccinations. The Health Board is focusing on *The Big Gwent Vaccination Conversation* which is part of a wider programme of engagement that will shape the Vaccine Equity Strategy and the Campaign Strategy for the region.

Scope, Risks & Approach

Scope	To evaluate the processes in place to monitor and promote the uptake of vaccinations and immunisations amongst the public. We will test the following objectives against a sample of vaccination / immunisation programmes: 1. To assess whether the Health Board has appropriate strategic and operational plans in place to improve vaccination uptake and reduce inequalities. 2. To determine whether appropriate governance, accountability, resources and performance monitoring/ reporting arrangements are in place to support the effective delivery of strategic/ operational plans to the Board. 3. To evaluate whether the Health Board works effectively with partners and the community to promote vaccination uptake, particularly amongst vulnerable and underserved communities.
Associated risks	• There is a risk that unclear plans, weak oversight, limited resources, poor data and access barriers may hinder vaccination uptake. • Ineffective communication, limited collaboration, and failure to learn from past programmes could further reduce effectiveness. • These issues may lead to reputational damage for the Health Board and Welsh Government, negatively impact population health and wellbeing, and increase pressure on health services.
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.

[1] National Immunisation Framework for Wales
[2] Statement by the Cabinet Secretary for Health and Social Care

	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
Access to information, records and correspondence	Access to information, documents and correspondence to support this review, is requested in accordance with the following: The Audit Committee has approved the Internal Audit Mandate and Charter reference 10.1: *'Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.'* The Health Board has approved Standing Financial Instruction 3.2.2: *'The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:* *a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;'*
Link to Health & Care Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Tracy Daszkiewicz	Executive Director of Public Health
	William Beer	Consultant in Public Health
	Anna Morgan	Deputy Head of Public Health
	Shannon Cuthbertson	Principal of Intelligence (Public Health)
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Rhian Gard	Audit Manager
Indicative timings	Fieldwork	August 2026
	Debrief meeting	September / October 2026
	Audit Committee	T.B.C
Brief agreement	Tracy Daszkiewicz, Executive Director of Public Health 08.07.2026	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Policy Management

Final Internal Audit Brief

Aneurin Bevan University Health Board

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

Introduction

Aneurin Bevan University Health Board (the Health Board) has a statutory responsibility to maintain appropriate Written Control Documents (WCDs), including policies, procedures, protocols, and guidelines. A robust policy framework is essential to ensure clinical and non-clinical activities are delivered consistently, safely, and in compliance with legislative and regulatory requirements.

In line with the Health Board's Risk Management and Assurance Framework and the Three Lines of Defence Model, policies are a key element of the second line of defence, providing staff with the governance, guidance, and controls necessary to support effective risk management, compliance, and organisational assurance.

The audit will be cognisant of the findings and conclusions from the 2022/23 Limited Assurance review to determine whether agreed actions have been implemented and appropriate progress made.

Scope, Risks & Approach

Scope	To ensure the policy management arrangements at the Health Board are effective and consistently applied to support compliance and governance – reflecting on recommendations raised at the Limited assurance report issued in 2022/23. Objectives of the area under review: 1. Clear, up to date guidance is available to staff, setting out responsibilities for the development, approval, implementation and management of policies. 2. Policies are subject to appropriate review, consultation, and formal approval prior to issue, ensuring quality, compliance and alignment with the Health Board's objectives. 3. Appropriate arrangements are in place to ensure policies are centrally managed, published consistently and reviewed within required timescales.
Associated risks	• Policies may become outdated and misaligned with organisational objectives due to unclear roles and responsibilities • Policies may not be fit for purpose due to insufficient review, challenge, and approval processes • Inconsistent policy management arrangements may result in variation in practice across the Health Board • Poor accessibility and awareness of policies may lead to non-compliance with legislative, regulatory and organisational requirements
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
Access to information,	Access to information, documents and correspondence to support this review, is requested in accordance with the following:

records and correspondence	The Audit Committee has approved the Internal Audit Mandate and Charter reference 10.1: *'Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.'* The Health Board has approved Standing Financial Instruction 3.2.2: *'The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:* *a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;'*
Link to Health & Care Quality Standards	This review may contribute towards assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Rani Dash	Director of Corporate Governance
	Bryony Codd	Head of Corporate Governance
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Rhian Gard	Audit Manager
Indicative timings	Fieldwork	October 2026
	Debrief meeting	November 2026
	Audit Committee	T.B.C
Brief agreement	Rani Dash, Director of Corporate Governance 15.07.2026	

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Value & Sustainability

Final Internal Audit Brief

Aneurin Bevan University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Introduction

Achievement of savings targets is critical for the Health Board to meet its statutory duty to break even. Consistent with the national approach, savings identification, reporting and monitoring has been developed through a Value and Sustainability model to develop transactional and transformational schemes.

The 2026/27 financial plan submitted by the Health Board to Welsh Government (March 2026), identified £45m savings and opportunities as followed:

- Identified savings schemes - £13.3m.
- Identified Health Board level savings opportunities with work to be undertaken to attribute to specific divisional schemes - £14.6m.
- Pipeline opportunities not yet identified - £17m.

Scope, Risks & Approach

Scope	To review the activity of the Value & Sustainability Board (and supporting workstreams) and the approach to savings identification, reporting, monitoring and delivery. Objectives of the area under review: 1. Governance & Accountability: There is a clear governance and accountability framework over the Health Board's savings programme. 2. Savings Identification & Planning: A robust pipeline of savings opportunities is developed, appraised and converted into deliverable, approved plans. 3. Monitoring: Savings plans are subject to robust, ongoing monitoring.
Associated risks	• Failure to achieve required savings. • Failure to meet the statutory duty to break even. • Adverse impact on quality and safety.
Limitations to scope	The audit will focus on the activities of the Health Board's Value & Sustainability Board and its workstreams. We will not review divisional savings activity.
Approach	The approach to audit assignments is risk based, where the risks are identified with management. Controls are identified to manage those risks and the assignment scope is designed to provide assurances on those issues. Additionally, we reserve the right to liaise with Audit Wales, Welsh Government or any other parties pertinent to the review. Assurance opinions and action plan risk ratings
Link to Health & Care Quality Standards	This review may contribute towards assurance over the following Health & Care Quality Standards:

Quality Domains	Quality Enablers
Safe; Timely; Effective; Efficient; Equitable; Person centred	Leadership; Information; Whole systems approach

Contacts & Timings

Client contacts	Robert Holcombe	Director of Finance, Procurement & Value
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
	Emma Rees	Audit Manager
Indicative timings	Fieldwork	August – September 2026
	Debrief meeting	October 2026
	Audit Committee	November 2026
Brief agreement	Robert Holcome, Director of Finance, Procurement & Value 5th August 2026	

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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Patient Experience

Final Internal Audit Brief

Aneurin Bevan University Local Health Board

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

Introduction

Patients and carers have the right to respectful, professional care that protects privacy and upholds dignity. High-quality care, underpinned by appropriate standards, should be a fundamental expectation in every care setting.

The Welsh Government's *NHS Wales People's Experience Framework* provides a national approach for assessing and improving how health and care organisations listen to, learn from and act on people's feedback. The framework promotes continuous feedback, the use of the People's Experience Survey (PES), and organisational self-assessment tools to support service improvement and the delivery of safe, effective and person-centred care.

Scope, Risks & Approach

Scope	To review the arrangements and processes in place within the Health Board for capturing and utilising patient experience. Objectives of the area under review: 1. To assess whether the Health Board has an effective Patient Experience Strategy that sets out its approach to capturing, learning from and acting on patient feedback and experiences. 2. Appropriate mechanisms and resources are in place for the collation and analysis of patient experience, with the identification of trends and themes and the triangulation to other types of data including complaints, concerns and incidents. 3. To determine whether patient feedback is effectively used to drive service improvement, with evidence of actions taken and good practice shared across the organisation. 4. Patient experience is monitored and reported to the Board (or appropriate sub-committee) to provide assurance that the key components of the service user experience are being assessed, and that action is taken to deliver improvements.
Associated risks	Patient feedback is not captured, reviewed or acted on, potentially resulting in: • Reputational damage due to negative patient experience; and / or • Harm to patients.
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
Access to information, records and correspondence	Access to information, documents and correspondence to support this review, is requested in accordance with the following: The Audit Committee has approved the Internal Audit Mandate and Charter reference 10.1: *'Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to*

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Link to Health & Care Quality Standards	This review may support assurance over the Health & Care Quality Standards.

Contacts & Timings

Client contacts	Jenny Winslade	Executive Director of Nursing
	Tanya Strange	Head of Nursing Person Centred Care
	Joanne Hook	Senior Nurse – Patient Experience Corporate Services
Audit & Assurance contacts	Stephen Chaney	Head of Internal Audit
	Eifion Jones	Deputy Head of Internal Audit
Indicative timings	Fieldwork	August / September 2026
	Debrief meeting	September 2026
	Audit Committee	T.B.C
Brief agreement	Jennifer Winslade, Executive Director of Nursing 11.08.26	

Audit and Assurance Services conform with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 September 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 there have been no adjustments made to the agreed forward work programme.

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 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:	N/A

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

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

ANNUAL PROGRAMME OF BUSINESS 2026/27

AUDIT, RISK & ASSURANCE COMMITTEE

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

- Aneurin Bevan University Health Board's Standing Orders;
- The discharge of the business needs of the individual Directorates
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee self-assessment for 2025 and the Structured Assessment 2025 recommendations
- The Board's Assurance Framework and Corporate Risk Register; and
- Key statutory, national, and best practice requirements and reporting arrangements.

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

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

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

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

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	19th May 2026 *Draft Accounts*	23rd June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Preliminary Matters								
Attendance and Apologies	**SI**	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2025/26	**An**	Chair & DofCG						√
Review of Committee Programme of Business	**SI**	Chair	√	√	√	√	√	
Annual Review of Committee Effectiveness 2024/25 to include a review of the Terms of Reference	**An**	Chair & DofCG	√					
Committee Annual Report 204/25	**An**	Chair & DofCG	√					
Corporate Governance, Risk & Assurance								
Review and report upon the adequacy of arrangements for declaring, registering, and handling interests	**An**	DofCG					√	
Receive full report of all offers of gifts and hospitality as declared	**An**	DofCG					√	
Compliance with Ministerial Directions and Welsh Health Circulars (WHC)	**BI**	DofCG		√**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 *(May report will be included in the Accounts)*	**BI**	DofF&P	√	√			√	
To Approve Reviewed and Updated Financial Control Procedures	**Ad hoc**	DofF&P	√		√	√	√	
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	**An**	DofCG						√
Review the Health Board's Annual Report (Overview & Performance Section) **(Part 1)**	**An**	DofCG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement **(Part 2)**	**An**	DofCG		√	√			
Review Draft/Final Annual Accounts and Financial Statements **(Part 3)**	**An**	DofF&P		√	√			
Audit Enquiries to those charged with Governance and Management	**An**	DofF&P		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	**An**	AW			√			
Final Annual Accounts Memorandum	**An**	AW					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	**An**	HofIA			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	**An**	Chair			√			
Counter-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy *(**Feb 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					√	
Undertake a review of outstanding clinical audit actions, including those from previous years	**An**	Medical Director					√	
To develop and share with the Committee a Local (Corporate) Clinical Audit Plan for Approval	**An**	Medical Director					√	
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	**An**	HoflA	√					
Receive Internal Audit Progress Report	**SI**	HoflA	√	√	√	√	√	√
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**SI**	HoflA	√	√	√	√	√	√
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**An**	HoflA with Chair	√					
Input clear numerical implementation dates against recommendations in the Capital Projects Report.	**SI**	HoflA			√			
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**	HoflA			√			
Satellite Radiotherapy unit internal audit paper	**SI**	HoflA			√ **D**	√		
External Audit – Audit Wales								

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2025/26					
			Quarter 1			Quarter 2	Quarter 3	Quarter 4
			28th April 2026	19th May 2026 *Draft Accounts*	23rd June 2026 *Final Accounts*	15th Sept 2026	24th November 2026	11th Feb 2027
Receive the External Audit Annual Audit Report	**An**	AW		√	√			
Agree the External Audit Annual Plan	**An**	AW	√					
Receive the 2026 Structured Assessment	**An**	AW					√	
Receive External Audit Progress Report 2025-26	**SI**	AW	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	**Ad hoc**	AW						
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Ad hoc**	AW						
Additional Papers/Actions								
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
HoR&A	Head of Risk and Assurance
HofCF	Head of Counter Fraud

Frequency of Inclusion Key	
SI	Standing Item
AN	Annually
BI	Biannually
Quarterly	Quarterly

PPV	Post Payment Verification
HoflA	Head of Internal Audit
AW	Audit Wales
Chair	Chair

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