Management of Nationally Reportable Incidents

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

Reasonable Assurance

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Review Reference	SBU-2526-11
Fieldwork	November - December 2025
Executive Sign Off	20 January 2026
Audit Committee	12 March 2026
Executive Lead	Liz Rix, Executive Director of Nursing and Patient Experience
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place for the identification, recording, management and reporting of nationally reportable incidents (NRIs).

Overview

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011), amended in 2023, sets out how NHS trusts and health boards in Wales manage concerns arising from patient safety incidents, complaints, or claims.

The 'Putting Things Right' (PTR) process governs reporting, investigation, and learning, supported by Welsh Government guidance. In 2023, the National Policy on Patient Safety Incident Reporting and Management replaced the previous Serious Incidents guidance. It standardises reporting across NHS Wales, emphasises the Duty of Candour, mandates use of Datix Cymru, and incorporates Safety-II principles to learn from both adverse and positive outcomes. It also clarifies nationally reportable incidents and joint investigations.

Following 2025 regulatory amendments and the launch of Listening to People (a new NHS Wales complaints system), PTR is being replaced. The new system introduces a two-stage resolution process: (1) early resolution through compassionate engagement and listening; and (2) formal investigation, including liability assessment and potential redress up to £50,000.

Based on the current arrangements, we have concluded **reasonable** assurance in this area. This reflects the presence of established governance structures, clear accountability for reporting and investigation processes, and evidence of ongoing engagement to strengthen compliance with legislative requirements. We also noted positive steps towards improving consistency in investigations and a commitment to learning from incidents, which provide a strong foundation for further enhancements ahead of the April 2026 compliance deadline.

The following matters require management attention:

1. Develop and implement a 'Listening to People' transition plan to ensure readiness for the April 2026 deadline, including policy and template updates, a communication and education strategy, and progress monitoring.
2. There are currently no mechanisms in place to monitor or verify that investigators receive and maintain appropriate training, resulting in limited assurance over investigator competency for NRI investigations.
3. NRI reporting and investigation processes do not consistently adhere to required timelines or procedural standards. Delays and incomplete documentation of key review meetings reduce assurance and impact compliance.
4. Post-investigation action plans are not consistently monitored or linked to specific NRIs, reducing assurance over their implementation and effectiveness.

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

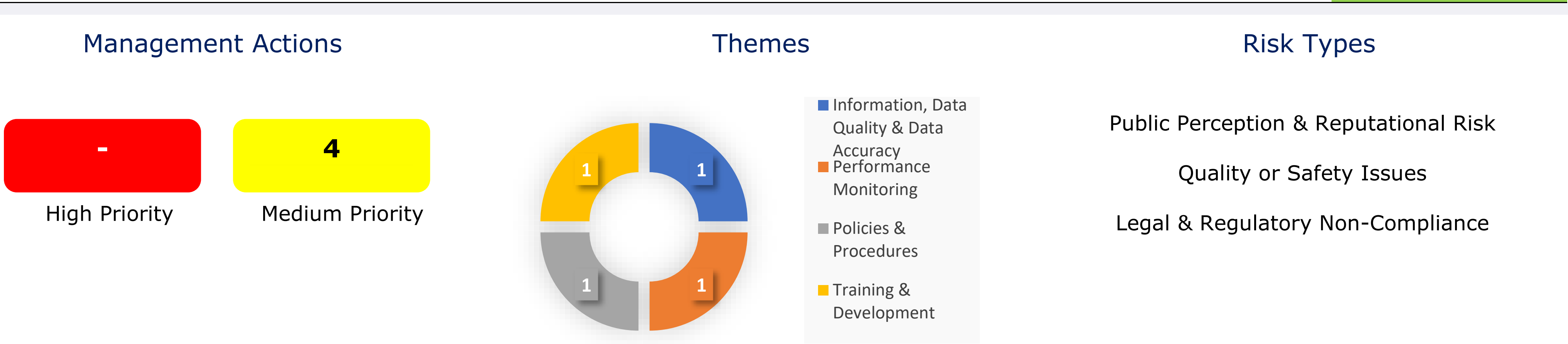
The following area has been recognised as an opportunity for enhancement and does not impact the overall assurance opinion: The health board could consider using AMaT to track recommendations and provide real time visibility of progress, enhancing the monitoring and management of actions following each investigation.

No additional key findings have been raised regarding the dissemination of lessons learned and associated feedback, as similar issues were previously identified and are still being addressed by the health board following the *Learning from Incidents and Concerns* Internal Audit Report 2024/25 (see Objective 4).

Scope & Assurance Summary

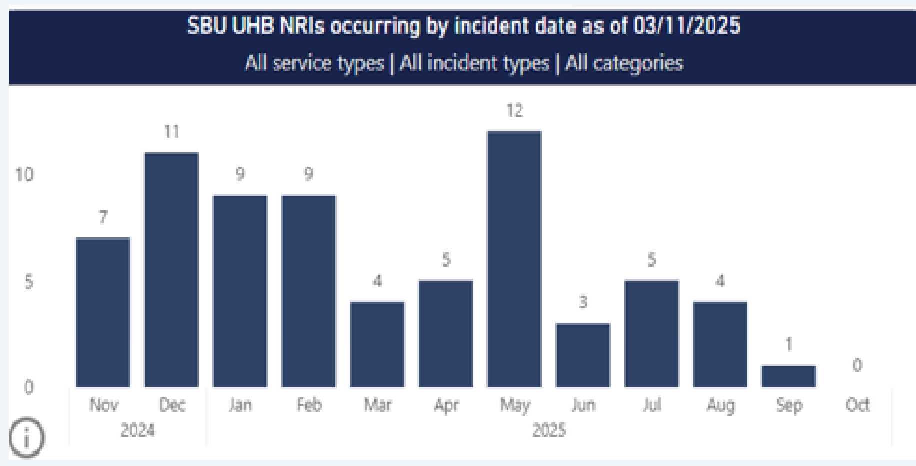
Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

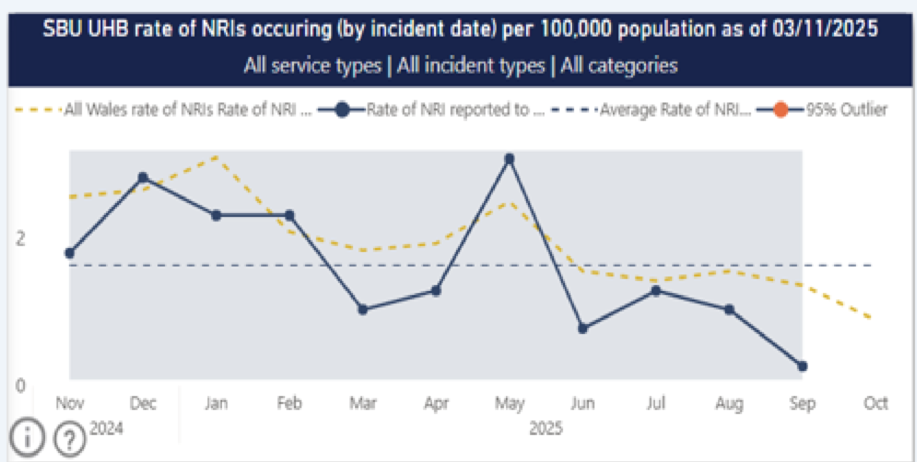
	Objectives	Related Findings	Assurance
1	There is a framework in place for managing NRIs which clearly sets out roles, responsibilities and accountability, and promotes consistent approaches to investigation health board wide.	1	**Reasonable**
2	Staff receive appropriate training to ensure consistent and effective incident investigation and response.	1,2	**Reasonable**
3	NRIs undergo appropriate investigation, including system analysis and evaluation of communication with families and patients, are resolved within a timely and effective manner; and are reported to the Welsh Government in line with established policies and procedures.	2,3	**Reasonable**
4	An appropriate reporting framework is established for NRIs, to ensure that lessons learned are shared across the organisation.	4	**Reasonable**

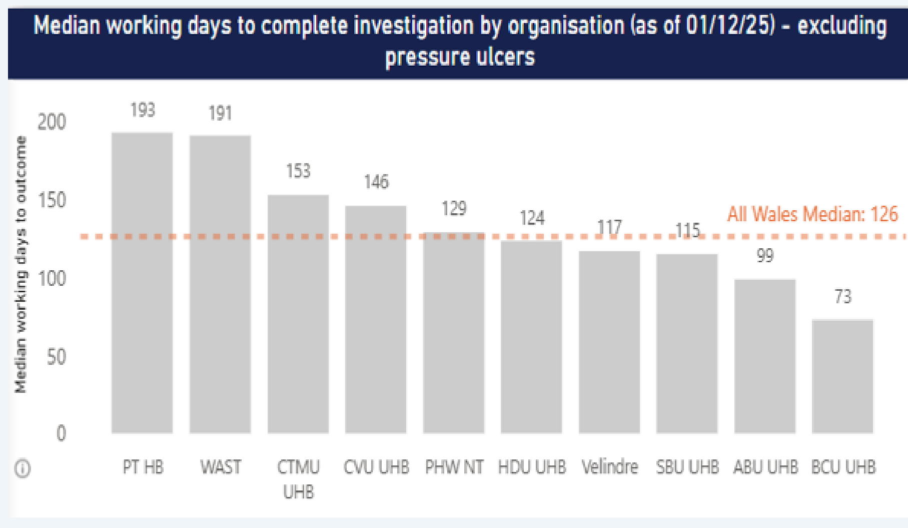


At a Glance: SBUHB NRIs for the last 12 months

The following graphs, extracted from the Beacon Dashboard, present comparative data between the health board and other NHS Wales organisations regarding the reporting of NRIs:







SBU UHB top 10 NRI categories occurring by volume (incident dates between Nov-24 and Oct-25) as of 03/11/2025

NRI category	Total
Neonate	17
Unexpected death	14
Treatment or procedure issues	10
Clinical assessment, clinical diagnosis	6
Pressure ulcer developed or worsened during care in this clinical care area/caseload	5
Self-harm / self-injurious behaviour	4
Access to services or admission delayed	2
Infection outbreak / period of increased incidence	2
Patient injury	2
Absconding or missing patient/service user	1
Administration errors	1
Completion and documentation of patient/service user observations	1
Diagnostic testing - Pathology	1
Medication storage, security and disposal	1
Pressure ulcer present before admission to this clinical care area/caseload	1
Screening and surveillance	1
Slip, trip or fall	1

Findings & Agreed Action Plan

Objective 1: There is a framework in place for managing NRIs which clearly sets out roles, responsibilities and accountability, and promotes consistent approaches to investigation health board wide.	**Reasonable**

Framework

The health board follows the NHS Wales National Policy on Patient Safety Incident Reporting and Management, supported by guidance such as the never events list and joint investigation procedures. This policy is scheduled for update at a national level during the current financial year. Existing toolkits reflect PTR principles but will require revision to ensure alignment with upcoming changes.

Locally, the health board operates under the Concerns Management Policy (August 2025), which adapts PTR guidance and aligns with national standards. This policy defines roles and responsibilities and is supported by approved Standing Operating Procedures (SOPs) accessible via SharePoint which detail the process for reporting and investigating NRIs. Additional resources include patient and staff information leaflets, specialist advisor guidance, and wellbeing materials for staff involved in incidents.

The framework is now in transition following amendments to the *Concerns, Complaints and Redress Arrangements (Wales) Regulations 2025* and the introduction of *Listening to People,* a new NHS complaints system for Wales announced in October 2025. This replaces PTR and will come into effect from 1 April 2026. While the announcement is recent, there is an opportunity for the health board to develop an implementation plan to ensure readiness for this change. Health board policies, templates and investigation processes will need to be updated by the confirmed implementation date (see **Key Finding 1**). Existing PTR cases will continue to be managed under the current rules, while from 1 April 2026, all new complaints will be handled in accordance with *Listening to People*, ensuring fairness and consistency during the transition period.

Investigation Approach

As stated in the policy, NRIs must be reported to the Welsh Government Delivery Unit within seven days under the Oversight and Escalation Framework. Investigations apply Safety-II principles [1], using tools such as the Yorkshire Contributory Factors Framework [2] and data recorded in Datix Cymru. Additionally, the Patient Safety Incident Investigation Team (PSIIT) follows a five-phase protocol from the Serious Incident Management Toolkit, designed to provide a structured and consistent approach for investigations within the organisation, supported by templates that currently reflect PTR principles (family engagement, learning, timeliness). The expectation for governance oversight includes senior clinical sign-off and structured learning dissemination (refer to Objective 4 for further details).

As above, noting the introduction of Listening to People, investigation templates and report processes will need to be updated to reflect the relevant requirements and priorities (see **Key Finding 1**).

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[1] Safety II principles: an approach which assumes that everyday performance variability provides the adaptations that are needed to respond to varying conditions, and hence is the reason why things go right [From Safety-I to Safety-II: A White Paper - NHS England]

[2] Yorkshire Contributory Factors Framework: a human factors-based model that categorises the underlying system and organisational factors contributing to patient safety incidents to identify and address root causes beyond individual error [Yorkshire Contributory Factors Framework - Improvement Academy]

	Key Findings	Risk & Impact	Agreed Management Action
1	**Implementation Planning for *Listening to People*** The health board's framework for managing concerns and complaints is in transition following amendments to the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2025 and the introduction of Listening to People, a new NHS complaints system for Wales announced in October 2025. This approach will replace *Putting Things Right (PTR)* and is scheduled to come into effect from 1 April 2026. While the announcement is recent, there is an opportunity for the health board to begin developing an implementation plan to ensure readiness for this change. Policies, templates, and investigation processes will need to be updated to reflect the new requirements and priorities. Existing PTR cases will continue under current rules, while all new complaints from April 2026 will be managed under Listening to People, ensuring fairness and consistency during the transition period.	Delays in planning for the April 2026 transition to *Listening to People* could result in policies and processes not being updated in time, leading to compliance gaps and inconsistent complaint handling.	**Agreed Action:** Develop and implement a Listening to People transition plan to ensure readiness for the April 2026 deadline. The plan will: 1. Update policies, templates, and investigation processes to reflect new requirements; progress is dependent on national work led by NHS Performance and Improvement which is unlikely to be completed by the implementation date of 1 April 2026. 2. Include a communication and education strategy to raise awareness and embed the principles of the new approach across staff. *3.* Ensure progress is monitored and reported through appropriate governance channels to maintain accountability and timely delivery. **Expected Evidence of Implementation:** 1. Approved implementation plan with timelines, responsibilities, and governance arrangements to be reported into Listening to People Programme Board. 2. Updated policies, SOPs, and investigation templates aligned to Listening to People requirements with updated policies to be approved at Listening to People Programme Board. 3. (a) Communication plan and supporting materials (e.g., staff briefings, intranet updates, FAQs) delivered via Gold Communication Plan; (b) Records of awareness sessions delivered to relevant staff groups delivered via focused events held with each Service Group (with evidence of attendance). *4.* Monitoring reports or dashboards showing progress against milestones and actions – completion of roadmap/implementation plan reported through to Listening to People Programme Board.

Key Findings	Risk & Impact	Agreed Management Action
	Medium Priority	**Officer:** (1&2) Head of Quality, Safety & Improvement/Deputy Executive Director of Nursing & Patient Experience; (3a) Executive Director, DICE; (3b) Head of Concerns Assurance/Head of Quality, Safety & Improvement; (4) Head of Quality, Safety & Improvement/Deputy Executive Director of Nursing & Patient Experience **Target Implementation Date:** (1) 1 March 2026; (2) 1 June 2026; (3a&b) 1 April 2026; (4) 1 October 2026 *It is acknowledged that progress will be dependent on national work led by NHS Performance and Improvement, which is unlikely to be completed by the implementation date of 1 April 2026.*
Theme: Policies & Procedures	Control Design	

Objective 2: Staff receive appropriate training to ensure consistent and effective incident investigation and response.	**Reasonable**

PSIIT staff received formal training in 2021/22 (via Consequence UK). For higher severity NRIs (those resulting in permanent harm or death related, as well as Never Events), investigations are led by a PSIIT member with support from a Clinical and/or Nurse Specialist Adviser. We note that, to date, no concerns have been raised regarding the quality of investigations.

However, refresher tracking and compliance monitoring were not centrally maintained, limiting corporate oversight and assurance that all investigators across the organisation meet required standards (see **Key Finding 2**).

Across wider health board staff groups, training was previously delivered on an ad-hoc basis. While the '*Through a Systems Lens*' session remains accessible via ESR, completion rates have not been routinely monitored. Consequently, assurance cannot be provided that all individuals involved in investigations, but particularly those involved in handling lower-severity NRIs (e.g. fracture of femur falls and grade 3+ pressure ulcers), have received adequate training. Feedback on training is currently collected via handwritten forms, with plans to move to electronic submissions (see **Key Finding 2**).

To address the gaps identified above, a training needs analysis was completed in September 2025. A central register of investigators, including training dates and compliance status, will now be maintained to strengthen oversight.

Looking ahead, the Listening to People guidance will reshape NRI investigations across NHS Wales, requiring the health board to align existing processes (such as Datix Cymru reporting and system analysis) with principles of clarity, empathy, and accessibility (see Objective 1 and **Key Finding 1**). Staff training will be critical to embed this approach.

A standardised training programme will launch in January 2026, aligned with the Listening to People framework and incorporating the Yorkshire Contributory Factors Framework to support a systems-based approach to learning and sustainable improvement. Key features include:

- Three 3.5-hour face-to-face sessions per week for three months (targeting approximately 550 staff, including PSIIT members).
- Pre-reading materials, post-training mentoring, and drop-in sessions for ongoing guidance.
- Attendance will be recorded on ESR, and staff will be expected to complete an investigation within four weeks of training to demonstrate application of learning.

We are advised that the PSIIT will audit investigation reports and provide feedback to ensure consistency and quality, to ensure proportionate allocation based on incident severity, and assurance to the Board regarding investigative capability.

Key Findings		Risk & Impact	Agreed Management Action
2	**Inconsistent Training Oversight and Limited Assurance on Investigator Competency** While PSIIT staff received formal training in 2021/22, refresher tracking and compliance monitoring have not been centrally maintained, limiting corporate oversight and assurance that all investigators meet required standards. Across wider Health Board staff groups, training has been delivered on an ad hoc basis, and although the Through a Systems Lens session remains available via ESR, completion rates are not routinely monitored. Consequently, the Health Board cannot provide assurance that all individuals involved in investigations—particularly those handling lower-severity NRIs—are adequately trained. Plans are in place to address these gaps through a training needs analysis, a central register of investigators, and the introduction of a standardised training programme aligned with the Listening to People guidance.	Without central oversight of training compliance, the Health Board cannot assure investigator competency, increasing the risk of inconsistent investigations and missed learning, which may affect patient safety and organisational reputation.	**Agreed Action:** 1. Create a central investigator register capturing training dates and compliance status for PSIIT and other staff groups. 2. Implement the standardised training programme (launching January 2026) and record attendance on ESR. 3. Introduce routine compliance monitoring and reporting to the Patient Safety & Compliance Group. 4. Move training feedback to electronic format for easier analysis and improvement. 5. PSIIT to audit investigation reports post-training to assure consistency and quality. **Expected Evidence of Implementation:** 1. Investigator Register & Roles: Central register showing names, roles, training dates, with an aim of 85% compliance of available staff with names provided by Service Group in October 2025 reported bi-annually into PSCG via Training Needs Analysis document. 2. Training Delivery & Attendance: Training schedule, ESR attendance reports, and evidence of post-training application to be reported with bi-annual reporting into PCSG via Training Needs Analysis document. 3. Compliance Monitoring via PSCG report feeding into Quality & Safety Group reporting 4. Electronic Staff Feedback of Training: System screenshots and summary analysis of feedback trends via bi-annual reporting into PSCG. 5. Investigation Quality Assurance: PSIIT audit of Service Group NRI reports with documented feedback and corrective actions to Service Groups reporting into PSCG via bi-annual reporting.
		Medium Priority	**Officer:** (1-5) Assistant Head of Concerns Assurance/Head of Concerns Assurance **Target Implementation Date:** (1-5) 31 March 2027
	Theme: Training & Development	Control Operation	

Objective 3: NRIs undergo appropriate investigation, including system analysis and evaluation of communication with families and patients, are resolved within a timely and effective manner; and are reported to the Welsh Government in line with established policies and procedures.	**Reasonable**

Policy Requirements

Under the NHS Wales National Policy on Patient Safety Incident Reporting and Management, health boards must:

- Reporting: NRIs meeting severe harm or unexpected/avoidable death criteria must be reported to the NHS Wales Executive within 7 working days of occurrence or awareness.
- Investigation: Investigations should begin promptly and aim for closure within an agreed timescale, typically 120 working days for most NRIs, or 60 working days for all avoidable pressure damage (grade 3 and above) and avoidable in-patient falls where significant head injury or fracture. Extensions must be justified, documented and approved.
- Governance: Open NRIs must be monitored by Quality & Safety Committees, with progress reported to NHS Wales Executive. Overdue cases are escalated nationally for assurance.

Current Process

Serious incidents typically undergo a case review or strategy meeting to determine whether they meet the NRI threshold. Once confirmed, Service Groups complete a notification form, approved by the relevant Director, and submit it to PSIIT for review and Executive sign-off (e.g. Medical Director / Director of Nursing & Patient Experience).

The PSIIT maintains a central spreadsheet to track NRIs, recording key dates such as incident occurrence, reporting to NHS Executive, strategy meetings, Datix entry, target completion, and outcome submission. Progress is monitored through daily reminders and Service Group meetings (fortnightly for Morriston, Neath Port Talbot, Singleton, and Primary and Community Care and Therapies; monthly for Mental Health & Learning Disabilities). Comparative data indicates the health board performs well against other NHS Wales organisations (refer to data included on page 3, At A Glance).

Performance Position

As of October 2025, the Quality & Safety Committee reported 16 NRI cases of the total 48 recorded for 2025/26, exceeded the 120-day timeline, and 12 remained open beyond closure targets (see **Key Finding 3**). While there are no formal consequences for exceeding timelines, delays impact compliance and family experience. External independent reviews have been commissioned for six cases.

For the period 1 December 2024 to 30 November 2025, a total of 88 NRIs were reported to NHS Wales Performance and Improvement, with 25 led by PSIIT and 63 led by Service Groups. Of these, 58 have been closed and 30 remain open, with 26 (86.7%) of the open cases overdue. Furthermore, of the 58 closed NRIs, 37 (63.8%) were closed after their expected closure date (see **Key Finding 3**).

Detailed testing of a sample of 10 NRIs was undertaken, with the following noted:

- Six incidents were not reported within seven working days, only two had documented reasons recorded on Datix, stating that the incidents were not immediately recognised as NRIs until the Serious Case Review (SCR) had been completed (see **Key Findings 2 & 3**).
- Seven incidents exceeded the expected closure timelines (see **Key Finding 3**), while details regarding the delays (primarily in relation to engagement with the respective Service Groups) were not recorded on Datix, they were documented on PSIIT's master spreadsheet.

- All incidents were appropriately recorded in Datix Cymru, with evidence of initial meetings, witness statements, Welsh Government notifications, and closure reports; timely Strategy Meetings and Serious Case Reviews held where relevant; and patient/family involvement and staff support during investigations in line with Duty of Candour and Just Culture principles.

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="3">3</td><td rowspan="2">Delays in Reporting and Closing NRIs Reduce Assurance and Impact Compliance

While processes for reporting and investigating NRIs are established and generally well-governed, timeliness remains a significant issue. Six of ten sampled incidents were not reported within the required seven working days, and seven exceeded expected closure timelines. At an organisational level, 26 of 30 open NRIs (86.7%) are overdue, and 63.8% of closed cases were completed after their target date. Although delays are documented on PSIIT's master spreadsheet, they are not consistently recorded on Datix as required. These delays, while not subject to formal sanctions, affect compliance with national policy and risk undermining family experience and organisational assurance.</td><td>Delays in reporting and closing NRIs reduce compliance with national policy and weaken organisational assurance. They risk undermining family confidence, delaying learning and improvement actions, and may negatively affect patient safety and the Health Board's reputation.</td><td>Agreed Action:
1. Timeliness Monitoring: Set up alerts for reporting/closure deadlines and ensure delay reasons are recorded on Datix.
2. Governance Oversight: Include overdue NRIs in routine reports and escalate persistent delays to Executive level.
3. Review PSIIT and Service Group capacity and skills, reviewing optimal workforce model to deliver compliance and effective systems for learning.
4. Review organisational SOPs for managing NRIs adopting a QI approach in order to create improvement, to include clarifying where responsibilities for monitoring timeliness will sit and routes for escalation.

Expected Evidence of Implementation:
1. Updated Datix records showing documented reasons for all delays.
2. (a) Compliance dashboards or reports highlighting overdue cases and escalation actions; (b) meeting minutes from monthly Quality & Safety Group and Executive performance reviews discussing NRI reporting and timeliness.
3. Report findings into Quality & Safety Group.
4. Revised SOPs approved in Quality & Safety Group.</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: (1&2) Assistant Head of Concerns Assurance/Head of Concerns Assurance; (3) Head of Quality, Safety & Improvement/Deputy Executive Director of Nursing & Patient Experience; (4) Assistant Head of Concerns Assurance/Head of Concerns Assurance

Target Implementation Date: (1&2) 1 September 2026; (3) 1 December 2026; (4) 31 March 2027</td></tr>
<tr><td>Theme: Information, Data Quality & Data Accuracy</td><td>Control Operation</td></tr>
</table>

Objective 4: An appropriate reporting framework is established for NRIs, to ensure that lessons learnt are shared across the organisation.	**Reasonable**

Internal Reporting - Corporate

Incidents are reported via Datix Cymru and classified as NRIs if they meet national criteria (e.g. death, severe harm, systemic failure). NRIs are escalated internally to Service Group leads and Executive Directors, and reported through several forums, including:

- Patient Safety & Compliance Group (PSCG) – bi-monthly, reporting to the Quality and Safety Group (QSG).
- Patient Stakeholder & Experience Group (PSEG) – bi-monthly, reporting to QSG.
- Quality & Safety Group (QSG) – monthly assurance reports to the Management Board.
- Quality & Safety Committee – receives in-committee reports bi-monthly.

Reports include early warnings, NRIs reported within timeframes, overdue cases, external reviews, closures and patient stories. Comparative data shows that the health board performs favourably against other NHS Wales health boards (refer to data included on page 3, At A Glance). The Yorkshire Contributory Factors Framework is used to analyse contributory factors, recorded in Datix Cymru.

Learning from NRIs – Service Group Level

Action plans are developed following investigations by Service Groups, with ownership assigned to divisional directors and oversight provided by the Quality & Safety Teams. These plans are discussed at divisional and business assurance meetings. While some examples were provided, they were high- level and could not be reconciled to the specific NRIs sampled during audit fieldwork (see **Key Finding 4**).

We note that the Primary and Community Care and Therapies Service Group is transitioning to recording and tracking actions within Datix to strengthen assurance. Additionally, there is an opportunity to utilise the AMaT system to track recommendations and provide real time progress reporting; however, this functionality has yet to be pursued.

Although thematic reports are produced periodically, there is insufficient evidence that lessons learned are consistently shared across the organisation. We raised a similar finding at our *Learning from Incidents and Concerns* report (issued May 2025, reasonable assurance) regarding capturing and evidencing learning. This finding remains open on the health board's audit tracker, and we have not sought to replicate the recommendation at this report.

External Reporting

NRIs are submitted via Datix Cymru to:

- NHS Wales Executive (Quality & Safety Team).
- Welsh Government (with final investigation reports also emailed to a shared inbox).
- Healthcare Inspectorate Wales (HIW).

We note that, over the past five years, feedback from Welsh Government and other external bodies has been limited.

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="3">4</td><td rowspan="2">Action Tracking and Learning

While a reporting framework for NRIs exists and incidents are escalated through appropriate governance forums, there is insufficient evidence that post-investigation actions are consistently tracked or linked to specific NRIs. Action plans reviewed at Service Group level could not be reconciled to sampled incidents, reducing assurance over implementation. Strengthening action tracking—through full utilisation of Datix and consideration of AMaT for real-time monitoring—would improve visibility and accountability.

We note that issues around systematic sharing of lessons learned were previously identified in our Learning from Incidents and Concerns report (May 2025) and are being addressed by the health board; therefore, this finding focuses on action tracking rather than learning dissemination.</td><td>Limited tracking of post-investigation actions reduces assurance that improvements are implemented effectively. This increases the risk of incomplete follow-through, repeated incidents, and missed opportunities for safety enhancements.</td><td>Agreed Action:
1. Test Datix to record and monitor all NRI action plans with clear ownership and timelines.
2. Explore AMaT or similar systems for real-time tracking and reporting of action plan implementation.
3. Regular review and reporting of action progress through governance forums.
4. Alignment with existing work on learning dissemination to avoid duplication and strengthen assurance through Patient Safety Congress function to include learning from Service Group NRIs.

Expected Evidence of Implementation:
1. Report findings of test to PCSG
2. Report outcome of investigation into PCSG.
3. Reports to PCSG demonstrating progress and closure of actions.
4. Revised Patient Safety Congress function to routinely include Service Group learning. Evidenced through PSC terms of reference and programmes.</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: (1-3) Assistant Head of Concerns Assurance/Head of Concerns Assurance; (4) Clinical Manager Quality, Safety & Improvement /Head of Quality, Safety & Improvement

Target Implementation Date: (1-3) 1 January 2027; (4) 1 April 2026</td></tr>
<tr><td>Theme: Performance Monitoring</td><td>Control Operation</td></tr>
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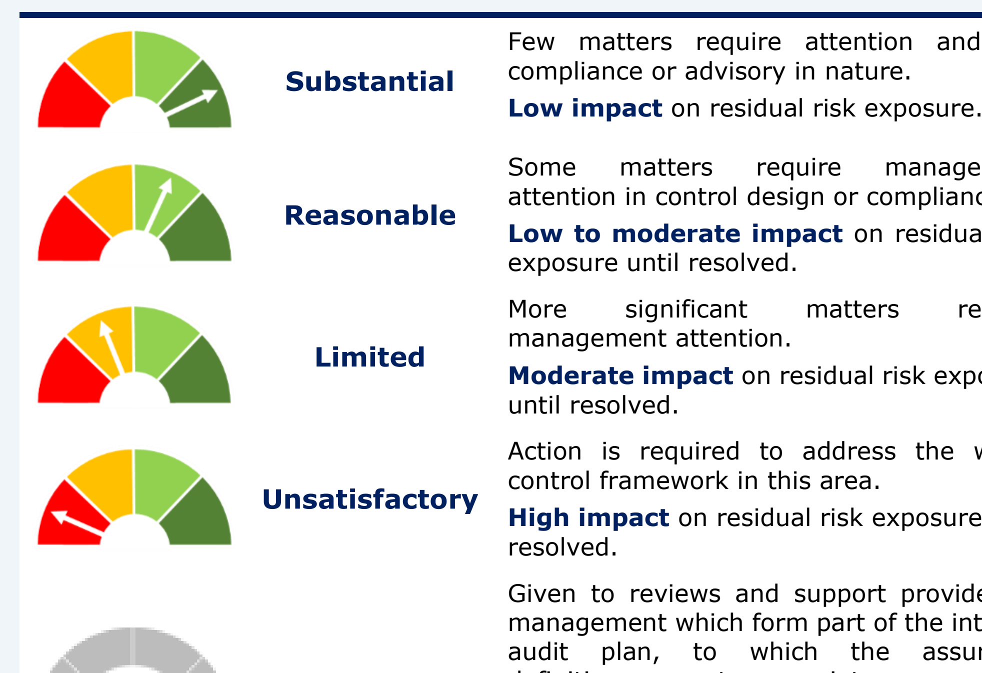
Appendix A: Assurance Opinion & Prioritisation of Findings

Assurance Opinion



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

Disclaimer

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Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Swansea Bay 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 Swansea Bay University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

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

Public Sector Internal Audit Standards

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

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