Professional Concerns

Final Internal Audit Report

2026/27

Swansea Bay University Health Board

Reasonable Assurance

Contents

Review Reference	SBU-2627-18
Fieldwork	May – July 2026
Executive Sign Off	20 August 2026
Audit Committee	10 September 2026
Executive Lead	Raj Krishnan, Interim Executive Medical Director
Audit Team	Osian Lloyd, Head of Internal Audit; Felicity Quance, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To assess the adequacy and effectiveness of arrangements for identifying, assessing, escalating, investigating and resolving professional concerns relating to medical staff.

Overview

Swansea Bay University Health Board (the 'health board') is required to maintain effective governance, risk management and control arrangements to ensure that professional concerns are managed appropriately and in line with NHS Wales policies, statutory responsibilities and relevant professional regulatory guidance, including that issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the requirements of the Upholding Professional Standards in Wales (UPSW) framework, and the principles of a 'just and learning' culture.

Professional concerns relate to the arrangements in place for identifying, assessing and managing concerns regarding the professional conduct, performance or capability of clinical staff, where such concerns may present a risk to patient safety, quality of care or compliance with professional standards. Concerns may arise from a range of sources, including incidents, complaints, performance management activity, speaking up concerns or safeguarding matters. This review focused primarily on the arrangements for managing concerns relating to medical staff.

At the health board, concerns regarding a doctor's performance or conduct are managed locally in line with the principles of the Vanderbilt Model[1] before escalation is considered. Isolated incidents are initially addressed through an informal conversation between the doctor and their service manager or clinical director, providing an opportunity for reflection and discussion. Where concerns persist or recur, such will be referred to Service Group Performance Advisory Groups ('PAG'), a governance arrangement unique to the health board, for consideration of any necessary actions and agreement of formal action plans and development requirements.

However, these arrangements have been implemented at different points in time and vary in their level of maturity. For example, the Primary Care & Therapies PAG has been operating for circa five years, whereas the Mental Health & Learning Disabilities PAG has been operational for approximately 18 months. Concerns that are more serious, persistent or unable to be resolved through local processes are escalated to the organisation-wide Responsible Officer Advisory Group ('ROAG'), which has also been operational for approximately five years. Further, where the relevant threshold is met, concerns may be escalated through the UPSW Framework.

We spoke to relevant Service Group Medical Directors at the outset of the audit and requested detailed evidence regarding the operation of PAGs across all Service Groups. Whilst governance documentation, including terms of reference, was obtained for all PAGs, detailed case information was only provided by the Primary Care & Therapies Service Group and the Mental Health & Learning Disabilities Service Group. Accordingly, conclusions regarding the operational effectiveness and consistency of PAG arrangements are based on the evidence available and should be considered in that context.

Based on the current arrangements, we have concluded **reasonable** assurance in this area. Established governance arrangements are in place for the management of professional concerns, supported by defined escalation routes, accountability structures and evidence of ongoing engagement to strengthen compliance with legislative and professional requirements. Detailed testing demonstrated that practitioners subject to professional concerns processes are generally treated appropriately, supported throughout the management of concerns and afforded opportunities to reflect, learn and improve within a supportive governance framework. However, improvements are required to strengthen consistency of governance arrangements across Service Groups, documentation standards, monitoring arrangements, organisational learning and Board-level oversight.

The following matters require management attention:

1. Opportunities exist to strengthen governance arrangements across PAG and ROAG processes to improve consistency, transparency, and assurance in the management of professional concerns.

[1] The Vanderbilt Model (officially the Promoting Professionalism™ Model) is an evidence-based framework developed by Vanderbilt University Medical Centre to identify, measure, and correct unprofessional behaviours in healthcare: Promoting Professionalism Pyramid | Vanderbilt Centre for Patient and Professional Advocacy

2. The Standard Operating Procedure lacks explicit, objective thresholds and triggers which may lead to inconsistency in approach from Service Groups.
3. Documentation, record-keeping and monitoring arrangements are applied inconsistently across Service Group PAGs, reducing transparency and limiting assurance regarding the management of professional concerns.
4. Arrangements for monitoring UPSW investigations require strengthening to support timely completion of cases.
5. Oversight of professional concerns at Board-level requires formalising to strengthen the reporting process.

Whilst operational arrangements for managing concerns are generally established and functioning effectively, opportunities remain to strengthen reporting, thematic analysis and Board-level oversight to support organisational learning and provide more consistent assurance regarding emerging risks and the effectiveness of the overall professional concerns framework.

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

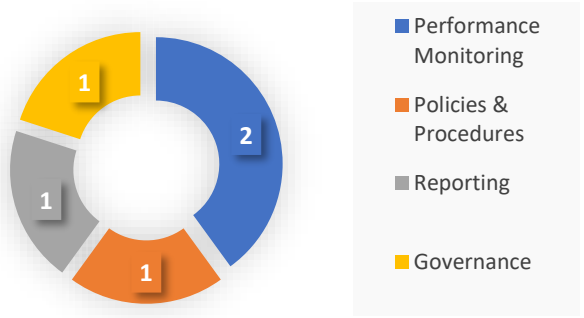
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Clear governance arrangements are in place for the management of professional concerns, with defined roles, responsibilities and accountability, supported by effective Board-level oversight.	1	**Reasonable**
2	Professional concerns are managed effectively, consistently and in a timely manner, in compliance with relevant regulatory, contractual and statutory requirements.	1,2,3	**Reasonable**
3	Staff that are subject to professional concerns processes are treated fairly, appropriately supported, and managed in line with the principles of a 'just and learning' culture, with clear and timely communication throughout.	1,2,3,4	**Reasonable**
4	Outcomes arising from professional concerns are reported effectively, analysed for themes, and based on accurate and complete information to support organisational learning and service improvement.	5	**Reasonable**

Management Actions

-	5
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Clear governance arrangements are in place for the management of professional concerns, with defined roles, responsibilities and accountability, supported by effective Board-level oversight.	**Reasonable**

Governance Arrangements

The Executive Medical Director, in their role as Responsible Officer (RO), supported by the Deputy RO, leads the management of professional concerns and makes key escalation and patient safety decisions in line with UPSW and GMC guidance. The health board seeks to resolve concerns at the earliest and most proportionate level possible, applying Vanderbilt Model principles. This may include an informal discussion through local management, with escalation via Clinical Directors where concerns persist.

Each Service Group operates a Performance Advisory Group (PAG), which oversees fact-finding where concerns require consideration beyond informal resolution. PAGs meet at least monthly, review evidence and make recommendations, including onward referral where appropriate, but do not have decision-making authority. While governance arrangements are broadly consistent, we identified gaps in documented escalation arrangements within the Primary Care and Therapies Service Group PAG and evidence that governance arrangements within the Mental Health Learning Disabilities Service Group (MHLDSG) continue to evolve. We also found that conflicts of interest were not consistently documented, although staff advised that individuals recuse themselves from discussions where necessary (see **Key Finding 1**).

Where local actions have been exhausted, cases are escalated to the Responsible Officer Advisory Group (ROAG), which meets monthly and has delegated authority to make decisions regarding the management and escalation of professional concerns. The Deputy RO is invited to all PAG and ROAG meetings to provide oversight, and an Independent Member attends ROAG on a rotational basis. However, we were unable to consistently verify attendance arrangements across all PAGs and were advised that resourcing pressures can affect attendance (see **Key Finding 1**). The planned review of the ROAG Terms of Reference has been deferred pending the outcome of this audit.

Concerns assessed as sufficiently serious, such as significant safeguarding issues or risks to patient safety, may bypass local processes and proceed directly to the formal UPSW process. This process includes defined governance arrangements, investigation and case management procedures, escalation pathways, hearings and appeals, restrictions of practice, practitioner support and patient safety controls. At the date of reporting, the health board had three active UPSW cases.

Guidance

The health board relies upon local procedures, supported by national guidance and professional judgement, to manage professional concerns. We were advised that a SharePoint site is being developed to improve accessibility of guidance for Clinical Directors and Clinical Leads.

The Professional Concerns SOP sets out governance arrangements below the UPSW framework, including the use of SBARs, PAGs, ROAGs and escalation routes. However, it does not define evidential thresholds or escalation criteria, such as what constitutes a pattern of behaviour, a serious concern, or when repeated lower-level concerns should be formally escalated. The SOP also lacks version control and review information, although management advised that it remains current (see **Key Finding 2**).

Similarly, the SOP for Clinical Leads and Directors relating to safeguarding allegations and concerns about practitioners outlines reporting, referral and risk assessment processes, but does not define escalation triggers or decision-making criteria.

National guidance provides the overarching framework, including the *Framework for the Management of Performance Concerns in General Medical Practitioners on the Medical Performers List Wales (2018)* and the *NHS England Practical Guide (2019)*, with the UPSW applying where concerns require formal investigation.

However, without defined local escalation criteria, PAGs are required to exercise significant professional judgement when determining escalation routes, creating a risk of inconsistent decision-making across service groups and reducing transparency and auditability (see **Key Finding 2**).

Board-level oversight

Limited evidence was presented regarding Board-level oversight arrangements at the health board – refer to *Objective 4* for further details.

Key Findings		Risk & Impact	Agreed Management Action
1	**Governance and Framework Oversight** Review of the PAG and ROAG governance framework identified several opportunities to strengthen governance documentation and oversight arrangements: • The PCTSG PAG Terms of Reference do not define the escalation route to ROAG. • Governance arrangements within the MHLDSG PAG continue to evolve, with ongoing review of roles and responsibilities. • PAG Terms of Reference require conflicts of interest and perceived bias to be declared and documented; however, this was not evidenced consistently in practice. • The ROAG terms of reference were due for review in June 2026 but had been deferred pending the outcome of this audit (noting that reference to UPSW arrangements are to be included). • Whilst oversight arrangements exist through Associate Medical Director for Quality & Safety/Professional Concerns involvement, evidence of attendance and oversight could not be consistently demonstrated across all PAGs reviewed. Collectively, these issues reduce consistency and transparency across the Health Board's governance arrangements for managing professional concerns.	Inconsistent governance arrangements, unclear escalation processes and limited evidence of oversight, may reduce assurance that professional concerns are managed consistently, transparently and in accordance with agreed procedures across the health board.	**Agreed Action:** 1. Terms of reference for ROAG and PAGs to be reviewed, updated and standardised as necessary, taking account of the findings of this review, formally approved through the appropriate governance arrangements and communicated to relevant stakeholders. 2. ROAG and PAG agendas to include the need to declare conflicts at the start of the meetings and for this to be recorded in the minutes, including nil declarations. 3. Continued attendance at PAGs by the Associate Medical Director for Quality & Safety/Professional Concerns. **Expected Evidence of Implementation:** • Updated and approved ROAG/PAG Terms of Reference endorsed by the Workforce & OD Committee. • Communication to PAG members, Clinical Directors and other relevant staff. • Evidence that escalation arrangements and UPSW references have been incorporated into the revised terms of reference. • Agenda/minutes for ROAG/PAG showing declarations of interest, including nil declarations. • PAG minutes showing attendance of Associate Medical Director for Quality & Safety/Professional Concerns.
		Medium Priority	**Officer:** Liz Wonnacott; Head of Service, Medical Directorate
	Theme: Governance	Control Operation	**Target Implementation Date:** 31 March 2027

Key Findings		Risk & Impact	Agreed Management Action
2	**Policies and Procedures** The guidance reviewed provides broad principles regarding risk, severity, proportionality and professional judgement; however, it does not prescribe objective evidential thresholds or decision-making criteria for escalation to ROAG or the UPSW Framework. In particular, the guidance does not define what constitutes a "pattern of behaviour", a "serious concern", or the threshold at which multiple low-level concerns should be subject to formal escalation. Consequently, escalation decisions are reliant on professional judgement, creating a risk of inconsistent application across Service Groups and reducing the transparency and auditability of decision-making.	Inconsistent application of professional concerns processes across Service Groups, resulting in similar concerns being managed differently and reducing assurance that escalation decisions are proportionate, transparent and consistently applied.	**Agreed Action:** Managing Professional Concerns SOP and associated documents to be reviewed and strengthened where necessary to support escalation decision-making, including consideration of escalation criteria, evidential thresholds and indicators of repeated or serious concerns. Revised guidance will be approved through the appropriate governance arrangements and communicated to PAG members, Clinical Directors and other relevant staff.
			Expected Evidence of Implementation: • Revised SOP and associated documentation with defined escalation criteria agreed by ROAG. • Evidence of approval through the appropriate governance arrangements. • Communication and/or briefing materials issued to PAG members, Clinical Directors and relevant staff, including evidence of dissemination.
		Medium Priority	**Officer:** Liz Wonnacott; Head of Service, Medical Directorate **Target Implementation Date:** 31 March 2027
	Theme: Policies & Procedures	Control Operation	

Objective 2: Professional concerns are managed effectively, consistently and in a timely manner, in compliance with relevant regulatory, contractual and statutory requirements.	**Reasonable**

PAG

As noted at Objective 1, significant reliance remains on local judgement at each separate PAG for dealing with lower-level professional concerns, creating a risk of inconsistent decision-making across service groups (see **Key Finding 2**). We found that monitoring of professional concerns is maintained using a log / spreadsheet at Morriston Service Group whereas the main method for monitoring at other Service Groups was the audit trail from the PAG minutes. Accordingly, there is no comprehensive record of all current and closed professional concerns maintained consistently across Service Groups (see **Key Finding 3**). As a result, sample testing was limited to current open cases.

We requested PAG case information from all four Service Groups but only received detailed case evidence from Mental Health and Learning Disabilities (MHLD), and the Primary Care and Therapies Service Group (PCTSG). Based on the limited evidence provided, a sample of three cases was reviewed. The PAGs were found to be operating broadly in line with the local SOP, and the principles set out within the Welsh and NHS guidance:

- There was evidence of informal discussions, action plans, fact-finding, PAG review and escalation to ROAG where appropriate, consistent with the SOP and the general principle of exhausting local actions before escalation. We acknowledge the speaking up safely culture at the health board.
- PAGs routinely consider Occupational Health referrals, wellbeing support, reflective practice, development plans, NHS Resolution actions and training interventions.
- We understand that appropriate support mechanisms are available to those affected by professional concerns, including practitioners subject to concerns.
- PAGs consult safeguarding specialists where appropriate, referring matters to Local Authority processes, undertaking safeguarding referrals and risk assessments, and considering safeguarding thresholds in accordance with the safeguarding SOP.
- Whilst differences in approach were evident between cases, for example referral to NHS Resolution in one case, and use of an informal fact-finding process in another, the rationale for selecting a particular approach and the associated risk considerations were not always clearly documented (see **Key Finding 3**).
- Whilst UPSW emphasises the importance of risk assessments, PAG documentation reviewed relied largely upon narrative discussion. Evidence of formal risk assessment, including consideration of likelihood, consequence and escalation thresholds, was not consistently demonstrated (see **Key Finding 3**).
- Documentation was not consistently maintained across the cases reviewed. Whilst PAG minutes, SBARs, action plans and updates to ROAG were available for some cases, SBARs were not available for the PCTSG cases reviewed and one MH&LD case (see **Key Finding 3**).

ROAG

Professional concerns are discussed at the monthly ROAG meetings, at which 43 cases have been discussed over the last 12 months. A log / spreadsheet is maintained of active and closed cases for monitoring purposes, with 15 cases 'active' at the time of audit.

Detailed testing of a sample of five ROAG cases was undertaken. There was evidence of consistent application of broad principles, including support before punishment, safeguarding referrals where safeguarding issues arose, reflective practice, action plans, fact-finding before formal escalation and closure where concerns are not substantiated. The evidence reviewed demonstrated a generally consistent and proportionate approach to decision-making at ROAG level.

UPSW

One closed UPSW case was reviewed and had exceeded both the timescales set out within its Terms of Reference and those expected under the UPSW framework by 77 working days. Whilst management advised that there were no formal consequences arising from the delay, the investigation was not completed within the anticipated timeframe (see **Key Finding 4**).

We discussed arrangements for retaining information relating to professional concerns where practitioners subsequently retire or leave the organisation, particularly where investigations remain ongoing. Whilst relevant information may be shared through appraisal and revalidation processes, references, Datix checks and regulatory disclosure requirements, we were advised that professional concerns outcomes are not routinely recorded within ESR. Consequently, the health board relies on a number of separate processes to maintain organisational knowledge of such matters, which may limit the completeness and accessibility of information where practitioners subsequently leave employment (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Case Documentation and Monitoring** Arrangements for monitoring professional concerns are inconsistent across service groups, resulting in inconsistencies in record keeping, case monitoring and the availability of management information. • PAG-level monitoring is inconsistent, service-led and not centrally standardised. Information provided for each case varied and supporting documentation was not consistently maintained. This limited the ability to undertake comparative analysis and assess effectiveness consistently across Service Groups. • SBARs were not held on file for the PCTSG cases reviewed and for one MHLDSG case. The SOP requires an SBAR to record key information supporting escalation, including the nature of the concern, risk assessment, actions undertaken and recommendations. • A log is maintained to monitor professional concerns at Morriston Service Group; however equivalent arrangements were not evident across the remaining Service Groups, where monitoring relied primarily upon the audit trail contained within PAG minutes. • Professional concerns outcomes are not routinely recorded in ESR and, while alternative arrangements exist through appraisal, revalidation and regulatory processes, this may limit the Health Board's ability to maintain a complete	Inconsistent documentation and monitoring arrangements may reduce transparency, limit auditability and hinder assurance that professional concerns are identified, recorded, monitored and managed consistently across Service Groups.	**Agreed Action:** 1. Managing Professional Concerns SOP and associated documents to be reviewed and updated to include minimum standards for the management, documentation and monitoring of PAG cases, taking into account the findings of this review. Revised requirements will be approved through the appropriate governance arrangements and communicated to relevant staff. 2. Explore with Learning and Organisational Development team the 'art of the possible' for using ESR to record medical professional concerns for wider discussion. **Expected Evidence of Implementation:** • Revised SOP and associated documentation with minimum standards for PAG case management, documentation and monitoring, agreed by ROAG and communicated to PAG members and Clinical Directors. • Outcome paper or documented proposal setting out the feasibility and preferred approach for recording professional concerns within ESR.

Key Findings		Risk & Impact	Agreed Management Action
	organisational record, particularly where practitioners leave employment or investigations remain ongoing.	**Medium Priority**	**Officer:** Liz Wonnacott; Head of Service, Medical Directorate **Target Implementation Date:** 31 March 2027
	Theme: Performance Monitoring	Control Operation	
4	**Management of UPSW Investigations** The UPSW case reviewed exceeded both the timescales specified within its Terms of Reference and those expected under the UPSW framework by 77 working days (approximately 15 weeks). Terms of Reference were issued on 20 February 2024 with an anticipated investigation period of six to eight weeks. However, the investigation report was not completed until 25 June 2024. The practitioner was subsequently met on 30 July 2024 and notified of the outcome in writing on 6 August 2024. We recognise that this reflected the complex nature of the case and the emergence of additional evidence during the investigation. Management advised that there were no formal consequences arising from the delay. However, the absence of formal arrangements to monitor progress against key milestones and timescales may increase the risk of delays in concluding investigations and impede the timely resolution of professional concerns.	Prolonged investigations may result in uncertainty for practitioners, delay the resolution of professional concerns, and reduce confidence in the fairness, effectiveness and timeliness of the health board's professional concerns process.	**Agreed Action:** Estimated timescales and key milestones to be formally noted at ROAG at the start of UPSW cases, with specific updates on progress against these and associated milestones during the investigation, which can be reported to the in-committee Workforce & OD Committee (if necessary) **Expected Evidence of Implementation:** • ROAG minutes noting estimated timescales and progress. • Updates to in-committee Workforce & OD Committee papers as/if required. • ROAG database or tracker demonstrating monitoring of milestone dates, revised completion dates and investigation status.
		Medium Priority	**Officer:** Liz Wonnacott; Head of Service, Medical Directorate **Target Implementation Date:** 31 March 2027
	Theme: Performance Monitoring	Control Operation	

Objective 3: Staff that are subject to professional concerns processes are treated fairly, appropriately supported, and managed in line with the principles of a 'just and learning' culture, with clear and timely communication throughout.	**Reasonable**

PAG and ROAG Level Concerns

Case records reviewed referenced reflection, insight, learning, action plans and review meetings, with concerns managed through developmental interventions wherever possible rather than immediate disciplinary action. Evidence included Occupational Health referrals, wellbeing support, welfare checks, phased returns to work, coaching, supervision, mentoring and engagement with NHS Resolution, reflective practice, development plans, training opportunities and monitored practice. This approach is consistent with the principles of the UPSW Framework and NHS England guidance, which promote support and remediation as the preferred response where appropriate. PAG and ROAG discussions and minutes further reinforced this learning and improvement culture rather than a purely punitive approach, focusing primarily on the support and remediation measures required to address concerns.

There was also evidence of communication with practitioners throughout the management of concerns, including notification of concerns raised, meeting with managers, involvement in return-to-work arrangements and access to representation where applicable. Documentation demonstrated liaison with Medical HR, safeguarding teams, Occupational Health and Executive Medical Director functions.

However, evidence was less robust in relation to documented communication plans, timescales, formal records of feedback to practitioners and the rationale for decisions taken. In several cases, further complaints, recurring concerns, amended terms of reference and revised action plans were referenced without clearly documenting how those developments had been communicated to the practitioner concerned (see **Key Finding 3**).

UPSW Concerns

Review of the sampled closed UPSW case demonstrated that the practitioner was provided with an opportunity to respond to the concerns raised and was kept informed throughout the investigation process through formal meetings and written communication. Whilst the investigation exceeded the expected timescales set out within the Terms of Reference (see **Key Finding 4**), communication with the practitioner was maintained throughout the process.

Objective 4: Outcomes arising from professional concerns are reported effectively, analysed for themes, and based on accurate and complete information to support organisational learning and service improvement.	**Reasonable**

The review identified opportunities to strengthen the health board's arrangements for reporting, oversight and organisational learning relating to professional concerns (see **Key Finding 5**). There is no agreed reporting framework, KPI suite or Board-approved reporting requirement, resulting in inconsistent reporting and limited organisational oversight.

Historically, formal reporting on professional concerns to Board committees has been limited. A request by the Workforce & Organisational Development (WOD) Committee for routine reporting on lower-level concerns, PAG referrals and ROAG activity was noted in April 2025, with management subsequently adopting a bi-annual reporting approach. We evidenced reports relating to professional concerns being presented to WOD In-Committee in August 2025 and April 2026, covering governance arrangements, training, workshops, and operating procedures. A further update is scheduled for October 2026. However, the committee work programme should be updated to formally reflect the agreed reporting arrangements (see **Key Finding 5**).

Independent Member attendance at ROAG meetings on a rotational basis was evidenced as requested by the Committee. A further report was presented to the Quality and Safety in-committee in April 2026, outlining the quality and safety implications of medical professional concerns cases and the actions being taken in response.

There was limited evidence of systematic thematic analysis, organisational learning or monitoring of actions arising from professional concerns, compared to arrangements observed in relation to safeguarding reporting. Whilst some local reporting was noted regarding aggregate figures for professional concerns raised within the MH&LD Service Group, equivalent arrangements were not evident across all Service Groups. Although learning is captured through PAG and ROAG discussions, opportunities remain to strengthen the extent to which themes, lessons learned and the effectiveness of actions taken are routinely shared, evaluated or reported across the organisation.

Furthermore, professional concerns data is not routinely triangulated with other sources of organisational intelligence, such as incidents, complaints, workforce data or disciplinary matters. As a result, opportunities to identify emerging themes, recurring concerns and wider organisational risks may be missed.

We appreciate that professional concerns are often sensitive and confidential in nature. However, proportionate Board-level reporting and oversight are required to provide assurance that concerns are being managed effectively, risks are understood and organisational learning is being achieved.

Key Findings		Risk & Impact	Agreed Management Action
5	**Board Oversight and Reporting** The Workforce & Organisational Development Committee receives regular information on workforce concerns, including speaking up safely activity, employee relations casework and safeguarding matters. However, formal reporting on professional concerns managed through PAG, ROAG and UPSW arrangements has not been embedded within a formally agreed reporting framework. As a result, the Committee may not obtain sufficient assurance regarding: • the volume and nature of professional concerns being managed across the health board; • whether concerns are being appropriately escalated, managed, and concluded; • compliance with regulatory and professional requirements; and • emerging risks and potential patient safety implications. In April 2025, the WOD Committee requested development of a quarterly (latterly amended to bi-annual) ROAG report and reporting on lower-level concerns managed through PAG arrangements. Reports were provided to WOD In-Committee in August 2025 and April 2026, with the next report scheduled in October 2026. The committee work programme should be updated to reflect the agreed bi-annual reporting arrangements.	The absence of a formal reporting framework may limit the health board's ability to identify emerging risks, monitor compliance with professional standards and obtain consistent assurance that professional concerns are being managed effectively and in a timely manner.	**Agreed Action:** 1. Managing Professional Concerns SOP and associated documents to be reviewed and updated to include a reporting framework setting out reporting arrangements to Board-level committees, taking account of the findings of this review, including reporting frequency, reporting responsibilities and minimum content requirements. Revised arrangements will be approved through the appropriate governance arrangements and communicated to relevant stakeholders. 2. The content of the Workforce & OD Committee work programme will be discussed with Corporate Governance colleagues in order to ensure that it accurately reflects the frequency and timing of the receipt of reports relating to matters dealt with through the managing professional concerns process. **Expected Evidence of Implementation:** • Revised SOP incorporating the reporting framework, approved by ROAG • Revised Workforce & OD Committee work programme. • Sample professional concerns report presented through the revised reporting arrangements.
		Medium Priority	**Officer:** Liz Wonnacott; Head of Service, Medical Directorate **Target Implementation Date:** 31 March 2027
	Theme: Reporting	Control Operation	

Appendix A: Assurance Opinion & Prioritisation of Findings

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 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.

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms 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.

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