



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **2026-02-10**
Time **09:30 - 13:00**
Location **Virtual via MS Teams; HDD Picton - Dolau Cothi**

Virtual Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 10 February 2026

1 Introductions

09:30, 0 min

1.1 Apologies

09:30, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

09:30, 0 min

2 Governance

09:30, 0 min

2.1 Minutes of the Meeting held on 9 December 2025

09:30, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.2 Table of Actions

09:30, 5 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.3 Matters Arising not on Agenda

09:35, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.4 Escalation Status Update Report

09:35, 15 min

Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

2.5 All Wales NHS Audit Committee Chairs' Meeting Update

09:50, 5 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.6 Scheme of Delegation

09:55, 5 min

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

3 Audit Wales

10:00, 0 min

3.1 Audit Wales Update Report

10:00, 5 min

Anne Beegan, Urvisha Perez, david.williams@audit.wales

3.2 Review of Investment in Digital Systems

10:05, 0 min

Anne Beegan, Urvisha Perez, Huw Thomas (Hywel Dda UHB - Director of Finance)

3.3 Review of the Management of Outpatients

10:05, 0 min

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.4 Review of Radiology Services

10:05, 0 min

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4 NWSSP – Audit and Assurance Services - Internal Audit

10:05, 0 min

4.1 Internal Audit Plan Progress Report

10:05, 5 min

James Johns (NWSSP - Internal Audit)

4.2 Escalation Governance (Substantial Assurance)

10:10, 10 min

James Johns (NWSSP - Internal Audit), Philip Kloer (Hywel Dda UHB - Chief Executive), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

4.3 Operational Governance Arrangements

10:20, 0 min
James Johns (NWSSP - Internal Audit)

4.4 Managed Practices (Reasonable Assurance)

10:20, 10 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)

4.5 Theatre Stock System Implementation

10:30, 0 min
James Johns (NWSSP - Internal Audit)

4.6 Vaccination and Immunisation (Limited Assurance)

10:30, 20 min
James Johns (NWSSP - Internal Audit), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Bethan Lewis (Hywel Dda UHB - Assistant Director of Public Health Strategic Business and Operations)

4.7 Level 3 and 4 Directorates

10:50, 0 min
James Johns (NWSSP - Internal Audit)

4.8 Decision Making for High Cost Drugs

10:50, 0 min
James Johns (NWSSP - Internal Audit)

4.9 Departmental / Local IT systems management

10:50, 0 min
James Johns (NWSSP - Internal Audit)

4.10 Patient Experience (Reasonable Assurance)

10:50, 10 min
James Johns (NWSSP - Internal Audit), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Louise O'Connor (Hywel Dda Health Board - Assistant Director)

4.11 Estates Assurance – Space Utilisation

11:00, 0 min
James Johns (NWSSP - Internal Audit)

5 BREAK

11:00, 10 min

6 Financial Focus

11:10, 0 min

6.1 Financial Assurance Report

11:10, 10 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6.2 Annual Statement of Financial Procedures

11:20, 5 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6.3 Counter Fraud Update

11:25, 5 min

Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

7 Assurance and Risk

11:30, 0 min

7.1 External Recommendations and Welsh Health Circulars Assurance Report

11:30, 10 min

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

8 Post Payment Verification

11:40, 0 min

8.1 Post Payment Verification (PPV) Annual Report

11:40, 0 min

8.2 Primary Care PPV Report

11:40, 0 min

9 For Information

11:40, 0 min

9.1 ARAC Workplan 2025/26

11:40, 0 min

10 Any Other Business

11:40, 0 min

11 Review of Meeting

11:40, 0 min

11.1 Matters and Risks for Escalation to the Board

11:40, 0 min

12 Date and Time of Next Meeting

11:40, 0 min

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302

1

09:30, 0 Mins

1 - Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

*Rhodri Evans (Hywel
Dda UHB -
Independent
Member)*

| For information

1.2

09:30, 0 Mins

1.2 - Declaration of Interests

All

| For information

2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meeting held on 9
December 2025

*Rhodri Evans (Hywel
Dda UHB -
Independent
Member)*

| For approval

Attachments

[2.1 Unapproved ARAC Minutes 9 December 2025.pdf](#)

**COFNODION Y CYFARFOD PWYLLGOR ARCHWILIO A SICRWYDD RISG
HEB EU CYMERADWYO / UNAPPROVED MINUTES OF THE AUDIT AND RISK
ASSURANCE COMMITTEE MEETING**

Date of Meeting: **09:30, Tuesday 09 December 2025**
Venue: **Virtual, via Microsoft Teams**

Present: Cllr. Rhodri Evans, Independent Member (Committee Chair) (VC)
Mr Maynard Davies, Independent Member (VC)
Mrs Eleanor Marks, Vice-Chair, HDdUHB (VC)

In Attendance: Ms Urvisha Perez, Audit Wales (VC)
Mr David Williams, Audit Wales (VC)
Ms Bethan Hopkins, Audit Wales (VC) (part)
Mr James Johns, Head of Internal Audit, NWSSP (VC)
Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary (VC)
Ms Rachel Williams, Head of Assurance and Risk, deputising for Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk (VC)
Mr Huw Thomas, Executive Director of Finance (VC)
Mr Terry Slater, Local Counter Fraud Specialist, deputising for Mr Ben Rees, Head of Counter Fraud (VC) (part)
Professor Philip Kloer, Chief Executive (VC) (part)
Mr Lee Davies, Executive Director of Strategy and Planning (VC) (part)
Mr Shaun Ayres, Director of Delivery (VC) (part)
Mr Andrew Carruthers, Chief Operating Officer (VC) (part)
Mr Gareth Cottrell, Deputy Chief Operating Officer (VC) (part)
Mr Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine (VC) (part)
Mr Thomas Alexander, Principal Programme Manager (VC) (part)
Ms Linda Jones, Regional Partnership Programme Manager (VC) (part)
Mr Gareth Rees, Deputy Director of Operations (VC) (part)
Mr Jan Bojanowski, Head of Clinical Engineering (VC) (part)
Ms Clare Moorcroft, Committee Services Officer (minutes) (VC)

| Minutes Ref. | Item | Action |
|---------------------|---|---------------|
| AC(25)184 | <p>Introductions and Apologies for Absence</p> <p>Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting. Apologies for absence were received from:</p> <ul style="list-style-type: none"> • Mr Winston Weir, Independent Member (Committee Vice-Chair) • Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk • Mr Ben Rees, Head of Counter Fraud | |
| AC(25)185 | <p>Declaration of Interests</p> <p>No declarations of interest were made.</p> | |

AC(25)186

Minutes of the Meeting held on 14 October 2025

Decision: RESOLVED – the Minutes from the meeting held on 14 October 2025 were approved as an accurate record.

AC(25)187

Table of Actions

An update was provided on the Table of Actions from the meeting held on 12 August 2025 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(25)164 – Mrs Joanne Wilson advised that this issue had been raised with Welsh Government, and correspondence received. Mr Lee Davies explained that an email response from Welsh Government had outlined the sequence of events leading to the escalation criteria being revised. He suggested that this be circulated to Members and any further queries addressed subsequently.

LD

AC(25)167 – in view of the fact that Mrs Eleanor Marks has requested that an update on the Operational Structure is presented to the next People, Organisational Development and Culture Committee (PODCC) meeting, it was agreed that this action should be closed.

AC(25)170 – Mr Maynard Davies enquired regarding the outcome of the meeting between the Chair of ARAC, Head of Internal Audit and Director of Corporate Governance. Mr James Johns advised that this is summarised in the Internal Audit Plan Progress Report later on the agenda and that he would update at that juncture.

AC(25)171 – it is unclear whether the revised Standard Operating Procedure (SOP) has been subject to the required governance processes; this will be clarified.

AC

AC(25)179 – Members heard that a meeting had taken place between the Director of Corporate Governance, Assistant Director of Assurance and Risk and Head of Assurance and Risk. The process of reviewing recommendations overdue by more than 6 months will take some time and due to the current pressures on operational services, this exercise will be postponed until the New Year. An update will be provided at the next meeting.

JW

AC(25)188

Matters Arising not on Agenda

There were no other matters arising.

AC(25)189

Escalation Status Update Report

Mr Lee Davies reminded Members that HDdUHB's Public Accountability Meeting with Welsh Government is taking place on 11 December 2025. This is likely to involve discussion of a number of issues relating to the Health Board's escalation status. Presenting the Escalation Status Update Report, Mr Shaun Ayres indicated that a different approach has been taken, mirroring the reporting format for the Finance and Performance Committee

(FPC). All escalation criteria associated with ARAC are broadly on track, with those rated as 'Advise' generally due to 'slippage' caused by deferral of certain work.

In terms of key issues, Mr Ayres highlighted the interrelation between the Audit Wales report on Patient Flow and Delayed Pathways of Care (DPOC) performance, outlined in the report's Analytical Addendum. DPOCs numbered 258 in October 2025, against a baseline of 203 and target (Annual Plan and Targeted Intervention) of 174. Clearly, a performance level of 258 is showing adverse deterioration. DPOCs during 2024/25 caused 55,482 delayed bed days at an estimated cost of £27.7m. A number of challenges have been highlighted around the Discharge of patients from hospital; however, Members heard that a significant proportion (approximately 26%) of discharge delays are associated with Health Board issues. Mr Ayres felt that this was the matter most deserving of ARAC's consideration, especially given the alignment with the Audit Wales report which appears later on the agenda.

From a high-level perspective, Mr Maynard Davies suggested that the assurance position has actually deteriorated; with one criteria rated as 'Advise' at the previous meeting, versus four at this meeting. In reference to Mr Ayres final comment, he agreed that – if it is the case that 26% of delays are attributable to the Health Board – the organisation needs to take steps to address this.

Mrs Wilson suggested that two of the criteria were not necessarily 'Advise'. With regard to MD1, a significant amount of information had been provided to Internal Audit, albeit some delayed due to one Clinical Care Group (CCG) having administrative capacity issues. The relevant Internal Audit report will be presented to the next ARAC meeting in February. MD5 (which should be attributed to Mrs Wilson rather than Mr Lee Davies) mentions the committees 3As report. This relates to a recommendation from Structured Assessment, which has not yet been discussed, and is on today's agenda. Mrs Wilson advised that it is intended to train all Independent Board Members in the 3As approach in January 2026. It was felt that the fact that these matters are being worked through should be recognised. With regard to the DPOC issue, Members were reminded that the Director of Operations and colleagues are joining later to discuss the Audit Wales report; the challenges and issues can be fully discussed at that point.

Mrs Eleanor Marks agreed that the rating of these criteria was debatable, noting the planned discussion at Board Seminar around the 3As report. She welcomed the report, however, particularly the 'dovetailing' of DPOC analysis with the Audit Wales review findings. Professor Philip Kloer suggested that the Public Accountability Meeting will represent an important moment for the Health Board. As indicated by Mr Ayres, it is likely that a number of these issues will be raised. Professor Kloer hoped to get from Welsh Government a sense of their opinion regarding the Health Board's progress. He understood, however, that none of

the health boards which have attended Public Accountability Meetings have received any feedback yet. In terms of 'Advise' versus 'Assure', it was suggested that other indicators may be more applicable in identifying whether there has been deterioration or improvement.

With regard to DPOCs, Professor Kloer understood that rates have reduced to approximately 212. A 'Reset Week' had recently taken place within the Health Board, and a national 'Reset' initiative is currently underway. Actions identified as a result will all be aimed at addressing the issues described. Data suggests that approximately 25% of discharge delays are related to Health Board issues; 25% are related to Social Care issues; and 50% are jointly 'owned'. Joint working is, therefore, clearly required. Mr Maynard Davies advised that his primary concern is whether the target is ever likely to be achieved, given the challenges involved. In response, Professor Kloer indicated that he would hope to see some improvement following the 'Reset' initiatives described above, or at the very least, learning.

Referencing the issue of feedback from Public Accountability Meetings, Mrs Wilson advised that a member of Welsh Government staff had indicated that this was delayed due to the condensed timetable of meetings. It is hoped that letters will be issued to health boards over the Christmas period.

In response to a more general query around Targeted Intervention and whether there is sufficient pace, Mr Ayres advised that he had no concerns regarding the criteria for which ARAC is responsible. He accepted that there are certain nuances and that the timing of reports impacts on their findings. In more general terms, there were probably three to five areas which were of most concern, including Urgent and Emergency Care (UEC), DPOC, hospital-acquired infections and the financial position. Members noted that these were among the five priority areas identified for discussion at the Public Accountability Meeting. Professor Kloer would add to these Planned Care and Cancer, where he would wish to see improved performance. He agreed that UEC is a significant challenge, particularly in terms of targets versus fragility; an issue which pervades all areas.

Returning to DPOCs, Cllr. Evans focused on the analytical addendum and queried whether ARAC should be aiming to respond to this in any way. In response, Mr Ayres suggested that it is intended to promote discussion around those issues within the Health Board's control and whether it can make changes to address these. In this regard, Mrs Wilson emphasised the need to differentiate between assurance and management. It may be appropriate to consider whether ARAC recommends referral of DPOC as a topic to FPC and/or the Quality, Safety and Experience Committee (QSEC). However, it was suggested that this be delayed until discussion of the Audit Wales report later on the agenda has taken place.

Decision: The Committee:

- **NOTED** the positive assurance ratings for MD2 (Board oversight and Duty of Quality), MD4 (Board sighted on key risks), and MD6 (Governance and leadership maturity), which confirm that the Health Board's core governance arrangements are functioning effectively.
- **NOTED** the 'Advise' ratings for MD1, MD3, MD5 and MD7, recognising that these reflect work in progress rather than fundamental concerns, with clear actions and timescales identified.
- **CONSIDERED** whether the DPOC analytical addendum provides sufficient assurance that the organisation understands the current position and the actions required to meet the TI de-escalation criterion.
- **SCRUTINISED** the linkage between DPOC performance and the enabling actions identified in the Audit Wales Discharge Planning report, particularly progress against R1 (discharge lounges) and R6 (training and policy embedding).
- **CONSIDERED** whether any matters should be escalated to Board or drawn to the attention of other Committees such as FPC and **AGREED** that the ARAC discussion on DPOC should take place in the first instance.

The Committee agreed to **ASSURE** the Board in relation to the Escalation Status Update.

Mr Lee Davies and Mr Shaun Ayres left the Committee meeting.

AC(25)190

All Wales NHS Audit Committee Chairs' Meeting Update

Decision: The Committee **NOTED** the All Wales NHS Audit Committee Chairs' (AWACC) Update

AC(25)191

Committee Self-Assessment

Mrs Wilson thanked Members for their participation in this exercise, noting that the response rate to the shortened and more focused survey had been excellent. Page 4 of the report outlines the areas identified for improvement. Cllr. Evans felt that Members' feedback was very fair and Mrs Marks agreed, adding that the high response rate was pleasing. In terms of feedback around the need for engagement and scrutiny from all Independent Members (IMs), Mrs Marks suggested that a discussion around adequate representation is needed. This is a generic point, not specific to ARAC. Overall, however, the areas identified as requiring improvement are sensible.

Mrs Wilson welcomed these comments. The issue of potential membership changes to committees is under consideration, and needs to be debated with the Health Board Chair and Mrs Marks as Vice-Chair. It will then be discussed with the wider IM body. Cllr. Evans suggested that the issue of deferred reports is challenging; however, he was not sure what can be done to address this. Mrs Marks advised that the same comment was

made at the last PODCC meeting, with the view expressed that deferral should be discussed with the committee Chair. Deferring reports is unsatisfactory, not least because it makes committee workloads difficult to manage. Mrs Wilson advised that a process has been put in place by which deferral must be agreed with the Chair. In respect to ARAC, she emphasised that there are weekly meetings with Internal Audit to discuss progress. The reports deferred on today's agenda are due to Health Board delays, meaning that Internal Audit also now has a backlog. In addition, a number of the reports due for presentation will have Limited Assurance ratings, necessitating more detailed discussion. Professor Kloer stated that he had assumed deferral of reports did have to be agreed with committee Chairs, and would support enforcing this. Mrs Wilson confirmed that this is the protocol; however, it has not been applied consistently.

Decision: The Committee **CONSIDERED** the outputs from the Committee Self-Assessment process and **AGREED** to the actions to be taken to improve its effectiveness.

The Committee agreed to **ASSURE** the Board in relation to the Committee Self-Assessment process.

AC(25)192

Audit Wales Update Report

Presenting the report, Mr David Williams advised that it had been hoped that the Charitable Funds accounts audit work would be complete this month. Whilst this had not been possible, Audit Wales are on track to deliver by the deadline of late January 2026. There are conversations ongoing around delivery of the wider financial audit work. Mr Huw Thomas thanked Audit Wales for their work on the Charitable Funds audit, which will be reported to the Corporate Trustee in January 2026. There is one issue outstanding, which was a recommendation last year that should have been addressed. It involves the report from the Charities' investment advisors, CCLA, which Audit Wales recommended should be the more detailed Type 2 report, rather than the routinely-provided Type 1 report. Even if this had been requested, it would not have been available by December without a change in CCLA's processes. Nevertheless, this will be taken forward for future audits.

With regard to performance audit, Ms Urvisha Perez indicated that the Structured Assessment and Regional Patient Flow reports are included on today's agenda. The Outpatient Review report is currently undergoing quality assurance. Exhibit 2 describes progress on these and other planned performance audit work. Two reports are due for submission to ARAC in February 2026, and Ms Perez was not aware of any reason why these should not be delivered by that date. There have been resource issues within the Audit Wales team which have resulted in some delays. The remainder of the report is as presented.

Decision: The Committee **NOTED** the Audit Wales Update Report.

Ms Perez introduced the Structured Assessment 2025 report, which is generally positive, with very few recommendations. She reminded Members that the focus of this review is on the Health Board's corporate arrangements. The wider Audit Wales Annual Audit Report will be presented to Public Board in January 2026. This year's Structured Assessment had found that the Health Board remains strongly committed to public transparency and continues to have good governance arrangements. Whilst there is good quality information to support scrutiny, there is an opportunity to clarify the 3As process to ensure its effectiveness. Since last year, the Board has stabilised and there are no interim arrangements in the Executive Team. There are strong arrangements to oversee risk, performance, service quality and safety and audit recommendations. The Health Board is taking positive steps to improve data quality and further strengthen governance arrangements for quality and safety. Audit Wales identified an opportunity to clarify committee oversight in the Board Assurance Framework (BAF) dashboard.

The Health Board is refreshing its long-term Strategy, and maintains good oversight around developing and delivering corporate plans and strategies. Whilst the Health Board is progressing its Clinical Services Plan (CSP) it was noted that this currently only covers the nine most fragile services. It is important not to lose sight of other services which are not included. Whilst appropriate financial oversight, control and management processes are in place, the financial position remains challenging. As in previous years, the Health Board was not able to submit a financially balanced Integrated Medium Term Plan (IMTP) to Welsh Government. It has, however, improved on its opening Plan deficit and has taken steps to achieve financial sustainability by 2028/29. Ms Perez advised that, as part of the clearance process, Audit Wales representatives had met with the Director of Corporate Governance, Executive Director of Finance, Chair of ARAC, Health Board Chair and Chief Executive to discuss the draft report. Finally, she wished to thank Mrs Wilson and her team for their support on the Structured Assessment.

Cllr. Evans thanked Audit Wales for facilitating discussion of the draft report, which had been extremely helpful. He acknowledged the need for a focus on 3As reporting practice. Mrs Wilson added that Audit Wales' ongoing dialogue with the Health Board is helpful, particularly in ensuring that there are no 'surprises' in terms of findings, and an ongoing dialogue on all Health Board matters. She and Mr Thomas had greatly appreciated the opportunity to comment on the first draft of the report. Mrs Wilson was pleased that there were only two recommendations, whilst emphasising that the report's focus is on corporate governance arrangements, recognising that more work is required on the operational arrangements. Finally, Members were advised that the management response had been finalised earlier than last year and was presented for their consideration.

Thanking all of those involved in preparing the report, Mr Maynard Davies agreed that only two minor recommendations should be welcomed. Commenting on the report, he highlighted that the financial position has further improved beyond that recorded therein. Mr Davies noted feedback around public openness around Board and committee business, and the statement that committee meetings are not recorded. It was observed that meetings are recorded for minuting purposes, and he enquired whether these recordings could be published. Mrs Wilson explained that, aside from Public Board, meetings are not livestreamed due to team capacity. Whilst consideration can be given to publishing recordings, when this was deliberated previously, there were concerns that to do so might stifle debate.

With regard to Paragraph 24, Mr Davies noted the statement around discussion at some of the newly formed committees being too operational. He would welcome feedback in his capacity as a committee Chair if this is the case, as it would be useful learning. Mr Davies welcomed the planned training session on 3As reports, emphasising that the IMs need to take ownership of this task. Cllr. Evans agreed that it is important to be aware of the 'line' between assurance and operational discussions. Professor Kloer thanked Audit Wales and Mrs Wilson and her team. He was delighted with the report's findings and felt that these were a fair reflection of the Health Board's position. The report makes a number of important points. Whilst these are themes often raised at Board and committees, it is useful to have them highlighted and summarised. An example is around the CSP and the statement that it includes only nine services. It is pleasing to have recognition of the organisation's progress in various aspects; however, it is accepted that there is much still to do.

Mrs Marks welcomed the professional 'critical friend' relationship between the Health Board and Audit Wales, which is important for both organisations. She too was pleased that the report made only two recommendations, whilst expressing that she would have liked to see additional detail around what might require work. Mrs Wilson's comments around the level of work already identified to address these two recommendation was, however, noted. Mrs Marks highlighted that the interview she had participated in had been very thorough, which should provide assurance around the process. Whilst accepting that the process is both robust and thorough, Mr Thomas reiterated that it is limited in its scope to the organisation's corporate governance arrangements. Certain issues 'fall easily' into either corporate governance or operational governance; however, others involve both. It is not possible to take assurance regarding the Health Board's operational governance arrangements from this exercise, as they are not within its scope.

With regard to Mr Davies' comments, Mr Thomas emphasised that the financial position is continuously changing and dynamic. He expressed concern around publishing meeting recordings,

suggesting that this may increase transparency at the expense of effectiveness. He was concerned that it would reduce the candour demonstrated by officers in discussions, which would in turn diminish the effectiveness of meetings. In addition, there is a risk of misinterpretation of discussions due to their technical and detailed nature and the issue of confidentiality.

Ms Perez acknowledged all of these comments. She agreed that the Structured Assessment only considers corporate governance arrangements, with the Annual Audit Report having a wider scope. The Health Board's Structured Assessment findings have been fairly positive for the last couple of years, suggesting that there is nothing fundamentally amiss with the arrangements in place. In terms of public access to meetings, Members heard that different health boards take different approaches. HDdUHB tends to publish its unapproved and approved minutes online quite quickly, which is one approach. As regards committee discussions becoming overly operational, Ms Perez suggested that this tends to be when IMs are not receiving adequate assurance around topics. Further questions often prompt more operationally focused responses. Mrs Wilson agreed, indicating that a different response in such instances might be to recognise that no assurance can be taken at this stage.

In terms of next steps, Members noted that the Structured Assessment Report will be presented to the Board in January 2026, alongside the Annual Audit Report, which will be issued before Christmas.

Decision: The Committee **NOTED** the Audit Wales Structured Assessment 2025 Report.

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales Structured Assessment 2025 Report.

Professor Philip Kloer left the Committee meeting.

AC(25)194

Review of the Management of Outpatients

DEFERRED to 10 February 2026 meeting

AC(25)195

Audit Fees Consultation 2026-27

Mr Williams advised that this letter represents the outcome of the consultation with regard to audit fees for 2026/27. It includes information on how fees are set, which reflect only the work undertaken. The letter also describes actions being taken to reduce costs, and is provided primarily for information.

Cllr. Evans requested assurance that information requested from the Health Board is being provided as required, in a timely fashion. From a financial audit perspective, Mr Williams confirmed that this was the case, with the organisation providing good quality information and participating in useful dialogue. In terms of performance audit, Ms Perez indicated that the information is generally good and received in a timely manner. On those

occasions when it is necessary to escalate, Mrs Wilson is always helpful in providing support.

Decision: The Committee **NOTED** the Audit Wales Audit Fees Consultation 2026-27 letter.

AC(25)196

Internal Audit Plan Progress Report

Mr Johns introduced the report, which provides the usual update on progress in delivering the Internal Audit Plan. Section 2 of the report details audit outcomes, with one audit finalised since the previous meeting and presented today, on the topic of Medical Devices Regulations. In terms of audit delivery, fieldwork has been challenging for a number of reasons and the team is not where it would wish to be at this stage of the year. The report contains a summary of the issues and challenges, which include additional audit work required and the secondary impact of this, a topic which has been highlighted in meetings with the Health Board. There were a number of challenges in relation to the Vaccinations and Immunisations audit; however, a draft version of the report has now been issued to the Health Board. Another report from an audit due for consideration in February 2026 has also already been issued.

There have been discussions around changes to the Plan, and (as mentioned earlier) a meeting with the ARAC Chair in relation to this took place in early November 2025. It has been suggested that audits on Health and Safety and Complaints are deferred, and that a number of follow-up audits are conducted, on Staff Sickness, Human Tissue Authority (HTA) and Emergency Department (ED) Data Validation. Other additional audit work has also been requested, including in relation to a specific financial system, WellSky. The Committee's approval is sought for these changes to the Plan.

Mr Terry Slater joined the Committee meeting.

Cllr. Evans requested clarification around the cause for delays. In regard to the Vaccinations and Immunisations audit, Mr Johns indicated that making progress in work with Health Board colleagues had been difficult. Certain events had necessitated the team to re-audit after a first draft had been prepared, and information received subsequently had been contradictory. Overall, it had proved challenging and had impacted on the team's ability to conduct other audits. For the Operational Governance audit, there had also been delays in submission of information and evidence from some of the CCGs, as mentioned earlier. Other audit work has been delayed for various reasons.

Noting the frustration that such issues cause, it was suggested that Mr Johns could be more explicit around the difficulties the team has experienced. Mrs Marks enquired whether there are too many audits included in the Plan, and whether ARAC can take any actions which might assist. Mrs Wilson did not feel that there are too many audits, whilst noting that the risks and environment

have changes as the year has progressed. She agreed that the Internal Audit team has experienced a particularly challenging month, emphasising that support has been provided in communicating with Health Board colleagues whenever possible.

Responding to Members' requests for more context around difficulties with the Vaccinations and Immunisations audit, Mr Johns explained that the first stage of fieldwork had been concluded and findings identified. The team had been content with these. However, the reaction to these findings had not been positive, with additional documents submitted once the report had been concluded which were not necessarily relevant or meaningful. There was also concern about whether these documents were actually operationalised within the Health Board. Key documents seemed to be missing and/or being worked on. The team had received conflicting and contradictory information from different sources within the organisation. A clearance meeting had taken place last week, noting a range of findings and a number of points. The report issued in draft returned a Limited Assurance rating. In summary, difficulties had arisen following the initial fieldwork and feedback stage, resulting in an unnecessarily elongated process.

Thanking Mr Johns for the additional information, Cllr. Evans indicated that this matter will be pursued at the next meeting when the report is presented. Mrs Marks also welcomed the context, emphasising that audit partners should explicitly state when they have experienced challenges with audits. ARAC needs to have an understanding of such issues. Cllr. Evans enquired whether the Chief Executive has been made aware of this matter, and was advised that he had. Mr Johns noted that it can be the case that issues during an audit are indicative of wider issues in a particular area or system. Mr Davies suggested that if the Health Board does not engage effectively with audit partners, the organisation loses any potential benefit of the audit and risks failing to identify underlying issues.

Mr Davies suggested that consideration be given to how the need to be honest and open with audit partners is communicated to the wider organisation. He emphasised that audits are for the benefit of the organisation, not the auditors. Agreeing, Mrs Wilson proposed that this be taken forward via the Audit and Risk team and their business partner approach with CCGs and other executive led functions. Members were also reminded that the Health Board's responsibility is to its population, rather than individuals within it. Having considered the issue of outstanding audit reporting, it was agreed that an additional meeting will be required prior to year-end. Potential dates would be considered.

RW

JW

Decision: The Committee:

- **TOOK ASSURANCE** with regard to delivery of the Internal Audit plan and from the outcomes of the finalised audit reports
- **APPROVED** updates to the plan

Whilst the Committee agreed to **ASSURE** the Board in relation to Internal Audit Plan progress, it agreed to **ADVISE** the Board regarding issues around responses to audits. These need to be timely, honest and open; and engagement with audit partners must be effective and constructive.

AC(25)197

Financial Assurance Report

Mr Thomas presented the Financial Assurance Report, noting that there were no 'Alert' issues. 'Advise' issues related to three breaches of Standing Financial Instructions (SFIs) resulting from retrospective purchase orders. All had been escalated and re-education provided. Staff overpayments increased slightly over the period, but the average recovery period has improved from six months to five and the value is relatively stable. The drivers for staff overpayments are as previously discussed and the need to monitor this area is recognised. Mr Thomas indicated that there are two losses over £5k which require approval: Firstly, Nurokor Limited following company liquidation, which was previously provided for. Members were reminded of previous discussions around this issue. Secondly, pharmacy wastage due to cold chain failure; the WellSky issue referenced at Public Board. Mr Thomas suggested that this is the most important item in the 'Advise' category. A 'root and branch' review has identified an aseptics module issue within WellSky. This had produced a non-material but significant overstatement of costs over two financial years. Corrections have now been posted and Audit Wales have been informed. A task and finish group has been convened to review controls and Internal Audit involvement has been requested, as alluded to earlier. Members were assured that the issue has been corrected and the cause is being addressed. There is no evidence of any wider misstatement. It is isolated to that particular issue.

Mr Davies requested clarification around whether the WellSky error is a system error or a system application error. Mr Thomas indicated that it was the latter. Drugs costs were effectively 'double-charged' as they were charged on entry to the system and on issue. This had led to an increased liability which was highlighted during analysis of the balance sheet. Mrs Marks welcomed the well presented report, enquiring whether there are any particular trends. In response, Mr Thomas highlighted page 5, where the balance outstanding in staff overpayments has grown. There is no indication of deliberate fraud; this is largely attributable to process error. As has been described before, the issue relates primarily to the structure and workforce in Estates and Facilities, where there are large numbers of Band 2 and 3 staff. These staff have limited notice period required, and sometimes leave without working their notice, making management processes challenging. It is possible that the new Electronic Staff Record (ESR) system may assist. If there are any issues suggesting potential fraud, these are referred to the Counter Fraud team for investigation.

Cllr. Evans requested assurance around the governance process for making the direct awards listed in the report. In response, Mr

Thomas advised that these are avoided whenever possible by use of tendering or framework award processes. Any which remain are considered at Financial Control Steering Group (FCSG). There is a particular focus on avoiding use of Single Tender Actions, which would be subject to significant scrutiny.

It was agreed that the breaches of SFIs would be highlighted in the 3As report to Board.

CM

Decision: The Committee:

- **SCRUTINISED** the award of contracts listed
- **DISCUSSED** the breaches of Standing Financial Instructions (SFIs)
- **DISCUSSED** the staff overpayments and **TOOK ASSURANCE** that actions to control them are sufficiently embedded
- **DISCUSSED** losses as detailed and **APPROVED** losses in excess of £5,000
- **DISCUSSED** the WellSky accounting issue and **TOOK ASSURANCE** that the implemented corrective actions will eliminate the risk of recurrence
- **TOOK ASSURANCE** from the actions taken to Improve Purchase To Pay (P2P) compliance; Manage Single Tender Actions (STAs) and Ensure National Minimum Wage (NMW) compliance

The Committee agreed to **ASSURE** the Board in relation to the Financial Assurance Report.

AC(25)198

Counter Fraud Update

Presenting the Counter Fraud Update Report, Mr Thomas suggested that this represents a clear articulation of the current position. Mr Terry Slater highlighted in particular work in relation to National Fraud Awareness Week, which had included visits to hospitals, GP practices and pharmacies. Ad hoc conversations also took place with members of the public and patients. It is hoped that this will prove effective in raising awareness of and potentially deterring fraud.

Referencing Appendix A, Cllr. Evans noted a significant increase in activity in relation to Carmarthenshire. Mr Slater advised that this relates in the main to working while on sick leave in two staff groups. These are areas which are always more likely to see such trends. Members were reminded that staff are permitted to work while on sick leave, providing that they have approval from Occupational Health and their manager. It only becomes potential 'false representation' when an individual is dishonest with the purpose of making a gain. Mrs Marks enquired whether this is likely to be a seasonal trend, and Mr Slater confirmed that cases are expected to rise due to the time of year and the financial pressures it brings. Need and opportunity are likely to cause an increase in cases.

In response to a suggestion that reminders regarding the rules around working while on sick leave should be sent, Members were assured that this is being undertaken. Communications have been issued via Viva Engage, which have included examples and media reports regarding criminal cases. Mrs Marks queried whether these are likely to resonate with staff who might be undertaking what they might consider 'lower level' work, such as casual bar work. Mr Slater advised that the need for reminders has also been added to forms regarding long-term sickness absence. It is also hoped that declaring additional employment becomes mandatory, as this would make it easier for managers to discuss the potential for working while on sick leave. Mrs Wilson indicated that consideration is being given to whether it can be made mandatory to declare secondary employment.

Decision: The Committee **RECEIVED** for information the Counter Fraud Update Report and appended items.

The Committee agreed to **ASSURE** the Board in relation to the Counter Fraud Update Report.

Mr Terry Slater left the Committee meeting.

AC(25)199

Medical Devices Regulations (Substantial Assurance)

Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Gareth Rees and Mr Jan Bojanowski joined the Committee meeting.

Mr Johns introduced the Medical Devices Regulations Internal Audit report, which had examined the management of medical devices. It had considered whether governance arrangements, controls and monitoring arrangements in place to ensure compliance with relevant regulations. Key messages are that there are appropriate arrangements in place around governance; underpinned by a range of policies and procedures. A system is in place for recording and monitoring devices; there are appropriate arrangements for the distribution and communication of safety notices and alerts; staff are appropriately trained. Of the four objectives in the report, three are rated as substantial assurance, with just one specific finding in relation to training compliance. An overall rating of Substantial Assurance has been concluded.

Welcoming the positive report, Cllr. Evans noted the finding around expired training and enquired whether this risk can be mitigated and/or tracked in any way. Whilst recognising that the auditors were correct to identify the issue, Mr Gareth Rees explained that this relates to a technical finding, which will trigger conversations with the relevant manufacturer.

Mr Jan Bojanowski added that the policy has been updated and the relevant wording was already part of the training matrix where details of the certificates are captured. Other data has also been added for clarification. The online portal has the most up-to-date list of all the service reports and test cards for the technicians to

follow. This particular manufacturer is the only one that includes an expiry on the training certificate. Overall, the team is content that the risk is mitigated.

Cllr. Evans congratulated the team on the audit findings. Members noted that Mr Bojanowski has only been in post since May 2025 and Mr Rees wished to place on record his thanks for the contribution he has made.

Decision: The Committee **NOTED** the Medical Devices Regulations (Substantial Assurance) Internal Audit report

The Committee agreed to **ASSURE** the Board in relation to the Medical Devices Regulations (Substantial Assurance) Internal Audit report.

Mr Gareth Rees and Mr Jan Bojanowski left the Committee meeting.

AC(25)200

Vaccination and Immunisation

DEFERRED to 10 February 2026 meeting

AC(25)201

Operational Governance Arrangements

DEFERRED to 10 February 2026 meeting

AC(25)202

Managed Practices

DEFERRED to 10 February 2026 meeting

AC(25)203

Level 3 and 4 Directorates

DEFERRED to 10 February 2026 meeting

AC(25)204

Review of Urgent and Emergency Care - Patient Flow (Regional Report)

Ms Bethan Hopkins, Professor Philip Kloer, Mr Peter Skitt, Mr Thomas Alexander and Ms Linda Jones joined the Committee meeting.

Ms Bethan Hopkins presented the Urgent and Emergency Care: Flow out of Hospital - West Wales Region report. Members heard that this is a regional report looking at cross-sector working between the Health Board and Local Authorities focused on resolving discharge delays, their causes and the impact they are having on the urgent and emergency care system in the West Wales region. The report has been cleared for factual accuracy through the Regional Partnership Board (RPB) in collaboration with the Health Board and the Local Authorities, reflecting its joint nature. The audit was extensive, including cross-sector interviews, data collection and analysis. It is recognised that the audit reflects a 'moment in time' and the data capture is relevant to the publishing period, but it is hoped that it provides a comprehensive overview of the position and the general successes and challenges within the region.

Key findings suggest that, despite patient flow being a key aspect of plans across partners, high numbers of delayed discharges continue to negatively affect urgent and emergency care services. This includes ambulance handovers and emergency department waiting times. Increased complexity of demand, capacity constraints and weaknesses in the discharge planning process are all key barriers to more effective patient flow. Whilst partners understand the need to drive improvement, more action is needed to secure the sustainable improvements required. Audit Wales recognises that the issues identified in this report will not be new information to teams. The challenges are also similar across Wales in general. However, the causes and the impacts differ on a regional basis. The report aims to provide a bespoke picture in the west Wales region and offers practical insights into some of the governance which sits around the local issues. The discharge planning report provided at the previous meeting includes a more detailed insight into the discharge planning specifically.

The regional report includes 15 recommendations; 4 directed at the Health Board, 9 jointly with a Local Authority and 2 Local Authority specific. Audit Wales has received management responses to the recommendations, coordinated through the RPB, which are included.

Mr Peter Skitt confirmed that all of the issues highlighted are known to the Health Board and steps are being taken to address them. Also, that the report represents a 'moment in time' and that the situation is dynamic. For example, Members were advised that the 'Winter Sprint Fortnight' Welsh Government discharge initiative is currently underway. As such, the organisation is aware of the actions required to address recommendations; the question is the pace which is possible and ensuring timely delivery on completion dates. As indicated, this requires a regional approach, with cross-organisational working; which can be challenging and complex. In summary, Members were assured that the report and its findings were accepted and that steps are being taken to address these. The need to work jointly with partners is acknowledged.

Mr Gareth Cottrell echoed these comments, adding that a 'two pronged' approach is being applied: The Health Board is attempting to maximise how it manages patients proactively; and is developing its relationships with the Local Authorities, to ensure as seamless working as is possible. This is challenging, which is stated in the report. The report also, quite rightly, highlights some of the difficult issues requiring navigation; including the expectations of patient families and relatives. This requires support for staff in maintaining compassion during what can be challenging conversations. Mr Cottrell welcomed the recognition within the report of the new operational structure.

Cllr. Evans enquired whether the report will also be considered by the three Local Authorities, and Ms Hopkins confirmed that it will be presented to the relevant committees in each. Whilst

welcoming the well-written report, Mrs Marks indicated that it raises for her a number of concerns and questions in relation to the care sector and discharge:

- Concern around the fragility of the care sector and its ability to cope with the increasing demand, the aging population and the complexity of their needs
- With only three Local Authorities and 380,000 people, there needs to be better 'joined-up thinking'
- Concerns around the complexity of the funding structures for care, including Continuing Health Care (CHC)
- The lack of weekend discharge; people are ill 24/7 and capacity needs to be freed-up by changes in approach to discharge
- In HDdUHB's rural population, the principle of caring for people near where they live is very important

Mr Andrew Carruthers shared all of these concerns, and agreed that all are valid. The first point is a long-standing issue of concern, given the significant fragilities in terms of sustainability, including financial. There is inconsistency around service provision on a 7 day basis in general, not just in relation to discharge. These are as much to do with the Health Board's capacity as care capacity. The UEC business case due for consideration at the January 2026 Public Board should begin to consider this; in conjunction with various other programmes of work. Members heard that at least one Local Authority partner has suggested in the past that DPOCs are not viewed as so much of a priority by them as they are by the Health Board. It had been suggested that the focus should be on reducing and managing demand and preventing admission rather than on the 'back door' of discharge and care packages. However, Mr Carruthers advised that he is working with Local Authority colleagues to agree a Memorandum of Understanding (MOU) or set of commitments, which would cover a broad spectrum of activity. The perception highlighted above would need to be addressed as part of this work. It was suggested that dedicated resource is probably required, and that there is a need to learn from others, where there has been more success in this area. In response to another of the comments above, Mr Skitt highlighted that the Health Board works with at least five Local Authorities rather than three. He noted that some of the work required is cultural, which will take time and effort. There are significant complexities and issues involved.

Ms Hopkins confirmed that similar comments to one made by Mr Carruthers had been made in other regions. This related to social workers' caseloads and the priority given to social care assessments by Local Authorities. Whilst there may be two individuals awaiting assessment in hospital, there may be 15 in the community, and a number of these might be living alone. This leads to potential for tensions in terms of priorities.

Whilst appreciating the complexity of the various elements involved in discharge and care packages, not least the financial ones, Mrs Marks emphasised the need to appreciate the perspective of patients and their families. She stated the need for a significant leadership effort, indicating that she was not currently assured of sufficient impetus. Whilst aware that this is a UK-wide issue, Mrs Marks emphasised the Health Board's responsibility to the local population.

Cllr. Evans enquired whether there are plans to secure a different form of engagement from Local Authorities. In response, Mr Skitt confirmed that the Health Board is working more closely with Local Authorities than ever, referencing the work already mentioned by Mr Carruthers. He agreed that a dedicated resource is required. The responsibility for CHC packages has now moved to Mr Skitt, and consideration needs to be given to making the processes less complex. Whilst there has been progress, there is still much to do. Joint Equipment Stores are an example of where partnership working has produced major benefits in enabling individuals to remain in their own homes. It is a model which might be applied successfully elsewhere, with consideration to be given to the potential for pooling resources such as CHC.

Professor Kloer reminded Members that a local 'Discharge Reset Week' took place recently and (as has been mentioned) the Health Board is in the midst of a national fortnight focused on discharge. He suggested that the Executive Team needs to analyse and understand the learning from both of these. It may form part of the assurance required by ARAC and the Board, and influence next steps. Whilst he appreciated that there are differences in the measures against which statutory bodies are held to account, and the reason for Local Authorities prioritising those in the community; he highlighted that there is still a 'tipping point' for hospitals. It is important to utilise every possible mechanism to influence change, and Professor Kloer welcomed the suggested consideration of pooled funds. He concluded by enquiring whether the dates in the management response are realistic. Cllr. Evans agreed, adding that these should be fixed dates rather than 'ongoing'. Mr Carruthers indicated that actions and dates have been jointly developed between partners, and he was confident that they should have the desired impact and would be achieved. Progress has been made on agreeing a way forward; timelines on making changes are required. He was happy to update Members outside the meeting on work being undertaken in this area.

AC

Mr Davies noted that in excess of 20% of discharge delays lie within the Health Board's remit, and enquired regarding actions being taken to address this. Secondly, he noted with concern the comments reported in paragraph 38 around 'families leaving patients in hospital because they are going on holiday.' Mr Davies emphasised that hospital is not necessarily the optimal place for elderly patients, who can experience deconditioning and increased fragility, and queried how this can be communicated. Mr

Carruthers agreed that hospitals are viewed as a 'safe place' and, whilst he did not wish to entirely dispel this view, it is a delicate balance between that and the potential impact of an extended stay on ongoing health, wellbeing and recovery. This issue is being discussed with the Communications team and the work undertaken during the Reset Week will be built upon, alongside the Discharge Toolkit and training. Mr Carruthers also agreed that the Health Board should not lose sight of the delays caused by internal factors. These currently include issues around the capacity deficit with therapies, which is precluding assessment of patients, together with wider-ranging issues. He emphasised that a great deal of the work being undertaken is focused on the Health Board's responsibilities and contribution to discharge processes.

In response to a query around how the report's findings will be taken forward, Ms Hopkins suggested that implementation of the Health Board specific recommendations will be tracked via the Audit Tracker. Joint recommendations could also be included, or be part of RPB monitoring processes. Local Authority specific recommendations will sit with them. In terms of completion dates, discussions are ongoing with the parties involved and these can form part of those discussions. Ms Hopkins advised that certain health boards do openly communicate to the public the risks involved in hospital stays, by stating that hospital should not be viewed as a 'neutral environment'. Leaflets can be utilised to help manage expectations. She highlighted that certain issues with 7 day discharge centre on what are quite practical concerns for patients and families. An example is that some organisations providing transport do not open 7 days a week. Whilst these may be outside of the Health Board's control, there needs to be an awareness of them and their impact.

Ms Linda Jones wished to return to a comment around the use of 'ongoing' in completion dates. She explained that this reflects the fact that a number of the actions are based upon existing workstreams. It was emphasised, however, that review meetings are being put in place to ensure that dates are achievable. On discharge in general, Ms Jones highlighted that a number of individuals relocate to west Wales to retire, and do not necessarily have family situated locally. However, there are practical issues which need discussion, and partners are aware of the need for messaging around these. With regard to completion dates, Mrs Wilson indicated that a lack of specifics makes tracking challenging. In addition, she was not sure that all the management responses are SMART (Specific, Measurable, Achievable, Realistic/Relevant, Timely). Both can impact on the escalation status of CCGs.

All of the issues discussed above, Professor Kloer noted, have a direct impact on the inconsistency of patient experience and poor patient experience in UEC. Whilst this is a Health Board responsibility, it should also be viewed as a Local Authority responsibility. Professor Kloer also expressed concern that the

use of 'ongoing' to reflect existing workstreams may give the impression of no change in approach. Finally, he referenced Appendix 2 and a potential issue around benchmarking with percentage figures. Ms Hopkins offered to provide the raw data to assist with clarity. In response to the first comment, Ms Jones assured Members that a great deal of work is being undertaken; however, it is not necessarily 'in response' to the audit findings, it was already underway as a result of the priority being given to this area. With regard to whether and how the management response, propriety and tracking of actions should be considered in more detail, Ms Hopkins suggested that the issue is whether parties are satisfied with these. Whilst expressing concern at the lack of assurance around completion dates, Mrs Wilson was aware that the management response has been agreed by the RPB and queried the ability to revisit its contents. It was agreed that this matter would be discussed outside the meeting.

BH

AC/JW

Decision: The Committee **NOTED** the Audit Wales Urgent and Emergency Care: Flow out of Hospital - West Wales Region report

The Committee agreed to **ADVISE** the Board regarding concerns around the significant issues in patient flow impacting on UEC and around completion dates. Whilst recognising the programmes of work being undertaken, the need for continued vigilance around this issue.

Ms Bethan Hopkins, Professor Philip Kloer, Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Peter Skitt, Mr Thomas Alexander and Ms Linda Jones left the Committee meeting.

AC(25)205

Risk Assurance Report

Ms Rachel Williams introduced the Risk Assurance Report, which is intended to provide assurance on the processes in place underpinning the new Risk Management Framework, approved by the Board in September 2025. Members heard that the report format had been revised to align with the assurance and risk reports provided to other committees. It begins by outlining those objectives from last year's Risk Management Strategy which have been achieved or (for those still in progress), how these have been incorporated into the Strategy for the coming year. The Risk Management Strategy was approved by the Board in September, alongside the Framework. The slides also outline plans to support achievement of the three objectives for 2025/26. There will be a focus on the identification and implementation of a new risk management system, as the existing contract in relation to the Datix system is due to cease in November 2027. HDdUHB is currently exploring options with colleagues from other NHS Wales organisations and is in the early stages of discussions with colleagues in the Digital team.

With regard to the risk landscape, there has been an increase in the number of open risks since the previous report (579 to 624 as at the end of October 2025). In terms of the functions, Estates and Facilities continues to hold the largest number of risks on the risk

register, reflecting the condition of the Health Board's aging estate and equipment. Operational Allied Health Professions and Health Sciences have commenced a wholesale review of their risk register, to ensure that relevant risks are articulated and reflected. This is a piece of work which will continue over the coming months. Planned and Specialist Care, along with Community and Integrated Medicine (CIM), are the other CCGs with a significant number of risks, reflecting the continuing challenges such as service fragility, workforce shortages, lack of funding and demand exceeding capacity. The Assurance and Risk team continues to support CCGs and functions in both Level 3 and Level 2 to support improved risk management and proactively achieve a deescalated position. Finally, work is continuing to embed the new approach to risk treatment; around risk acceptance and tolerance, with the majority of risks on Datix now including a rationale to justify the Target Risk Scores provided and an expected date when these will be achieved.

Highlighting the significant number of risks within Estates and Facilities, Mr Davies emphasised that this impacts on many other aspects; not least, patient care. Agreeing, Mrs Wilson added that this also applies to Operational Allied Health Professions and Health Sciences. Noting that CIM CCG remains at Level 3, Mrs Marks queried the pace at which emerging risks are added to Datix. Mrs Wilson advised that there has been discussion around whether this CCG should be escalated to Level 4. A decision was delayed due to the planned discussion scheduled for Board Seminar; however, this discussion had since been deferred. She shared Mrs Marks' concerns. Whilst Members were assured that the Assurance and Risk team do encourage services to add risks to Datix, their influence is limited. Also, the escalation score is not based on risks alone; it also involves compliance with Welsh Health Circulars, etc. The issue of pace in adding risks is one which relates to operational capacity. Risks are not necessarily on the Datix system, however, they are discussed at operational meetings. Whilst noting this, Mrs Marks highlighted that this does not facilitate Board awareness of issues. The escalation level in this case would be examined prior to the next report.

RW

Decision: The Committee **TOOK ASSURANCE** on risk management arrangements and processes in order to report progress to the Committee, including the revised performance management arrangements.

The Committee agreed to **ASSURE** the Board in relation to the Risk Assurance Report, whilst noting caveats around the need to strengthen processes to ensure risks are added to Datix in a timely fashion.

AC(25)206

ARAC Workplan 2025/26

The Committee **NOTED** the Audit Work Programme 2025/26, which will be updated in line with discussions and to align with Audit Wales and Internal Audit Plans.

AC(25)207

Any Other Business

There was no other business reported.

AC(25)208

Matters and Risks for Escalation to the Board

As noted.

AC(25)209

Date and Time of Next Meeting

9.30am, 10 February 2026

2.2

09:30, 5 Mins

2.2 - Table of Actions

*Rhodri Evans (Hywel
Dda UHB -
Independent
Member)*

| For assurance

Attachments

[2.2 Table of Actions ARAC 9 Dec 2025.pdf](#)

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 9 December 2025

| Minute No. | Meeting Date | Subject | Action | Lead | Timescale | Progress/Date Achieved |
|------------|--------------|--|---|-----------|--|---|
| AC(25)171 | 14/10/2025 | Validation of Emergency Department Waiting Time Data (Limited) | To review and revise the SOP and take it forward via CCG and wider Health Board governance processes | PS | December 2025 February 2026 | <p><u>9 December 2025</u> In Progress The Review of the existing SOP has commenced, with a view to presenting to CIM CCG at the end of November 2025.</p> <p><u>10 February 2026</u> In Progress Due to operational pressures, it has not been possible to take the revised SOP through the governance process. Revised delivery date of end of March 2026 proposed.</p> |
| AC(25)179 | 14/10/2025 | Internal and External Recommendations and WHC Tracking Assurance Report | To examine recommendations overdue by 6 months or more, to identify whether they can be closed, or whether additional support is required | JW | December 2025 February 2026 | <p><u>9 December 2025</u> In Progress A meeting will be scheduled in December 2025 between the Director of Corporate Governance/ Board Secretary, Assistant Director of Assurance and Risk, and Head of Assurance and Risk to review those recommendations overdue by greater than 6 months (based on the escalation data at October month end) to determine the appropriate course of action to</p> |

| Minute No. | Meeting Date | Subject | Action | Lead | Timescale | Progress/Date Achieved |
|------------|--------------|---------|--------|------|-----------|--|
| | | | | | | <p>support the progression of these overdue recommendations with relevant Clinical Care Groups / Executive Functions.</p> <p><u>10 February 2026</u> Complete Meeting held in December 2025 between the Director of Corporate Governance/ Board Secretary, Assistant Director of Assurance and Risk, and Head of Assurance and Risk to review those recommendations overdue by greater than 6 months and develop a plan to review these with the relevant CCGs and Functions Meetings are being scheduled for January and February 2026 with relevant Lead Executives and CCG/Function leads to review recommendations and agree on next steps. Progress on these meetings will be presented to ARAC as part of the Internal and External Recommendations and WHC Tracking Assurance Report.</p> <p>The progression of the implementation of recommendations is assessed on a monthly basis as part of the Health Board's Internal Escalation Framework, reporting to</p> |

| Minute No. | Meeting Date | Subject | Action | Lead | Timescale | Progress/Date Achieved |
|------------|--------------|-------------------------------------|---|------|---------------|--|
| | | | | | | CCG and Executive Functions on a monthly basis, and regularly reported to the relevant Board Committee via the Assurance and Risk Report. Due to ongoing operational pressures, the Chief Operating Officer has requested that these meetings are stood down and will therefore be rearranged for Summer 2026. Estates and Facilities and Primary Care meetings have progressed as planned. |
| AC(25)187 | 09/12/2025 | Table of Actions | AC(25)164 – to circulate to Members the email response from Welsh Government | LD | February 2026 | Complete |
| | | | AC(25)171 – to clarify whether the revised Standard Operating Procedure (SOP) has been subject to the required governance processes | AC | February 2026 | See AC(25)171, above. |
| | | | AC(25)179 – to provide an update on the process of reviewing recommendations overdue by more than 6 months | JW | February 2026 | See AC(25)179, above. |
| AC(25)196 | 09/12/2025 | Internal Audit Plan Progress Report | To take forward via the Audit and Risk team communicating to the wider organisation the need to be | RW | February 2026 | Complete Communication on the significance of being open, honest, transparent and timely when responding to audit requests has been included within |

| Minute No. | Meeting Date | Subject | Action | Lead | Timescale | Progress/Date Achieved |
|------------------|-------------------|---|---|-----------|----------------------|---|
| | | | honest and open with audit partners | | | the Assurance and Risk Reports which are presented to CCG and Function meetings during January and February 2026. In addition, this detail has been uploaded to the Assurance and Risk Sharepoint site ensuring this information is accessible to staff across the organisation, and will also be incorporated in to the New Managers Training package, which is due to commence in January 2026. |
| | | | To consider potential dates for an additional ARAC meeting | JW | February 2026 | Complete There are ARAC meetings scheduled in April, May and June 2026, which at present should be sufficient to receive the remaining audit reports from the IA Internal Audit Plan for 2025/26. This will be reviewed as part of the weekly meetings with Internal Audit and considered at future agenda setting meetings. |
| AC(25)197 | 09/12/2025 | Financial Assurance Report | To highlight in the 3As report to Board breaches of SFIs | CM | January 2026 | Complete Included in ARAC Update Report to January 2026 Public Board meeting. |
| AC(25)204 | 09/12/2025 | Review of Urgent and Emergency Care - Patient Flow (Regional Report) | To update Members outside the meeting on work being undertaken in this area | AC | February 2026 | Complete Discussed as part of establishment of the Winter Resilience Incident Control Group and the UEC business case. |

| Minute No. | Meeting Date | Subject | Action | Lead | Timescale | Progress/Date Achieved |
|------------|--------------|-----------------------|---|-------|---------------|---|
| | | | To provide the raw data for Appendix 2 (reasons for delayed discharges) | BH | February 2026 | Complete Circulated via email on 6 January 2026. |
| | | | To discuss outside the meeting whether the contents of the management response can be revisited | AC/JW | February 2026 | In Progress Colleagues at the Regional Partnership Board were due to meet on 21 January 2026 to discuss the management responses and underpinning processes to monitor progress against the recommendations. The Head of Assurance and Risk is currently scoping a date to meet with the Regional Partnership Programme Manager and the Community and Integrated Medicine Clinical Care Group Director to further review the responses as a result of this meeting, and support the ongoing monitoring of the implementation of the recommendations in February 2026, pending availability of leads due to current operational demands. |
| AC(25)205 | 09/12/2025 | Risk Assurance Report | To examine prior to the next report the escalation level for the CIM CCG | RW | April 2026 | Complete Monthly analysis continues for all CCGs and Functions as part of the internal escalation framework, with progress to be provided to ARAC on the performance of CIM within the Governance domain in April 2026, via the next Risk Assurance Report. |

2.3

09:35, 0 Mins

2.3 - Matters Arising not on Agenda

*Rhodri Evans (Hywel
Dda UHB -
Independent
Member)*

| For discussion

2.4

09:35, 15 Mins

2.4 - Escalation Status Update Report

Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

| For assurance

Attachments

[2.4 Escalation Update ARAC February 2026.pdf](#)



1. Finance,
strategy and
planning

2.
Performance
and
outcomes

**Escalation
Domains**

3. Fragile
services

4. Quality of
care

ARAC - 10 February 2026

Escalation Progress Report



ARAC update: oversight & escalation | January 2026

Key messages

1) Positive progress

- Leadership & Governance has been de-escalated to Level 1 (routine).
- Governance actions now sit within Business As Usual (BAU) assurance routes.

2) What remains for ARAC

- ARAC retains oversight of escalation risk, controls and evidence.
- Risk of “standing down” oversight while Level 4/3 domains remain. However, the residual de-escalation criterion are all fully aligned to committees.

3) Next 2 months

- Assurance will pivot to whether credible delivery plans exist.
- Annual Plan 2026/27 is the vehicle for integrated oversight and line of sight.

Escalation at a Glance

Escalation status at a glance (Jan 2026)

Current escalation levels are multi-domain - de-escalation in Governance & Leadership is welcome but does not remove the need for grip and wider oversight elsewhere.

| Domain | Current level | Assurance focus (high level) |
|-------------------------------------|---------------------------------|--|
| Leadership & Governance | Level 1 (routine) | BAU assurance; sustain standards and evidence; avoid loss of grip |
| Finance | Level 4 (targeted intervention) | Recovery trajectory, control environment, opportunities pipeline |
| Strategy & planning | Level 4 | Approvable annual plan; integrated planning; Clinical Services Plan (CSP) roadmap; regional planning |
| Fragile services (CSP specialities) | Level 4 | Integrated improvement plans; workforce/estates dependencies; Board sight |
| Urgent & emergency care | Level 4 | Trajectories + enabling metrics (flow/long stays); sustained improvement |
| Quality of care: HCAIs | Level 4 | Root cause + Quality Improvement (QI) plan; outbreak response; sustained reductions |
| Planned care & cancer | Level 3 (enhanced monitoring) | Improvement plan; waiting time criteria; patient experience/concerns and theatres |



Why this is now a different ARAC conversation

Governance papers can step down into BAU routes, but ARAC's escalation assurance duty remains.

- Leadership & Governance criteria are now “business as usual” (routine arrangements).
- The Oversight & Escalation Framework still expects Board ownership, clear governance, SROs and evidence of progress.
- For non-quantifiable areas, Welsh Government can de-escalate based on sustained improvement with a credible improvement plan (even if not every criterion is fully met).
- For quantifiable outcomes/targets (which most of the the Health Board's are at this stage) , de-escalation is automatically triggered once criteria are met and sustained; requiring continuous readiness and an evidence pack.
- Therefore, ARAC focus pivots from “governance actions” to ensure credible plans are consistently in place and the control environment, risk movement, and quality evidence is fully aligned across remaining domains.

Question – There needs to be a consideration how this can be done pragmatically without cutting across the other committees? Could a more fundamental question focus on whether there are overarching delivery plans in place and whether they are delivering?



What needs to be assured now (high level)

ARAC assurance question: are there credible, resourced and monitored plans to deliver the remaining de-escalation criteria?

Plan quality (the “how”)

- Prioritised actions with named SROs/owners and clear accountability.
- Trajectories and milestones aligned to de-escalation criteria and national measures.
- Dependencies and decision gates explicit (workforce, estates, partners).
- Controls: triggers, tolerances, and escalation routes when delivery slips.
- A committee with overarching oversight across all domains?

Evidence and Assurance (the “show”)

- A single evidence register (actions, minutes/decisions, trajectories, audits).
- Demonstrated learning from concerns/complaints/incidents where required.
- Sustained improvement for required periods (where criteria are quantifiable).
- Independent scrutiny where appropriate (e.g., Internal Audit / QSE oversight).

Strengths and Areas Requiring Further Scrutiny



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Current position: strengths and where assurance is thin

An honest view (to support effective ARAC assurance).

Strengths to build on:

- Governance and Leadership de-escalation achieved and embedded into BAU.
- Annual plan architecture is moving to “evidence not narrative” (decision gates, minimum inputs).
- Specific programme propositions are strengthening (e.g., Flow/Frailty via 7-day Clinical Streaming Services (CSS)/Same Day Emergency Care (SDEC)/Hospital@Home), but will require oversight and impact analysis in line with representations?

Where assurance is thin (risk)

- Not yet a single integrated plan showing end-to-end line of sight across all escalation domains.
- Welsh Government feedback highlights limited evidence and (critically) missing supporting actions with owners/timelines.
- Interdependencies: workforce constraints, Healthcare Acquired Infections (HCAI) pressures and variable Clinical Care Group (CCG) deliverability can create new risks if not considered holistically..

Annual Plan = Delivery + Assurance Vehicle

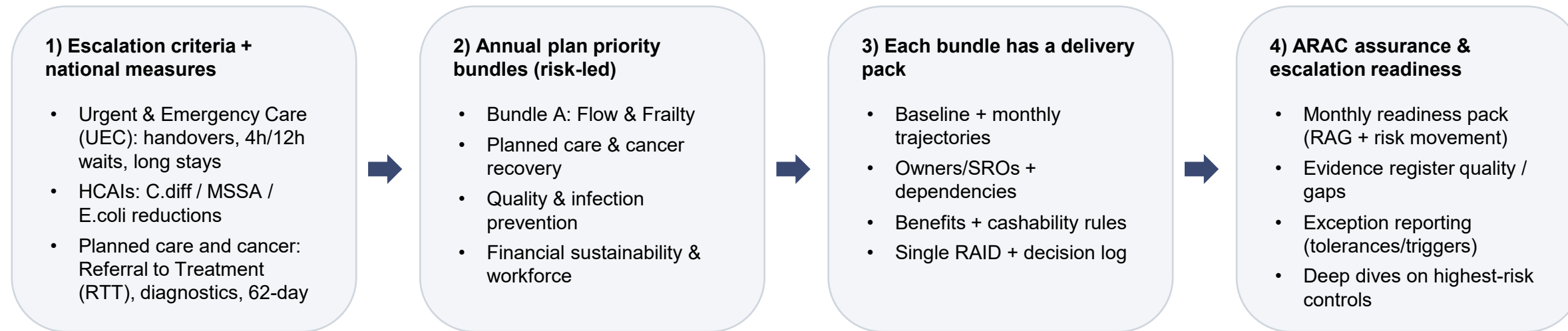


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Annual Plan 2026/27: the assurance vehicle for de-escalation

The annual plan should provide a single “line of sight” from escalation criteria → delivery actions → trajectories → risk and assurance.



What changes in practice:

- ARAC receives a consistent escalation readiness pack, using annual plan trajectories as the “single source of truth”.
- Assurance focuses on integration, dependencies, risk controls and the quality of the evidence base (not the volume of reporting).
- Oversight around whether programmes are sufficiently resourced to deliver the intended outcomes?



Next 2 months: oversight & assurance cadence

Aim: maintain the momentum of de-escalation while strengthening assurance on the remaining Level 4/3 areas.

February 2026 – build the assurance spine

- Confirm SROs and committee assurance map for each escalation domain.
- Lock metric definitions, baselines and trajectories (incl. enabling actions, metrics).
- Stand up a single evidence register (with “done” definitions).
- ARAC deep dive: finance control environment + top escalation risks.

March 2026 – integrate and sign off

- Integrate finance, workforce, service trajectories and dependencies.
- Finalise priority bundles and “what stops/defers” decisions.
- Board approval of Annual Plan 2026/27 and associated assurance pack.
- ARAC assurance: evidence quality, exception triggers and readiness for next escalation review.

What ARAC will see (each cycle)

- RAG summary by domain (trajectory + actions + evidence).
- Top risks and movement (new risks emerging from CCG plans and dependencies).
- Exceptions: where tolerances are breached, and what decisions are required.

What we need from ARAC

Proposed ARAC actions/decisions (to strengthen escalation assurance over the next 2 months):

ARAC to agree

- **Note** the de-escalation to Level 1 for Leadership & Governance and confirm BAU reporting route.
- **Endorse** the shift in assurance focus to: plan credibility, controls and evidence across remaining Level 4/3 domains.
- **Agree** a standing “escalation readiness” pack to ARAC (monthly/meeting cycle) until Annual Plan submission.
- **Agree** 2–3 targeted deep dives where assurance is highest risk (suggest: where plans don’t provide the requisite assurance).
- **Confirm** how ARAC will monitor new risks emerging from CCG delivery plans and interdependencies (workforce, estates, infection).

2.5

09:50, 5 Mins

2.5 - All Wales NHS Audit Committee Chairs'
Meeting Update

*Rhodri Evans (Hywel
Dda UHB -
Independent
Member)*

| For information

Attachments

[2.5 AWACC Meeting Notes 26 January 2026.pdf](#)

**ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING
NOTES FROM THE MEETING HELD REMOTELY VIA
MICROSOFT TEAMS ON 26 JANUARY 2026 AT 10AM**

Please note, this is not intended to serve as a formal minute of the meeting. It is a Copilot-generated summary designed to support those who were unable to attend and to inform the actions and decisions log.

It was agreed at the meeting held on 30 September that formal minutes would not be taken or presented in a public format. This decision reflects the nature of the All Wales Audit Chairs Committee, which is not a decision-making forum but rather a valuable peer support group.

MEMBERS PRESENT:

| | |
|----------------|---|
| Peter Curran | Chair, Welsh Ambulance Services NHS University Trust |
| Anne Beegan | Audit Wales (<i>Part 1 only</i>) |
| Simon Cookson | NWSSP Internal Audit (<i>Part 1 only</i>) |
| Graham Dainty | Head of NHS Counter Fraud Services (Wales) (<i>Part 1 only</i>) |
| Stephen Elliot | Powys Teaching Health Board, Independent Member |
| Rhodri Evans | Hywel Dda University Health Board, Independent Member (<i>joined at 11:36am during item 7.1</i>) |
| Gareth Jones | Velindre NHS Trust, Independent Member |
| Iwan Jones | Aneurin Bevan University Health Board, Independent Member |
| Alistair Klaas | Independent member – Executive Board (DDHCW) (<i>Deputising for Marian Jones</i>) |
| Alun Lloyd | Health Education and Improvement Wales |
| Trish Mills | Director of Corporate Governance/Board Secretary, Welsh Ambulance Services NHS University Trust |
| Carl Window | Counter Fraud Manager, Welsh Ambulance Services NHS University Trust (<i>Part 1 only</i>) |
| Dave Thomas | Audit Wales (<i>Part 1 only</i>) |
| Anthony Veale | Audit Wales (<i>left at 10:30am</i>) |

IN ATTENDANCE:

| | |
|---------------|--|
| Sarah Harland | Secretariat, Welsh Ambulance Services NHS University Trust |
|---------------|--|

APOLOGIES:

| | |
|-----------------|--|
| Pippa Britton | Chair of the Board, Public Health Wales |
| Andrew Doughton | Audit Wales |
| Dave Edwards | Cardiff & Vale University Health Board, Independent Member |
| Helen Jones | Audit Wales |
| Marian Jones | Digital Health Care Wales, Independent Member |

| | |
|-----------------|--|
| Paul Lambert | Betsi Cadwaladr University Health Board Independent Member |
| Ceri Mcgaugie | Betsi Cadwaladr University Health Board, Corporate Office |
| Patsy Roseblade | Cwm Taf Morgannwg, Independent Member |
| Nuria Zolle | Swansea Bay University Health Board, Independent Member |

PART A - EXTERNAL BRIEFINGS

Agenda Item 3 Audit Wales Update

- **Transition & Thanks:** Dave Thomas confirmed his upcoming retirement in March and thanked the group for their engagement.
- **Governance Activities:** Audit Wales has been active in the governance space, collaborating with the All Wales Director of Corporate Governance Group and presenting on best practices for SMART setting objectives in IMTPs and measuring impact.
- **National Reports:** Anne Beegan highlighted ongoing national reports, including access to education for children (with health board relevance), urgent and emergency care, and planned care. Updates on NFI work and fraud-related reports (GP practice list and community pharmacy data pilot) were shared, noting generally good arrangements but some areas for improvement.
- **2025-26 Accounts Audit Update:** Anthony Veale provided a heads-up for the upcoming accounts round:
 - All health boards met last year's deadlines, with Powys slightly delayed but resolved.
 - Regularity opinions for health boards were qualified due to the three-year break-even duty; trusts and SHAs were unqualified.
 - Remuneration report issues (salary sacrifice, temporary senior posts) have clearer guidance this year.
 - Additional senior officer disclosures for hosted bodies expected.
 - Timetable remains similar: accounts due to Welsh Government by early May, audit report by end of June.
 - No major technical changes anticipated; minor updates only.
 - Audits will start earlier, with more interim work post-COVID.
 - No expected disruption from Senedd elections unless a political issue arises during the audit.
- **Structured Assessment Themes:** Dave and Anne noted overall positive findings in corporate governance across health bodies, with variability in Board Assurance Frameworks (BAFs), risk assurance, and financial savings planning. Workforce planning and skills for cost savings and transformation remain areas to watch.

Agenda Item 4 Update from Internal Audit

- **Audit Progress:** Simon Cookson reported audit progress is on track, with most work delivered as planned for 2025/26. The busiest period is January to May, with some last-minute changes expected. About 60% of findings relate to compliance with existing policies and procedures.
- **External Quality Assessment (EQA):** The next EQA will be under new global internal audit standards, requiring a more formal process and sign-off by each Audit Committee. Timing is flexible but ideally completed by summer next year.
- **AI and Efficiency:** Internal audit is exploring AI to improve efficiency, but quality assurance and control will be a focus to mitigate risks. No formal standards yet link AI to audit requirements, but this may change in the future.
- **Audit Metrics:** The percentage of limited/unsatisfactory audits is currently 14% (down from 17-18% last year). Management response times are slightly behind last year but tend to improve as year-end approaches.
- **Resource Pressures:** Internal audit is also facing financial pressures and is looking for ways to work more efficiently.
- **Knowledge Sharing:** There has been a relaunch of the audit database and increased training/support following interest from the Governance Conference.

Agenda Item 5 Counter Fraud

- **Liaison Group Activities:** Carl Window updated on the Counter Fraud Liaison Group's recent work, including positive feedback on group effectiveness and ongoing collaboration with Audit Wales on the National Fraud Initiative (NFI). NHS compliance with NFI is strong, but further improvements and collaboration with internal audit/accounts payable teams are being considered.
- **Strategy & Accreditation:** Input is being provided to the Fighting Fraud Strategy, and accreditation requirements for Counter Fraud qualifications are under review, with updates expected soon from the National Account Fraud Authority.
- **Risk Assessment:** The group is focusing on more coordinated risk assessment approaches across Wales, with outcomes to be shared with the Counter Fraud Steering Group.
- **Chair & Terms:** Carl's role as chair is up for review, but they will continue for stability through the next financial year.
- **Quarterly Report & Resources:** Graham Dainty noted the quarterly report is shared with Directors of Finance and can be made available to Audit Chairs. Resource levels vary across health boards, with Aneurin Bevan best resourced. Graham also announced his upcoming retirement and succession planning.
- **Welsh Government Directions:** New directions for Counter Fraud are expected soon, which will clarify accreditation and training requirements.

Agenda Item 6 Update from the Director of Corporate Governance

- **Community of Practice Conference:** Trish Mills highlighted the success of the first corporate governance community of practice conference, with strong engagement and positive feedback. Plans are underway for another event, likely in October, possibly in Wrexham.
- **Master Classes & Blogs:** Three master classes have been held so far and were well received, covering topics like risk, audit trackers, and governance. These sessions are open to all governance team members and are complemented by a schedule of monthly blogs and master classes.
- **Board Induction Programme:** HEIW presented a new module-based induction programme for board members, designed for both new and existing non-executive and executive directors. The programme will align with local induction and include modules on data interpretation, financial literacy, and performance measures.
- **Shared Learning:** The group is focused on sharing best practices and lessons learned, especially around risk and public accountability meetings, to avoid duplication and promote efficiency across organisations.
- **Information Flow:** Trish emphasised that updates and learnings from the group should flow through Directors of Corporate Governance to individual organisations and that agenda items that are relevant for Audit Committee oversight can be brought to this group as needed.

PART B - ALL WALES AUDIT COMMITTEE CHAIRS

Agenda Item 7.1 Deep Dive -Challenges (including conflicts) faced by Audit Committee Chairs and Members

The Committee discussed the governance implications of audit committee cross-membership, including independence, role clarity and the practical constraints arising from limited non-executive capacity. It was agreed that Directors of Corporate Governance would discuss how best to embed clarity on roles and responsibilities within their organisations to support effective management of any associated conflicts.

Agenda Item 7.2 Deep Dive - planning for next session (Board Assurance Framework, Risk Management & Appetite, Counter Fraud issues, Audit Committee role in partnership working, Clinical Audits, Financial sustainability/Digital)

The group agreed that the next deep dive would focus on risk management and risk appetite from an audit committee oversight perspective, rather than operational detail, with Trish and the Chair to draft and circulate a high-level scope for comment, recognising differing levels of organisational maturity.

Agenda Item 8 Invitation for all members to feedback from their experiences and learnings from the recent Public Accountability Meetings

Members reflected on their experiences of Public Accountability Meetings.

Agenda Item 9 Reflections of the Meeting

The group agreed in principle to hold one meeting per year in person, potentially opening it up to other Audit Committee members. The Chair, Trish and Stephen Elliot volunteered to form a small group to plan the logistics and details for the in-person meeting, aiming for around April. They will send out proposals to the wider group.

The date and time of the next meeting is to be confirmed.

2.6

09:55, 5 Mins

2.6 - Scheme of Delegation

*Joanne Wilson
(Hywel Dda UHB -
Director of Corporate
Governance/Board
Secretary)*

| For approval

Attachments

[2.6 SBAR Scheme of Delegation ARAC February 2026.pdf](#)

[2.6 Master SoD 2026 for review by ARAC 10.02.26.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

| | |
|--|---|
| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 10 February 2026 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Revised Scheme of Delegation |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Joanne Wilson, Director of Corporate Governance/Board Secretary |
| SWYDDOG ADRODD: REPORTING OFFICER: | Charlotte Wilmshurst, Assistant Director of Assurance and Risk |

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

To present the amendments to the Hywel Dda University Health Board's (HDdUHB's) Corporate Scheme of Delegation (SOD) to the Audit and Risk Assurance Committee for review, prior to onward submission to the Board for approval on 26 March 2026.

Cefndir / Background

It is necessary to ensure that Local Health Board, Trust and Joint Commissioning Committee (JCC) Model Standing Orders and Standing Financial Instructions are kept up to date and take account of any developments. NHS organisations in Wales are required to review their Standing Orders and Standing Financial Instructions against these Model Standing Orders and Standing Financial Instructions on an annual basis.

The Health Board's current Corporate Scheme of Delegation (SOD) was approved by Board on 29 May 2025. Revisions have been made in line with changes to Executive portfolios agreed by the Remuneration and Terms of Service Committee since that time.

The full version of the SOD was recently reviewed at Formal Executive Team on 21 January 2026, identifying the revised responsibilities in respect of their portfolio areas in light of the gaps identified and also in line with changes agreed and approved at Remuneration and Terms of Service Committee meetings since the Scheme of Delegation was previously approved by the Board, as follows:

- Transfer of the management of Facilities, Estates, Property and Discretionary Capital transferred from Chief Operating Officer to Director of Allied Health Professions and Health Science.
- Transfer of Major Capital transferred from Chief Operating Officer to Director of Strategy and Planning.
- Transfer of direct line management of Allied Health Professions from Director of Allied Health Professions and Health Science to Chief Operating Officer.

- Transfer of responsibility for Medical Records Directorate from Chief Operating Officer to Director of Finance.
- Joint responsibility for the management of Clinical Audit between Medical Director and Director of Nursing, Quality and Patient Experience.
- Transfer of Medicines Management, performance issues (Medical, dental, pharmacy, optometry), management of performance panels and matters arising from managed practices to Medical Director
- Transfer of Primary Care Estates, Primary Care and Community Strategic Plan to Director of Strategy and Planning, following the departure of the Director of Primary Care, Community Strategy and Long Term Care.
- Transfer of the management of the Out of Hours Service from the Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer.

Asesiad / Assessment

An annual review of the Scheme of Delegation has been undertaken. The revised document is attached as Appendix 1, and for ease the changes have been extracted below:

| Section | What has changed? | Rationale? |
|---------------------------------------|--|--|
| STANDING ORDERS | <p>WORKING IN PARTNERSHIP 6 Identification and engagement with all key partners and regular review of effectiveness</p> | Amended Operational Responsibility to include All Executives as this is a key part of their roles. |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | <p>AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT 3.4 External Audit Formally consider and review the External Audit Strategy</p> <p>Review the External Audit Annual Plan and the associated fees, and consider any material changes to the annual audit plan</p> | Additional wording included to match the narrative from the relevant sections from the SFI. |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | <p>AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT 3.5.4 Fraud and Corruption Provide a written report to the Director of Finance and Audit Committee, at least annually, on counter fraud work within the LHB</p> | Delegated responsibility changed from Director of Finance to Local Counter Fraud Specialist as this is part of their role. |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | <p>FINANCIAL MANAGEMENT AND BUDGETARY CONTROL</p> | Additional/amended wording included to match the narrative from the relevant |

| | | | |
|--|---|---|--|
| | <p>5.2.1 Budgetary Delegation 5.3.2 Financial Management and Budgetary Control 5.3.3 Financial Management and Budgetary Control</p> <p>ANNUAL ACCOUNTS AND REPORTS 6.2 Annual Accounts and Reports 6.5 Annual Accounts and Reports</p> <p>CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS 8.2 Petty Cash</p> <p>INCOME, FEES AND CHARGES 9.4.1 Income Due and Debt Recovery 9.4.2 Income Due and Debt Recovery</p> <p>NON-PAY EXPENDITURE 10.2.1 Non Pay Expenditure 10.3 Non Pay Expenditure 10.6.1 Prepayments</p> <p>PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES 11.1 Procurement and Contracting for Goods and Services 11.2 Procurement and Contracting for Goods and Services 11.7 Sustainable Procurement 11.9 Planning Procurement</p> | <p>sections from the SFI as per WHC/2025/012.</p> | |
|--|---|---|--|

| | | | |
|---------------------------------------|--|---|--|
| | <p>11.10 Process Procurement / Procurement Thresholds 11.11 Procurement Thresholds 11.12 Procurement Thresholds 11.13 Procurement Thresholds 11.15 Evaluation, Approval and Award 11.16 Contract Management 11.17 Extending and Varying Contracts 11.19 No Purchase Order, No Pay</p> <p>CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS 15.4.8 Capital Procedures and Responsibilities Ensure for each capital project over £2m that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so.</p> | | |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | <p>STORES AND RECEIPT OF GOODS. 16.2.1c Control of Stores, Stocktaking, Condemnations and disposal. c) Responsible for the control of pharmaceutical stocks 16.2.2 Control of Stores, Stocktaking, Condemnations and disposal. Security arrangements and custody of keys</p> | Following a change to Director portfolios, as agreed in RTSC on 3 December 2025, Delegated Responsibility has changed from the Director of Primary Care, Community Strategy and Long Term Care to Medical Director. | |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | <p>FUNDS HELD ON TRUST (CHARITABLE FUNDS) 20.2.2 Accountability to Charity Commission and the Welsh Ministers</p> | Senior Finance Business Partner replaced with Head of Accounting and Statutory Reporting | |

| | | |
|---------------------------------|--|--|
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Improving Patient Experience Developing a Patient Experience Strategy | Operational responsibility changed from Assistant Director of Patient Experience to Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Management of Patient Safety Alerts Maintaining a record of patient safety alerts and monitoring compliance | Operational responsibility changed from Assistant Director of Nursing Quality and Governance to Assistant Director of Nursing Assurance and Safeguarding (grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Health and Care Standards Assessment Completing assessment and compliance with the standards | Operational responsibility changed from Assistant Director of Nursing Quality and Governance to Assistant Director of Nursing Assurance and Safeguarding (grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Performing the role of the NCEPOD Ambassador and collation and provision of information to contribute to NCEPOD audit findings. | Delegated responsibility changed from Director of Nursing, Quality and Patient Experience to Medical Director and Operational Responsibility changed from Assistant Director of Nursing for Planned and Specialist Care Clinical Care Group to Assistant Director – Medical Directorate. |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Safeguarding of Adults and Children Implementation of policy and procedures | Assistant Director of Nursing MHL D added to operational responsibility list. |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Safeguarding of Adults and Children Safeguarding supervision | Operational responsibility changed from Assistant Director of Nursing Quality and Governance to Assistant Director of Nursing Assurance and Safeguarding (grade 5 only) Operation Team (other) |

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| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Safeguarding – Deprivation of Liberties Supervising Authority | Delegated responsibility changed from Director of Primary Care, Community and Long Term Care to Chief Operating Officer and Community and Integrated Medicine Clinical Care Group Service Director added to Operational Responsibility. |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Management of Infections, Diseases and Notifiable Outbreaks | Operational responsibility changed from Assistant Director of Nursing Quality and Governance to Assistant Director of Nursing Assurance and Safeguarding |
| SCHEME OF DELEGATION FROM OTHER | QUALITY, SAFETY AND EXPERIENCE Referrals to any professional body for any Primary care contractor including Medical and Dental | Delegated and Operational responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Medical Director |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Development of a Primary Care Strategy | Name change from Primary Care Strategy to Community by Design Strategic Plan with Delegated and Operational responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Director of Strategy and Planning. |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning (including Primary Care Services) a) Approval to commission new healthcare services from NHS, private, third sector or independent organisations | Removed Director of Primary Care, Community Strategy and Long Term Care from both Delegated and Operational responsibility. |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning (including Primary Care Services) b) Agreement to provide services and payments in accordance with Medicines Management Incentive Scheme | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Medical Director |

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| <p>SCHEME OF DELEGATION FROM OTHER</p> | <p>COMMISSIONING Commissioning (including Primary Care Services) c) Maintaining a register of commissioning contracts d) Ensuring every commissioning contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance e) Agreement of annual contract with existing providers and within existing budgets - NHS, third sector, independent or private f) Agreement of contract variations m) Ensuring there is a commissioning framework in place which sets out expectations around what will be included in documentation and approach to management including meetings n) Ensuring there is a contracting framework in place which sets out expectations around what will be included in documentation and approach to management including meetings o) Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place p) Ensuring that there are regular meetings in place to monitor performance against commissioning contracts, that recovery plans are agreed where there are performance or finance issues and that matters of concern are escalated appropriately</p> | <p>Removed Director of Primary Care, Community Strategy and Long Term Care from both Delegated and Operational responsibility. Added Chief Operating Officer in replacement.</p> | |
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| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning (including Primary Care Services) q) Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs) | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning of Continuing Healthcare and Funded Nursing Care a) Approving new care packages in line with HB policy and procedures b) Authorising emergency care packages or changes to care packages outside panel | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. Service Director for Community and Integrated Medicine added to Operational Responsibility |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning of Continuing Healthcare and Funded Nursing Care c) Authorising of invoices against agreed packages of care | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning of Continuing Healthcare and Funded Nursing Care d) Authorising CHC retrospective claims including Powys and UHB claims | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. Operational responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Service Director for Community and Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING Commissioning of Continuing Healthcare and Funded Nursing Care e) Decision to go to arbitration or take legal action in relation to any commissioning or provider contract | Changed Operational Responsibility from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer |

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| SCHEME OF DELEGATION FROM OTHER | COMMISSIONING N/A Provision of Low Vision Service for HDdUHB population. | Delegated and Operational responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL Operational Delivery of: f) Primary Care | Following a change to Director portfolios as agreed in RTSC on 3 December 2025 Delegated Responsibility has changed from the Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer; Operational Responsibility has transferred to Assistant Director of Primary Care. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL Operational Delivery of: m) Out of Hours Service | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL Operational Delivery of: r) Hospital Helicopter Landing Sites (HHLS) – Accountable Manager | New entry – delegated to the Chief Operating Officer with the Service Director for Community and Integrated Medicine having Operational Responsibility. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL Operational Health Records Management a) Physiotherapy Records b) Occupational Therapy Records c) Speech and Language Therapy Records d) Dietetics Records e) Podiatry Records | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Chief Operating Officer (and Director of Primary Care, Community Strategy and Long Term Care for j, aaa, aab & aac) to Director of Finance. |

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| | <ul style="list-style-type: none"> f) Orthoptic Records g) Audiology Records h) Cardio Physiologist Records i) Neurophysiology Records j) OOH Clinical Service Records k) Acute Medical Records l) Primary Care m) District Nursing n) Community o) Outpatient service records p) Palliative Care Records q) Nursing Records r) Mental Capacity Records s) Specialist Nurse (tissue viability records) t) Cancer Services Records u) Community Paediatric Records v) Acute Paediatric and Neonates Records w) Community Children's Service Records x) Midwifery and Women's Health Records y) Obstetrics and Gynaecology Records z) Pathology Records aa) Radiology Records ab) Cardiology Records ac) Renal Records ad) General Medicine Records ae) Gastroenterology Records af) Neurology Records ag) Stroke Records ah) Care of The Elderly | <p>Operational responsibility for l) Primary Care has changed from Primary Care Clinical Care Group Service Director to Assistant Director of Primary Care</p> <p>Operational responsibility for m) District Nursing has changed from Primary Care Clinical Care Group Service Director to Clinical Care Group Service Director – Community and Integrated Medicine.</p> <p>Operational responsibility for n) Community has changed from Primary Care Clinical Care Group Service Director to Clinical Care Group Service Director – Community and Integrated Medicine.</p> | |
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| | <ul style="list-style-type: none"> ai) General surgery, vascular, breast care records aj) Ophthalmology Records ak) Ear, Nose and Throat Records al) Trauma and Orthopaedics Records am) Plaster Services Records an) Dermatology Records ao) Rheumatology Records ap) Theatres Records aq) Day Surgery Unit Records ar) Pre-assessment Records as) Endoscopy Records at) Anaesthetics Records au) Urology Records av) Critical Care Records aw) Mental Health and Learning Disability Records ax) Psychology Records ay) Mental Health Subject Access Requests az) Acute Subject Access Requests aaa) Managed Practices records aab) Low Vision records aac) Dental services records for specific services and not independent Dental Practices | | |
| SCHEME OF DELEGATION FROM OTHER | <p>OPERATIONAL Managed Practices Delivery of managed practices Management and service delivery of Health Board Managed Practices (including premises contracts)</p> | <p>Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer.</p> | |

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| | | Operational Responsibility has changed from Director of Primary Care, Community Strategy and Long Term Care to Assistant Director of Primary Care. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL N/A Medicines Management Development of a medicines optimisation strategy (primary & secondary care) | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Medical Director. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL N/A National Contracts for GMS, Dental, Community Pharmacy and Optometry, including implementation, monitoring, performance management and reporting | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL N/A Performance issues (Medical, dental, pharmacy, optometry) management of performance panels and matters arising from managed practices. | New entry – delegated to Medical Director with the Assistant Director of Primary Care having Operational Responsibility |
| SCHEME OF DELEGATION FROM OTHER | OPERATIONAL Estates a) Develop an estates strategy and rationalisation plan f) Delivery of Capital Estates Projects | Change of job title from Director of Estates and Facilities to Programme Director Capital and Major Infrastructure. |

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| SCHEME OF DELEGATION FROM OTHER | CORPORATE Partnership Working Health Board link with Llais | Operational Responsibility added Communications and Engagement Director given the close working links to Llais. |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Communications a) External Communications including relationships with press, key stakeholders and the public b) Internal communications with staff (Corporate Information) c) Developing and maintaining the organisation's external website, staff intranet, social media and e-Communications d) Responsibility for the effective implementation, delivery and evaluation of the organisation's Communications and Engagement Strategy | Operational Responsibility changed from Assistant Director of Communications to Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Annual Report b) Annual Report – Performance Report | Operational Responsibility changed from Assistant Director of Communications to Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Sponsorship b) Sponsorship of HB events | Operational Responsibility changed from Assistant Director of Communications to Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Advertising b) other | Operational Responsibility changed from Assistant Director of Communications to Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Partnership Governance | Added Delegated Responsibility to Chief Executive Officer and added Director of |

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| | b) Performance management and monitoring of outcomes of work delivered through partnerships and other inter-organisational arrangements | Strategy and Planning to the Operational Responsibility. |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Partnership Governance Regional Partnership Board Governance | Changed Delegated Responsibility from Director of Primary Care, Community Strategy and Long Term Care to Chief Executive Officer |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE Equality, Diversity and Human Rights Public Sector Equality Duty (2016) | Changed Operational Responsibility from Director of Public Health to Assistant Director of Business, Partnerships and Inclusion / Consultant in Public Health |
| SCHEME OF DELEGATION FROM OTHER | CORPORATE N/A Targeted Intervention | Job title change from Deputy Director of Operational Planning and Commissioning to Director of Delivery |
| SCHEME OF DELEGATION FROM OTHER | WORKFORCE Workforce Planning, Recruitment and Retention b) Establish & implement workforce plans to address key performance measures in sickness reduction, appraisal rates, mandatory training, job planning and employee relations, support & investigation | Change of Operational Responsibility from Head of Strategic Workforce Planning to Assistant Director of People Planning. |
| SCHEME OF DELEGATION FROM OTHER | WORKFORCE N/A Staff Side and Employee Relations | Changed operational responsibility from Head of Workforce to Assistant Director of People Management. |
| SCHEME OF DELEGATION FROM OTHER | WORKFORCE N/A Workforce Equality and Diversity | Removal of Director of Public Health from Delegated Responsibility. |
| SCHEME OF DELEGATION FROM OTHER | WORKFORCE Disciplinary investigations and dismissal of staff | Following a change to Director portfolios as agreed at RTSC on 3 December 2025 Delegated Responsibility and Operational |

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| | Dismissal of Primary Care contracted Medical and Dental staff (and other Contractor professionals) i.e. Optometry and Community Pharmacy | Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Medical Director. |
| SCHEME OF DELEGATION FROM OTHER | WORKFORCE N/A Workforce Policies and Procedures | Changed operational responsibility from Head of Workforce to Assistant Director of People Management. |
| LEGISLATION COMPLIANCE | CONCERNS N/A The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 | Replaced with new legislation – National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023 |
| LEGISLATION COMPLIANCE | CORPORATE N/A Social Services and Wellbeing (Wales) Act 2014 | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility and Operational Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| LEGISLATION COMPLIANCE | CORPORATE N/A The Partnership Arrangements (Wales) Regulations 2015 | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility and Operational Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| LEGISLATION COMPLIANCE | CORPORATE N/A The Health and Social Care (Wales) Act 2025 | New entry – New legislation Delegated and Operational Responsibility given to Chief Operating Officer. |

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| LEGISLATION COMPLIANCE | PATIENT SAFETY N/A Human Tissue Act 2004 – Corporate Licence Holder | Operational Responsibility changed from Director of Research, Innovation and Value and Consultant Histopathologist (Pathology Lead) to Clinical Care Group Service Director - Allied Health Professions and Health Sciences, Designated Individual - Consultant Pathologist |
| LEGISLATION COMPLIANCE | PATIENT SAFETY N/A Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 | Operational Responsibility changed from Assistant Director of Nursing for Quality, Assurance & Professional Regulation to Assistant Director of Nursing, Assurance and Safeguarding (Grade 5 only) Operation Team (other) |
| LEGISLATION COMPLIANCE | PATIENT SAFETY N/A Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Quality | Operational Responsibility changed from Assistant Director of Nursing Quality & Governance to Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only). |
| LEGISLATION COMPLIANCE | PATIENT SAFETY N/A Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Candour | Operational Responsibility changed from Assistant Director of Nursing Quality & Governance to Assistant Director of Nursing Assurance & Safeguarding |
| LEGISLATION COMPLIANCE | SAFEGUARDING N/A Children’s Act 1989, 2004 - Provides the legislative framework for child protection in Wales | Operational Responsibility changed from Assistant Director of Nursing for Quality, Assurance & Professional Regulation to Assistant Director of Nursing Assurance & Safeguarding |

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| LEGISLATION COMPLIANCE | SAFEGUARDING N/A Care Standards Act 2000 - Provides for the administration of a variety of care institutions, including, independent hospitals, nursing homes and residential care homes | Delegated responsibility changed from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. Operating Responsibility – Clinical Care Group Service Director – Community and Integrated Medicine added. |
| LEGISLATION COMPLIANCE | SAFEGUARDING N/A Protecting Vulnerable Groups Act 2006 - Provides the legislative framework for the new Vetting and Barring scheme | Operating Responsibility changed from Assistant Director of Nursing for Quality, Assurance & Professional Regulation to Assistant Director of Nursing Assurance & Safeguarding |
| LEGISLATION COMPLIANCE | FINANCE N/A Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 | New entry – new legislation Delegated responsibility given to Chief Operating Officer and Operational Responsibility to Clinical Care Group Service Director, Community and Integrated Medicine/Head of Long Term Care |
| LEGISLATION COMPLIANCE | FINANCE N/A Health Service Procurement (Wales) Act 2024 | New entry – new legislation Delegated and Operational Responsibility given to Director of Finance. |
| CAPITAL SCHEMES | Fire Enforcement Work WGH | Change of job title from Director of Estates and Facilities to Programme Director Capital and Major Infrastructure. |
| CAPITAL SCHEMES | Fire Enforcement Work GGH | Change of job title from Director of Estates and Facilities to Programme Director Capital and Major Infrastructure. |

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| CAPITAL SCHEMES | Cross Hands Health & Wellbeing Centre, Cross Hands, Carmarthenshire | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| CAPITAL SCHEMES | Aseptic Unit, Withybush General Hospital | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Medical Director. |
| CAPITAL SCHEMES | Cylch Caron, Tregaron | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| CAPITAL SCHEMES | Fishguard Wellbeing Centre | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred from Director of Primary Care, Community Strategy and Long Term Care to Chief Operating Officer. |
| CAPITAL SCHEMES | Llandovery Health and Wellbeing Hub | Removed from Scheme of Delegation due to the embryotic nature of the project. |
| CAPITAL SCHEMES | Sexual Assault Referral Centre (SARC) | Following a change to Director portfolios as agreed at RTSC on 3 December 2025, Delegated Responsibility has transferred |

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| | | from Project Director - Clinical Care Group Service Director – Community and Integrated Medicine to Director of Strategy and Planning (SRO) |
| CAPITAL SCHEMES | GGH Front Door Project | New entry Delegated Responsibility – Chief Operating Officer Operational Responsibility - Project Director - Director of Operational Planning & Performance |
| CAPITAL SCHEMES | Technical Estates Fund (TEF) | New entry Delegated Responsibility – Executive Director of Allied Health Professions and Health Science Operational Responsibility - Project Director - Head of Operations |
| CAPITAL SCHEMES | Pentre Awel | New entry Delegated Responsibility – Director of Strategy and Planning (SRO) Operational Responsibility - Project Director - Medicines Management Clinical Lead, Transformation Programme Office |
| CAPITAL SCHEMES | Picton Terrace | New entry Delegated Responsibility – Director of Strategy and Planning (SRO) Operational Responsibility – Head of Property |

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **REVIEW** and **RECOMMEND** the revised version of Hywel Dda University Health Board's (HDdUHB's) Scheme of Delegation for onward approval to the Board on 26 March 2026.

| Amcanion: (rhaid cwblhau) Objectives: (must be completed) | |
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| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Not Applicable |
| Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | Not Applicable |
| Amcanion Cynllunio Planning Objectives | Not Applicable |
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

Gwybodaeth Ychwanegol:

Further Information:

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| Ar sail tystiolaeth: Evidence Base: | Model Standing Orders and Standing Financial Instructions |
| Rhestr Termiau: Glossary of Terms: | Included within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg | Formal Executive Team Director of Corporate Governance/Board Secretary |

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| Parties / Committees consulted prior to Audit and Risk Assurance Committee: | |
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| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
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| Ariannol / Gwerth am Arian: Financial / Service: | Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved |
| Ansawdd / Gofal Claf: Quality / Patient Care: | Where applicable, included within the report. |
| Gweithlu: Workforce: | Where applicable, included within the report. |
| Risg: Risk: | A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed. |
| Cyfreithiol: Legal: | Model SOs are issued by Welsh Ministers to Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Health Boards in Wales must agree SOs for the regulation of their proceedings and business. SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others; and SFIs, they provide the regulatory framework for the business conduct of the Health Board. |
| Enw Da: Reputational: | Not Applicable |
| Gyfrinachedd: Privacy: | No direct impacts |
| Cydraddoldeb: Equality: | <p>The Model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SOs were subject to an in-house EqIA screening in September 2012, the outcome of which indicated no negative impacts in relation to the Health Board's duties under the Equality Act 2010. A summary report was produced to this effect. The March 2014 revisions have been scrutinised with no negative impacts identified; therefore, no amendments will be made to the report produced in September 2012.</p> <p>The most recent amendments outlined above and attached have been subject to an EqIA Screening, and there is no evidence at this stage of potential adverse impact in relation to equality, diversity or human rights. Should any issues arise at any stage following implementation of the revised SOs, a full EqIA will be undertaken as appropriate.</p> |

CORPORATE SCHEME OF DELEGATION

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM FOR CHIEF EXECUTIVES OF LOCAL HEALTH BOARDS

| SOURCE | REF | SECTION HEADER | SUB HEADER | | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|--------------------------------|------------|----------------|------------|--|-----------------|----------------------------|
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3a | Section 3 | N/A | Responsibility for:- a) The overall organisation, management and staffing of the LHB and its arrangements related to quality and safety of care as well as matters of finance, together with any other aspect relevant to the conduct of the LHB's business in pursuance of the strategic direction set by the LHB's Board, and in accordance with its statutory responsibilities; i) ensuring that all items of expenditure, including payments to staff, fall within the legal powers of the Board; ii) acting within the scheme of delegations and ensuring that you comply with guidance on classes of payment that you should authorise personally. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3b | Section 3b | N/A | b) Ensuring that in delegating functions to officers you are satisfied of their ongoing capacity and capability to deliver on those functions, facilitating access to the information they need, ongoing training and development, as well as professional or specialist advice where appropriate. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3c | Section 3c | N/A | c) Prudent and economical administration, for the avoidance of waste and extravagance, and for the efficient and effective use of all resources | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3d | Section 3 | N/A | d) Ensuring that the assets for which you are responsible are properly safeguarded, particularly: i) information, including systems for maintaining the trust of patients and the public by ensuring that the LHB will store, share and use information, including their personal information safely, and securely; and ii) land, buildings or other property (including stores and equipment) | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3e | Section 3 | N/A | e) Ensuring that, in the consideration of policy proposals relating to the expenditure or income for which you have responsibility, all relevant financial considerations (including any issues of propriety, regularity or value for money) are taken into account | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3f | Section 3 | N/A | f) Ensuring that risks to the achievement of the LHB's objectives and fulfilment of its statutory responsibilities are identified, that their significance is assessed, and that a sound system of internal control is in place to manage them; i) implementing an appropriate framework of assurance covering all aspects of LHB business, ensuring that research and evaluation work is planned so that strategic objectives and spending programmes for which you have responsibility are routinely evaluated to assess their effectiveness and value for money; ii) ensuring, as a key source of your internal assurance, that you establish arrangements for internal audit in accordance with the International Standards for the professional practice of Internal Audit as adopted by the NHS in Wales, Welsh Government and HM Treasury, and ensuring that appropriate action is taken in response to reports produced by Internal Audit. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3g | Section 3 | N/A | g) Ensuring that there are appropriate arrangements to counter fraud and that procedures for dealing with suspected cases of fraud are complied with | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3h | Section 3 | N/A | h) Ensuring that the LHB co-operates fully with external auditors, regulators and inspectors - including the Wales Audit Office (WAO), Healthcare Inspectorate Wales (HIW), and the Care and Social Services Inspectorate Wales (CSSIW), and ensuring that appropriate action is taken in response to any reports produced by such bodies | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 3i | Section 3 | N/A | i) Signing the LHB's accounts and, in doing so, accepting personal responsibility for their proper presentation fully supported by sound financial procedures and records, and in accordance with the LHB Accounts Directions issued by Welsh Ministers, ensuring that losses or special payments are properly identified and handled in accordance with defined requirements | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 4 | Section 4 | N/A | In regard to the planning, designing, developing and securing the delivery of safe, high quality primary, community, in hospital care services and, specialised and tertiary services for the citizens within the geographical areas covered by the LHB:- i) Ensure the LHB carries out these responsibilities in a way that fulfils its duty to ensure the quality and safety of healthcare and the proper stewardship of public money. ii) Take account of your corporate responsibilities and accountability to the LHB Board of which you are a member. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 5 | Section 5 | N/A | Ensure compliance with the principles set out within Managing Welsh Public Money and the framework and standards of good governance set for the NHS in Wales (as embodied within the Welsh Government's Citizen Centred Governance Principles and reflected within the contents of the NHS Wales Governance e-manual) i) Assist the Chair in ensuring that his/her establishment and implementation of the LHB's governance framework accords with these standards and principles. | Chief Executive | N/A |

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| ACCOUNTABLE OFFICER MEMORANDUM | Section 6 | Section 6 | N/A | Work in partnership with other organisations to achieve its strategic aims and objectives. i) Ensure that the wider impact of the activities for which you are responsible are properly identified and, where appropriate, taken into account in determining the governance and accountability arrangements overseeing such work ii) Ensure that the governance arrangements are formally recorded and that you put in place appropriate arrangements to provide you with assurance on those areas for which you are accountable. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 7 | Section 7 | N/A | Take joint responsibility for the delivery of a service through joint arrangements that involve the pooling of budgets. Such arrangements may be handled under a specific statutory authority, e.g., Section 33 of the National Health Service (Wales) Act 2006. - Where you and another Accountable Officer or Officers take joint responsibility, ensure that there is absolute clarity on all aspects of the service for which you are responsible and accountable. Specifically, you must set down, in a formal agreement, the governance and financial accounting arrangements, including audit and assurance requirements, in accordance with any requirements determined by the Welsh Government. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 8 | Section 8 | N/A | Ensure that where your LHB contracts with a third party for the provision of goods or services it does so in accordance with all relevant legislation together with any requirements determined by the Welsh Government. i) Ensure that appropriate systems are in place to provide assurance that such funds are allocated in accordance with the terms of the contract and are not misappropriated. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 9 | Section 9 | N/A | Responsibility to see that appropriate advice is tendered to the Board on all matters of financial propriety, regularity and value for money, and more broadly on all considerations of prudent and economic administration, efficiency and effectiveness | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 10 | Section 10 | N/A | If the Board or the Chair is contemplating a course of action which you consider would infringe the requirements of propriety, regularity or value for money, set out in writing to the Chair and the Board your objection to the proposal, the reason for your objection and your duty to inform NHS Wales Chief Executive and the external auditors if your advice is overruled. Wherever possible, the NHS Wales Chief Executive should be informed before the Board takes its decision. If it is not possible, due to the urgency of the situation, to notify the NHS Wales Chief Executive beforehand, and if the Board decides nonetheless to proceed against advice, a written instruction to take the action in question must be sought. The request for the instruction and the instruction itself should be communicated to the NHS Wales Chief Executive and to the external auditors without undue delay, and before the decision is implemented, so that any necessary intervene with the Board can be taken and Welsh Ministers informed. | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 11 | Section 11 | N/A | The Chief Executive should be generally available for consultation and that in any temporary period of unavailability, e.g., due to illness, or during normal periods of annual leave, responsibility should be delegated to a senior officer of the LHB | Deputy Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 12 | Section 12 | N/A | Should it becomes clear that the Chief Executive is so incapacitated that they are unable to discharge these responsibilities over a period of four weeks or more, the NHS Wales Chief Executive should be notified so that an Acting Accountable Officer can be designated pending the Chief Executive's return. The same applies if, exceptionally, an absence of more than four weeks is planned during which the Chief Executive cannot be contacted. | Deputy Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 14 | Section 14 | N/A | Responsibility for the Budgets assigned and to be held to account for the exercise of the responsibilities as Accountable Officer directly | Chief Executive | N/A |
| ACCOUNTABLE OFFICER MEMORANDUM | Section 16 | Section 16 | N/A | May be required to attend Public Accounts Committee with NHS Wales Chief Executive about matters relevant to the proper stewardship of funds within the NHS in Wales. i) May be required to appear before the Public Accounts Committee separately depending on the matter under consideration. | Chief Executive | N/A |
| STANDING ORDERS | xxvii & xxviii | GENERAL | Applying Standing Orders | Non Compliance and Variation of Standing Order | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | xxxi | GENERAL | Applying Standing Orders | Final interpretation of Standing Orders | Chair | Director of Corporate Governance/Board Secretary and where appropriate the Director of Finance (for SFIs) |
| STANDING ORDERS | xxxiii | GENERAL | The role of the Board Secretary | Responsibility for providing advice to the Board on all aspects of governance/committee services | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 2.1 | RESERVATION AND DELEGATION OF LHB FUNCTIONS | Chair's Action on Urgent Matters | Use of Chair's Action and onward reporting to Board | Chair | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 2.3.1 | RESERVATION AND DELEGATION OF LHB FUNCTIONS | Delegation To Officers | Compilation of Scheme of Delegation for functions delegated to Chief Executive for consideration and approval by the Board | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 2.3.1 | RESERVATION AND DELEGATION OF LHB FUNCTIONS | Delegation To Officers | Delegation of functions within Directorates/departments/localities in line with the framework established by the Chief Executive and agreed by the Board | Executive Directors/Directors | Executive Directors/Directors |

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| STANDING ORDERS | 6 | WORKING IN PARTNERSHIP | Working In Partnership | Identification and engagement with all key partners and regular review of effectiveness | Chair | Director of Public Health and Director of Primary Care, Community Strategy and Long-Term Care- All Exec Leads |
| STANDING ORDERS | 7.2 | MEETINGS | Annual Plan of Board Business | Development of the Annual Plan of Board Business | Chair | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 7.3 | MEETINGS | Calling Meetings | Call meetings of the Board | Chair | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 7.4 | MEETINGS | Preparing for Meetings | Preparation of Board meetings | Chair | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 7.5 | MEETINGS | Conducting Board Meetings | Report decisions made & review HB business conducted in private session | Chair | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 7.5 | MEETINGS | Conducting Board Meetings | Chair all HB Meetings & associated responsibilities | Chair (or Vice Chair in Chair's Absence) | Chair (or Vice Chair in Chair's Absence) |
| STANDING ORDERS | 7.6 | MEETINGS | Record of Proceedings | A record of proceedings of Board Meetings | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 8.1 | VALUES AND STANDARDS OF BEHAVIOUR | Declaring and recording Board members' interests | Establishment, maintenance and annual review of a Register of Interests declared by all Board Members | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 8.3 | VALUES AND STANDARDS OF BEHAVIOUR | Dealing with officers' interests | Establishment, maintenance and annual review of a Register of Interests for relevant LHB Officers | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 8.7 | VALUES AND STANDARDS OF BEHAVIOUR | Register of Gifts, Hospitality and Sponsorship | Establishment, maintenance and annual review of a Register of Gifts, Hospitality, Sponsorship and Honoraria for Board Members and LHB Officers | Chair and Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 9.1 | SIGNING AND SEALING DOCUMENTS | Register of Sealing | Establishment, maintenance and bi-annual reporting of a Register of Sealings | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 9.2 | SIGNING AND SEALING DOCUMENTS | Signature of Documents | Signing and sealing of legal documents such as transfers of land, lease agreements and other important/key contracts on behalf of the Board | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING ORDERS | 9.2.2 | SIGNING AND SEALING DOCUMENTS | Signature of Documents | Signing any agreement or other document (not required to be executed as a deed) on behalf of the Board where the subject matter has been approved either by the Board or a Committee to which the Board, as per the authority delegated within the Financial Scheme of Delegation | Chief Executive | Nominated Officers (as per financial scheme of delegation) |
| STANDING ORDERS | 9.3 | SIGNING AND SEALING DOCUMENTS | Custody of Seal | Safe custody of Seal in a secure place | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 1.1.3 | INTRODUCTION | General | Approval of all financial procedures | Director of Finance, through Sustainable Resources Finance and Performance Committee | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 1.1.4 | INTRODUCTION | General | Provision of advice in regard to the interpretation/applications of SFIs | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 1.2.1 | INTRODUCTION | General | Report non-compliance with SFIs for consideration by Audit Committee (to formally consider the matter and make proposals to the Board on any action taken) | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 1.3 | INTRODUCTION | General | Ensure the LHB meets its statutory obligation to perform its functions within the available financial resources | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.2.1 | RESPONSIBILITIES AND DELEGATION | The Board | Accountability for overall Financial Control | Chief Executive and Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.2.2 | RESPONSIBILITIES AND DELEGATION | The Board | Overall responsibility for ensuring that financial obligations and targets are met and overall responsibility for the system of internal control | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.2.3 | RESPONSIBILITIES AND DELEGATION | The Board | To ensure that Board Members and LHB Officers, and new appointees are notified of and understand their responsibilities within the SFIs | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | a) Implementing Financial Policies and coordinating any corrective action necessary to further these policies | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems are incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions in order to disclose, with reasonable accuracy, the financial position of the LHB at any time | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | d) The provision of financial advise advice to other Board members and LHB officers, and LHB committees and Advisory Groups | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | e) the design, implementation and supervision of systems of internal financial control and, | Director of Finance | Deputy Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.1 | RESPONSIBILITIES AND DELEGATION | The Board | f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.3.2 | RESPONSIBILITIES AND DELEGATION | The Board | Ensuring an ongoing training and communication programme is in place to affect these SFIs | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.4.1 | RESPONSIBILITIES AND DELEGATION | The Board | Responsible for security of LHB's property, avoiding loss, exercising economy, efficiency, and sustainability in the use of resources & conforming with SeOs, SFIs, financial procedures and Scheme of Delegation | All Board Members, LHB Officers, LHB Committees and Advisory Groups | All Board Members, LHB Officers, LHB Committees and Advisory Groups |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 2.5.1 | RESPONSIBILITIES AND DELEGATION | The Board | Ensure any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income are made aware of these SFIs and their requirement to comply | Chief Executive | All Executive Directors/Directors |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.1.1 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Audit Committee | Establishment of an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook. | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.2.1a | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Chief Executive | a) Ensuring arrangements are in place to review, evaluate and report on the effectiveness of internal financial control including establishment of an Internal Audit function | Chief Executive | Director of Finance and Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.2.1b | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Chief Executive | b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.2.1c | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Chief Executive | c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.2.1d | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Chief Executive | d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover: • a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards major internal financial control weaknesses discovered, • progress on the implementation of Internal Audit recommendations, • progress against plan over the previous year, • a strategic audit plan covering the coming three years, and • a detailed plan for the coming year | Chief Executive | Head of Internal Audit/Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.3.1 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Internal Audit | Ensure there is an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. | Chief Executive | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.4.1 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | External Audit | Ensure that there is a cost effective external audit service | Audit and Risk Assurance Committee | Director of Finance and Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.4.24 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | External Audit | Invite External Audit representative to attend every Audit Committee | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.4.43 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | External Audit | Formally consider and review the External Audit Strategy-risk based annual audit plan, designed to deliver the Auditor General's objectives | Audit and Risk Assurance Committee | Director of Finance and Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.4.53 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | External Audit | Keep under Review the External Audit Annual Plan and the associated fees, and consider any material changes to the annual audit plan | Audit and Risk Assurance Committee | Director of Finance and Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.5.1 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Fraud and Corruption | Monitor & ensure compliance with Directions issued by Welsh Ministers on fraud and corruption | Chief Executive and Director of Finance | Local Counter Fraud Specialist |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.5.2 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Fraud and Corruption | Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual and guidance | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.5.4 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Fraud and Corruption | Provide a written report to the Director of Finance and Audit Committee, at least annually, on counter fraud work within the LHB | Director of Finance Local Counter Fraud Specialist | Local Counter Fraud Specialist |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.5.5 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Fraud and Corruption | Participate in the annual National Fraud Initiative. It must provide the necessary data for the mandatory element of the initiative by the due dates. | Director of Finance | Local Counter Fraud Specialist |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.5.5 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Fraud and Corruption | The Audit Committee should consider the LHB's participation in additional dataset matching in order to support the detection of fraud across the whole public sector | Director of Finance | Local Counter Fraud Specialist |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.6.1 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Security Management | Monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management | Chief Executive | Director of Allied Health Professions and Health Science |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 3.6.2 | AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT | Security Management | Overall responsibility for controlling and coordinating security | Chief Executive | Director of Allied Health Professions and Health Science, and Chief Operating Officer |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.2.4a | FINANCIAL DUTIES | First Financial Duty – The Breakeven Duty | a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution including any sums to be held in reserve; | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.2.4b | FINANCIAL DUTIES | First Financial Duty – The Breakeven Duty | b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements; | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.2.4c | FINANCIAL DUTIES | First Financial Duty – The Breakeven Duty | c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.2.4d | FINANCIAL DUTIES | First Financial Duty – The Breakeven Duty | d) Regularly update the Board on significant changes to the initial allocation and the application of such funds | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.2.5 | FINANCIAL DUTIES | First Financial Duty – The Breakeven Duty | Ensure the LHB meets its First Financial Duty | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 4.3.7- & 4.3.9 | FINANCIAL DUTIES | Second Financial Duty – The Planning Duty | To develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP). The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework | Chief Executive | Director of Strategy and Planning |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.1.1 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budget Setting | Prepare and submit budgets for approval and delegation by the Board | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.1 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition. | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.1 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Accountability letters setting out: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports must be signed by the delegated budget holder. | Chief Executive | Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.2 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | The budgetary total of virement limit set by the Board must not be exceeded. | Chief Executive, Director of Finance, Budget Holders | Chief Executive, Director of Finance, Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.3 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Ensure budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement | Director of Finance | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.4 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Ensure non-recurring budgets are not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance | All budget holders | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.5 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately. | Executive Directors/Directors | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.6 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Sign up to their allocated budgets at the commencement of the financial year | All budget holders | All budget holders |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.2.7 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Budgetary Delegation | Ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.1 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | Monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances. | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.2 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | Devise and maintain systems of financial management, performance reporting and budgetary control as per SFI 5.3.2 i.e. Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement including including a) regular financial reports, for revenue and capital to the Board, for the Board to understand the current and forecast financial position, evaluate risks and opportunities and make informed decisions b) regular reports to budget holders, covering the areas for which they are responsible c) an accountability and escalation framework d) investigation and reporting of variances from financial, activity and workforce budgetse e) monitoring of management action to correct variances; f) arrangements for the authorisation of budget transfers and virements. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.3 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | Establish project management controls and financial reporting systems to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval. • Accountable for managing services within the delegated budget • investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources • develop plans to address adverse budget variances | Director of Finance All budget holders | Deputy Director of Finance All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.4 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | Ensure that: a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation | All budget holders | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.4 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement | All budget holders | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.4 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board. | All budget holders | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.3.5 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Financial Management and Budgetary Control | Responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and (SFI 9.1) | Chief Executive | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 5.5.1 | FINANCIAL MANAGEMENT AND BUDGETARY CONTROL | Reporting to Welsh Government - Monitoring Returns | Responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 6.2 | ANNUAL ACCOUNTS AND REPORTS | Annual Accounts and Reports | Sign the accounts on behalf of the LHB | Chair and Chief Executive | Chair and Chief Executive and Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 6.2a | ANNUAL ACCOUNTS AND REPORTS | Annual Accounts and Reports | Signing of the: Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement a) Annual Governance Statement | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 6.3 | ANNUAL ACCOUNTS AND REPORTS | Annual Accounts and Reports | Ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FRM) and International Financial Reporting Standards | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 6.5 | ANNUAL ACCOUNTS AND REPORTS | Annual Accounts and Reports | Signing of the: e) Accountability Report Preparation of the Annual Report in line with the Welsh Government's Manual for Accounts | Chief Executive | Chief Executive Director of Corporate Governance/Board Secretary / Director of Finance / Communications and Engagement Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.1.1 | BANKING ARRANGEMENTS | General & Bank Accounts | Responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.1.2 | BANKING ARRANGEMENTS | General & Bank Accounts | Approval of banking arrangements | Board | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.3.1 | BANKING ARRANGEMENTS | Banking Procedures | Prepare detailed instructions on the operation of bank accounts | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.3.2 | BANKING ARRANGEMENTS | Banking Procedures | Advise the LHB's bankers in writing of the conditions under which each account will be operated | Director of Finance | Deputy Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.3.3 | BANKING ARRANGEMENTS | Banking Procedures | Approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 7.4.1 | BANKING ARRANGEMENTS | Review | Review the banking arrangements of the LHB at regular intervals to ensure they reflect best practice; that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1a | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable; | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1b | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: b) Ordering and securely controlling any such stationery ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1c | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: c) Provision of adequate facilities and systems for officers whose duties include collecting and holding cash | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1d | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1e | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: e) Ensuring effective control systems are in place for the use of payment cards | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.1.1f | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | General | Responsible for: f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 8.2 | CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS | Petty Cash | Responsible for issuing instructions restricting the use of petty cash. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.2.1 | INCOME, FEES AND CHARGES | Income Systems | Design and maintain procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.2.2 | INCOME, FEES AND CHARGES | Income Systems | Ensure that systems are in place for the prompt banking of all monies received. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.3.1 | INCOME, FEES AND CHARGES | Fees and Charges | Responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.3.2 | INCOME, FEES AND CHARGES | Fees and Charges | Inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions | All Officers | All Officers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.4.1 | INCOME, FEES AND CHARGES | Income Due and Debt Recovery | Inform the Director of Finance of any income due that arises from any contracts, service level agreements, leases, activities such as private patients or other transactions. | Budget holders and managers | Budget holders and managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.4.2 | INCOME, FEES AND CHARGES | Income Due and Debt Recovery | Inform the Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made | Budget holders and managers | Budget holders and managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.4.3 | INCOME, FEES AND CHARGES | Income Due and Debt Recovery | Responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 9.4.6 | INCOME, FEES AND CHARGES | Income Due and Debt Recovery | Responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to. | Chief Executive and Director of Finance | Chief Executive and Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.1.42 | NON-PAY EXPENDITURE | Scheme of Delegation, Non Pay Expenditure Limits and Accountability | Approval of the non-pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation | Chief Executive | Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.1.2.3 | NON-PAY EXPENDITURE | Scheme of Delegation, Non Pay Expenditure Limits and Accountability | Set out in the operational scheme of delegation and authorisation: a)The list of managers who are authorised to place requisitions for the supply of goods and services; and b)The maximum level of each requisition and the system for authorisation above that level | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1a | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed; | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1b | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services non-pay expenditure ; | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1c | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | c) Ensure systems are in place for the prompt payment of all properly authorised authorisation of all accounts and claims; | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1d | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | d) Ensure systems are in place for providing a Directors and officers strictly follow NHS Wales -system and procedures of verification, recording and payment of all amounts payable. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1e | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | e) Ensure systems are in place for ensuring that payment for goods and services is only made once the goods and services are received. Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices. | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1f | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | f) Responsible for ensuring compliance with the Public Sector payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.2.1g | NON-PAY EXPENDITURE | The Director of Finance's responsibilities | g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs; | Director of Finance | Executive Directors |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.3 | NON-PAY EXPENDITURE | Duties of Budget Holders and Managers | Full compliance with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance and details in section 10.3.1 | All Budget Holders | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.6.1 | NON-PAY EXPENDITURE | Prepayments | Approval of proposed prepayment arrangements if specified conditions set out in 10.6.1 are satisfied | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 10.6.2 | NON-PAY EXPENDITURE | Prepayments | Ensure that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered | All Budget Holders | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Services | Responsibility for procurement services delivered by NHS Wales Shared Services Partnership Procurement Services | Chief Executive | Director of Finance/NWSSP Director of Procurement |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Services | Responsible for ensuring that the LHB's Executive Directors, Independent Members and officers strictly follow procurement, tendering and contracting procedures | Chief Executive | Executive Directors, Independent Members and officers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.7.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Sustainable Procurement | Adopt a Sustainable Development Strategy consistent with the NHS Wales Sustainable Development Strategy Support social, environmental, economic and cultural goals in Wales, by being mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible within the legislative framework. The principles of Well-being of Future Generations (Wales) Act 2015 (the WCFG Act 2015) should be adopted at the earliest stage of planning | Director of Finance | Assistant Director of Finance – Financial Planning & Statutory Reporting-Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.7.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Sustainable Procurement | Benchmark its performance in sustainable procurement and produce annual action plans for improvement through its use of the Sustainable Procurement Assessment Framework (SPAF) | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.7.26 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Sustainable Procurement | For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA) | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.7.5 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Sustainable Procurement | The LHB is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on ethical employment in supply chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage. | Chief Executive | Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.8.1 11.7.6 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Sustainable Procurement | The LHB shall make use of the tools developed by Value Wales in implementing the principles of the WBFCA 2015. The LHB shall benchmark its performance against the WBFCA 2015. For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA). | Director of Finance | NWSSP/Head of Procurement |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.9.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Planning Procurement | Ensure that the LHB has procedures that set out: a) Requirements and exceptions to formal competitive tendering requirements; b) Tendering processes including post tender discussions; c) Requirements and exceptions to obtaining quotations; d) Evaluation and scoring methodologies; and e) Approval of firms for providing goods and services Ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement. Section 11.11,11.12 | Director of Finance | Director of Finance/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.9.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Planning Procurement | Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine: • the likely financial value of the procurement, including whole life cost • the likely 'route to market' which will consider the legislative and policy framework set out above. • the availability of funding to be able to award a contract following a successful procurement process. • that the procurement follows current legislative and policy frameworks including Value Based Procurement | Director of Finance | Director of Finance Budget holder/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.10.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Process | Source goods from the Health Board's approved catalogue. If the item is not included in the catalogue seek advice from Procurement Services on opportunities to source goods through public sector contract frameworks. | All budget holders | All budget holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | a) Quotations up to £5,000 (at the discretion of Director of Finance 'Goods and Non-Health Services Only' - In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the 2023 Act and the limits below. The limits apply to the Whole Life Cost Contract Value (excluding VAT). The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations. | Director of Finance | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2.a | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | Below £5,000 Evidence of value for money has been achieved Purchase Order | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2.b | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | £5,000 - £24,999 Evidence of 3 written quotations Simple form of Contract/Purchase Order | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2.c | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | £25,000 plus to the prevailing Procurement Act 2023 threshold Advertised open call for competition. Minimum of 4 tenders received if available Formal Contract and Purchase Order | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2.d | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | Over the prevailing Procurement Act 2023 threshold Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route Formal Contract and Purchase Order | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.2.e | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | Contracts above £1 million Welsh Government approval required Formal Contract and Purchase Order See Schedule 1 | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.44.1a10.3 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | In Scope Health Services Only' - in the absence of an existing suitable procurement framework, follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations. There is no minimum financial threshold for application of the PSR Wales Regulations. | Director of Finance | All Budget Holders/NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1b | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | | Director of Finance | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1e | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | e) Authorise and record where the required number of quotations is not available (Note 3.5, Scd 1, SFIs) | Director of Finance | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1d | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | d) Formally authorise and record single quotations and report to Audit Committee (Note 3.6, Scd 1, SFIs) | Director of Finance | Director of Finance and NWSSP/Head of Procurement |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1e | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | Competitive Tenders — Total value of contract its entire period: e) Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and relevant thresholds (in compliance with relevant Directives as appropriate) | Director of Finance | Budget Holders/NWSSP (Procurement) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1f | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | f) Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of relevant threshold (in compliance with relevant Directives as appropriate) | Chief Executive and Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1g | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | g) Authorise acceptance of lower number of tenderers based on receipt of a full report detailing the reasons (note 5.3 Sed 1, SFIs) | Chief Executive and Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1h | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | h) Establish all firms on the tender list are financially sound and professionally competent through a pre-qualification/financial vetting process (note 5.1 Sed 1, SFIs) | Director of Finance | NWSSP (Procurement) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1i | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | i) Receipt and custody of tenders prior to opening (note 8.3, Sed 1, SFIs) | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1j | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | j) Decide if late tenders should be considered (paper based procurement only) (note 8.3, Sed 1, SFIs) | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1k | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | k) Maintain Tender Register in a secure place (note 9.3, Sed 1, SFIs) | Director of Finance | PA to Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1m | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | m) Evaluation of tenders in a robust and fair manner (note 10.2, Sch 1, SFIs) | Chief Executive | Chief Executive or nominated project group or other |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.11.1n | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | n) Extending contracts on a single occasion provided that it does not exceed 50% of original value of the contract to a maximum of £75,000. Contract extensions must be reported to Audit and Risk Assurance Committee (note 10.8, Sch 1, SFIs) | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.12.4 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Designing Competitions | Nominate officer who shall oversee and manage each contract on behalf of the LHB and engage with Procurement team so as to ensure that these implicit obligations in SFIs are met | Chief Executive | Director of Finance Budget holder/manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.14.4e13 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | e) Approve Single Tender Actions (that meet with requirements set out in Section 11.13) up to £25,000 & report to Audit and Risk Assurance Committee | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.13 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Procurement Thresholds | Approve Single Tender Actions (that meet with requirements set out in Section 11.13) exceeding £25,000 & report to Audit and Risk Assurance Committee | Chief Executive and Director of Finance | Chief Executive and Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.15 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Evaluation, Approval and Award | The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval. Approval must follow Scheme of Delegation. All communication must be managed by Procurement Services; and • permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder | Director of Finance | NWSSP Procurement Service and Budget holder/manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.16 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Contract Management | The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include: • retaining accurate records • monitoring contract performance measures • engaging suppliers to ensure performance delivery • implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement | Director of Finance | NWSSP Procurement Service and Budget holder/manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.17.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Extending and Varying Contracts | Goods and Non-Health Services Only - extending or varying the contract is possible if the provision to do so was included in the original contract award. If there is no such provision, the 2023 Act define such limitations. (Section 74-77 of the Act) | Director of Finance | NWSSP/Budget holder |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.17.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Extending and Varying Contracts | In Scope Health Services Only - modification is possible if the provision to do so was included in the original contract award or framework agreement or the contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character. If these provisions are not met the PSR Wales Regulations define limitations concerning modifications of contract. Further approvals will also be required if no extension was provided for in the original contract. | Director of Finance | NWSSP Head of Procurement/Budget holder |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.13.1 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Single Quotation-Application or Single-Tender Application | In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character as required in SFI 11.13.1 | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.19 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | No Purchase Order, No Pay | Ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis. | Chief Executive | Director of Finance All officers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 11.20.2 | PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES | Official Orders | Authorise who may use and be issued with official orders | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 12.1.1 | HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES | Healthcare Agreements | Responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements (IPCA), where appropriate) for its provision of health care services | Chief Executive | Director of Strategy and Planning (Medical Director for IPCAs) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 12.3.1 | HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES | Healthcare Agreements | Ensure that regular reports are provided to the Board detailing performance and associated financial implications of all health care agreements | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 13.2.2 | GRANT FUNDING | Policies and procedures | Ultimately responsible for ensuring that the LHB's grant and procurement procedures: <ul style="list-style-type: none"> • Are kept up to date; • Conform to statutory requirements; • Adhere to guidance issued by the Welsh Ministers; • Are consistent with the principles of sustainable development; and • Are strictly followed by all Executive Directors, Independent Members and staff within the organisation | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.1.1 | PAY EXPENDITURE | Remuneration and Terms of Service Committee | Establish a Remuneration and Terms of Service Committee | Board | Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.1.2 | PAY EXPENDITURE | Remuneration and Terms of Service Committee | The Committee shall report in writing to the Board the basis for its recommendations. | Remuneration & Terms of Service Committee | Director of Workforce & OD and Director of Corporate Governance/Board Secretary |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.1.3 | PAY EXPENDITURE | Remuneration and Terms of Service Committee | Present to the Board for approval, proposals for the setting of remuneration and terms of service for employees and officers not covered by the Committee | Chief Executive | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.2.4-2 | PAY EXPENDITURE | Funded Establishment | Approval of any variation of funded establishment of any department | Chief Executive | All Executive Directors/Directors |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1 | PAY EXPENDITURE | Staff Appointments | Authorisation of engagement, re-engagement, re-engagement of employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside of their approved budget and funded establishment | Chief Executive | All Executive Directors/Directors |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1a | PAY EXPENDITURE | Staff Appointments | a) Authority to fill funded posts within the establishment with permanent staff | All Budget Holders | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1b | PAY EXPENDITURE | Staff Appointments | b) Authority to appoint staff to posts not on the formal establishment | Executive Directors/Directors | Executive Directors/Directors |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1c | PAY EXPENDITURE | Staff Appointments | c) Additional increments – the granting of additional increments to staff within budgets (subject to the rules of Agenda for Change) | Director of Workforce & OD | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1d | PAY EXPENDITURE | Staff Appointments | d) Applications for re-grading (in line with the agreed policy on Agenda for Change and in accordance with all Wales Terms and Conditions). | Director of Workforce & OD | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1e | PAY EXPENDITURE | Staff Appointments | e) Authority to complete standing data forms affecting pay, new starters, variations and leavers | Line Managers and Heads of Service | Line Managers and Heads of Service |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1f | PAY EXPENDITURE | Staff Appointments | f) Authority to authorise overtime | Heads of Service/General Managers | Heads of Service/General Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1g | PAY EXPENDITURE | Staff Appointments | g) Authority to authorise travel and subsistence expenses (within 3 months of incurring expenditure) | Line Managers and Heads of Service | Line Managers and Heads of Service |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1h(i) | PAY EXPENDITURE | Staff Appointments | h) Authority to book Bank or Agency Staff for (i) Consultants and Middle Grades | Chief Operating Officer | Executive Directors/Directors/ Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1h(ii) | PAY EXPENDITURE | Staff Appointments | h) Authority to book Bank or Agency Staff for (ii) Nursing Staff | Chief Operating Officer | Executive Directors/Directors/ Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1h(iii) | PAY EXPENDITURE | Staff Appointments | h) Authority to book Bank or Agency Staff for (iii) All other Staff | Chief Operating Officer | Executive Directors/Directors/Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1i(i) | PAY EXPENDITURE | Staff Appointments | i) Annual Leave approval | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1i(ii) | PAY EXPENDITURE | Staff Appointments | (ii) Annual leave approval to carry forward in exceptional circumstances 5 days | Executive Director/Director or nominated deputy (via Line Manager) | Executive Director/Director or nominated deputy (via Line Manager) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1i(iii) | PAY EXPENDITURE | Staff Appointments | (iii) Approval of Special Leave (including compassionate, carers and leave without pay (in line with All Wales Special Leave Policy) | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1j | PAY EXPENDITURE | Staff Appointments | j) Approval of leave without pay | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1k(i-iii) | PAY EXPENDITURE | Staff Appointments | k) Approval of Medical and Dental Staff Leave of Absence (i) Doctors below Consultant Grade a) Annual Leave b) Study Leave (ii) Consultant Staff a) Annual Leave b) Study Leave (iii) Clinical Directors a) Annual Leave b) Study Leave | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1k(iv) | PAY EXPENDITURE | Staff Appointments | (iv) Medical Director a) Annual Leave b) Study Leave | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1l | PAY EXPENDITURE | Staff Appointments | l) Approval of time off in lieu | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1m | PAY EXPENDITURE | Staff Appointments | m) Approval of maternity, paternity and adoption leave in line with LHB Policy | Line Managers and Workforce & OD Manager | Line Managers and Workforce & OD Manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1n | PAY EXPENDITURE | Staff Appointments | n) Approval of sick leave – return to work on phased basis to assist with recovery in line with All Wales Sickness Policy | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1o | PAY EXPENDITURE | Staff Appointments | o) Approval of extension of sick leave on full or half pay - Directors | Remuneration & Terms of Service Committee | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1p | PAY EXPENDITURE | Staff Appointments | p) Approval of extension of sick leave on full or half pay – Other staff | Director of Workforce & OD | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1q(i) | PAY EXPENDITURE | Staff Appointments | q) Study leave & Conferences (i) In-house learning & development programmes | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1q(ii) | PAY EXPENDITURE | Staff Appointments | q) Study leave & Conferences (ii) Applications for higher award | Line Managers, Care Group Director/General Manager Professional Head & Executive led Panel | Line Managers, Care Group Director/General Manager Professional Head & Executive led Panel |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1r(i) | PAY EXPENDITURE | Staff Appointments | r) Approval of relocation costs (i) Chief Executive & Directors | Remuneration & Terms of Service Committee | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1r(ii) | PAY EXPENDITURE | Staff Appointments | r) Approval of relocation costs (ii) Medical and Dental Staff | Director of Workforce & OD (as per Relocation Expenses Policy) | Assistant Director of People Management |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1r(iii) | PAY EXPENDITURE | Staff Appointments | r) Approval of relocation costs (iii) Other Staff groups | Director of Workforce & OD (as per Relocation Expenses Policy) | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1s(i) | PAY EXPENDITURE | Staff Appointments | s) Approval of lease cars (i) Chief Executive | Chair | Chair |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1s(ii) | PAY EXPENDITURE | Staff Appointments | s) Approval of lease cars (ii) Directors | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1s(iii) | PAY EXPENDITURE | Staff Appointments | s) Approval of lease cars (iii) Other Staff groups | Budget Holders | Budget Holders/NWSSP (Procurement) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1t(i) | PAY EXPENDITURE | Staff Appointments | t) Approval of mobile phones (i) Chief Executive | Chair | Chair |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1t(ii) | PAY EXPENDITURE | Staff Appointments | t) Approval of mobile phones (ii) Directors | Chief Executive | Chief Executive |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.3.1t(iii) | PAY EXPENDITURE | Staff Appointments | t) Approval of mobile phones (iii) Other Staff groups | Budget Holders | Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.4.1 | PAY EXPENDITURE | Staff Appointments | Present to the Board for approval, procedures for the determination of commencing pay rates, conditions of service, etc, for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies | Chief Executive | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.1 | PAY EXPENDITURE | Payroll | The Director of Workforce and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that: a) pays the correct staff with the correct amount, b) all payments are supported by properly authorised documentation. | Director of Workforce & OD | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2a | PAY EXPENDITURE | Payroll | Responsible for: a) Securing the provision of an efficient, value for money payroll service | Director of Workforce & OD | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2b | PAY EXPENDITURE | Payroll | Responsible for: b) Specifying timetables for submission of properly authorised time records and other notifications | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2c | PAY EXPENDITURE | Payroll | Responsible for: c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2d | PAY EXPENDITURE | Payroll | Responsible for: d) Agreeing the timing and method of payment with the payroll service | Director of Workforce & OD | Assistant Director of People Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2e | PAY EXPENDITURE | Payroll | Responsible for: e) Authorising the release of payroll data where in accordance with the provisions of the Data Protection Act 1998 (C.29); Director of Workforce & OD Head of Information Governance | Director of Workforce & OD | Head of Information Governance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2f | PAY EXPENDITURE | Payroll | Responsible for: f) Verification and documentation of data | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2g | PAY EXPENDITURE | Payroll | Responsible for: g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2h | PAY EXPENDITURE | Payroll | Responsible for: h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2i | PAY EXPENDITURE | Payroll | Responsible for: i) Security and confidentiality of payroll information | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2j | PAY EXPENDITURE | Payroll | Responsible for: j) Checks to be applied to completed payroll before and after payment | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.2k | PAY EXPENDITURE | Payroll | Responsible for: k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.3a | PAY EXPENDITURE | Payroll | a) Ensuring that any arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, contract terms and conditions; adequate internal controls and audit review procedures | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.3b | PAY EXPENDITURE | Payroll | b) Ensuring a sound system of internal control and audit review of any internally provided payroll service | Chief Executive | Director of Workforce & OD |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.3c | PAY EXPENDITURE | Payroll | c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts | Chief Executive | Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.5.4 | PAY EXPENDITURE | Payroll | Submitting time records, and other notifications in accordance with agreed timetables, completing time records and other notifications in accordance with the contract of Service Level Agreements, and submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. | Line Managers | Line Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 14.6.1 | PAY EXPENDITURE | Contracts of Employment | Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation, and dealing with variations to, or termination of, contracts of employment | Director of Workforce & OD | NWSSP |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1a | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | a) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans | Chief Executive | Director of Strategy and Planning |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1b | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | b) Responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost | Chief Executive | Senior Responsible Owner for each capital scheme |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1c | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | c) Ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1d | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | d) Ensure that an annual capital programme is adopted by the Board prior to the commencement of the financial year | Director of Strategy and Planning | Director of Strategy and Planning |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1e | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | e) Ensure the availability of resources to finance all revenue consequences of the investment, including capital charges | Chief Executive | Director of Strategy and Planning |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.1f | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | f) Ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities | Director of Allied Health Professions & Health Science | Head of Property Performance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.1.3 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Plan | The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI | Director of Strategy and Planning | Head of Capital Planning |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.2.1 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Investment Decisions | A business case is produced in line with Welsh Ministers' guidance for the development of business cases as set out in: a) NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance b) Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework | Director of Strategy and Planning | Senior Responsible Owner for each capital scheme |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.5a | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Issue to the manager responsible for any capital scheme: a) Specific authority to commit expenditure | Director of Strategy and Planning | Senior Responsible Owner for each capital scheme |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.5b | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Issue to the manager responsible for any capital scheme: b) Authority to proceed to tender | Director of Strategy and Planning | Senior Responsible Owner for each capital scheme |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.5c | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Issue to the manager responsible for any capital scheme: c) Approval to accept a successful tender | Director of Strategy and Planning | Senior Responsible Owner for each capital scheme |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.6 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs | Chief Executive | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.7 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.4.8 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Capital Procedures and Responsibilities | Ensure for each capital project over £2m that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.6.1 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Asset Registers | Maintenance of asset registers (on advice from Director of Strategy & Planning and Director of Finance) | Chief Executive | Asset Owners |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.6.5 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Asset Registers | Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.7.1 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Security of Assets | Overall control of fixed assets | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.7.2 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Security of Assets | Approval of fixed asset control procedures | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 15.7.3 | CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS | Security of Assets | All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance | Director of Finance | Budget Holders/NWSSP (Procurement) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | SFI 16.2.1a | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | a) Delegate overall responsibility for control of stores (subject to Director of Finance). Further delegation for the day-to-day responsibility subject to delegation being entered in a record available to the Director of Finance | Chief Executive | Chief Operating Officer |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | SFI 16.2.1b | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | b) Responsible for systems of control over stores and receipt of goods | Director of Finance | Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | SFI 16.2.1c | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | c) Responsible for the control of pharmaceutical stocks | Director of Primary Care, Community Strategy and Long Term Care Medical Director | Head of Medicines Management |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | SFI 16.2.1d | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | d) Responsible for the control of fuel, oil and coal stocks | Chief Operating Officer | Service Director, Estates & Facilities Group |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.2 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Security arrangements and custody of keys | Chief Operating Officer/ Director of Primary Care, Community Strategy and Long Term-Care Medical Director | Designated Manager /Pharmaceutical Manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.3 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Set out procedures and systems to regulate the stores | Director of Finance | Chief Operating Officer |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.4 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Agree stocktaking arrangements | Director of Finance | Designated Manager /Pharmaceutical Manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.5 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Approve alternative arrangements where a complete system of stores control is not justified | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.6 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.2.6 | STORES AND RECEIPT OF GOODS | Control of Stores, Stocktaking, condemnations and disposal | Approve system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking | Designated Manager | Designated Manager |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 16.3.1 | STORES AND RECEIPT OF GOODS | Goods supplied by an NHS supplies agency | Identify persons authorised to requisition and accept goods from NHS Supplies store | Chief Executive | All Budget Holders |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.1.1 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Disposals and Condemnations | Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.1.2 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Disposals and Condemnations | Advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate, when disposing of LHB asset | Head of Department or authorised deputy | Head of Department or authorised deputy |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.1.3a | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Disposals and Condemnations | a) Condemning and disposal of all unserviceable articles | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.1.3b | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Disposals and Condemnations | b) Report evidence of negligence in use to Director of Finance who will take appropriate action | Condemning Officer | Condemning Officer |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.1.4 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Disposals and Condemnations | Take appropriate action on reported evidence of negligence in use | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.2 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Prepare procedural instructions on the recording of and accounting for losses and special payments; and ensure that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.3 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Discovery or suspicion of loss of any kind must be reported immediately to Heads of Department who should then inform the Chief Executive and Director of Finance. | All Staff | All Staff |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.4a | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | a) Where a criminal offence is suspected, the police must be informed if theft or arson are involved | Director of Finance | Deputy Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.4b | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | b) Where a fraud or corruption or anomalies which indicate fraud or corruption is suspected the Local Counter Fraud Specialist, NHS Counter Fraud Services Wales and NHS Protect in accordance with Directions issued by Welsh Ministers on fraud and corruption must be informed | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.5 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Notify the Audit Committee, Auditor General's representative and the fraud liaison officer within the Welsh Government's Department for Health, Social Services and Children of all frauds | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.6 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Notify the Audit Committee and Auditor General's representative of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial) | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.7 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.8 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Maintain losses and special payments register | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.9 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out in Schedule 3 of the SOs | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.10 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Consider whether any insurance claim can be made from the Welsh Risk Pool or from other commercial insurance arrangements for any loss | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 17.2.13 | DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS | Losses and Special Payments | Ensure all losses and special payments are reported to the Audit Committee at every meeting | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.1.1 | DIGITAL, DATA and TECHNOLOGY | Digital Data and Technology Strategy | Develop an IM&T Strategy | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.1.2 | DIGITAL, DATA and TECHNOLOGY | Digital Data and Technology Strategy | Publish and maintain a Freedom of Information (FOI) Publication Scheme | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.2.1a | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the responsible Director | a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LHB's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (C.29); | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.2.1b | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the responsible Director | b) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.2.1c | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the responsible Director | c) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out. | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.2.1d | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the responsible Director | d) Ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law. | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.2.1e | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the responsible Director | e) Ensure comprehensive incident reporting. | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.3.1 | DIGITAL, DATA and TECHNOLOGY | Responsibilities and duties of the Director of Finance | Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. | Director of Finance | Deputy Director of Finance |

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| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.4.1 | DIGITAL, DATA and TECHNOLOGY | Contracts for data and digital services with other health bodies or outside agencies | Ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.4.2 | DIGITAL, DATA and TECHNOLOGY | Contracts for data and digital services with other health bodies or outside agencies | Where another health organisation or any other agency provides a computer service for financial applications, assurances should be periodically sought to ensure that adequate controls are in operation | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 18.5.1 | DIGITAL, DATA and TECHNOLOGY | Risk assurance | Ensure that risks to the LHB arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate IT disaster recovery plans. | Director of Finance | Digital Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 19.1.4 | PATIENTS' PROPERTY | LHB Responsibility | Inform staff of their responsibilities and duties for the administration of the property of patients | Chief Operating Officer | Departmental/Senior Managers |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 19.2.1 | PATIENTS' PROPERTY | Responsibilities of the Chief Executive | Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission | Chief Executive and Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 19.3.1 | PATIENTS' PROPERTY | Responsibilities of the Director of Finance | Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients | Director of Finance | Deputy Director of Finance |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.1.3 | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Corporate Trustee | Establish a Charitable Funds Committee to ensure that each trust fund which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements | Board | Director of Nursing, Quality & Patient Experience |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2 | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Take account of the Schedule of Matters Reserved to the Board and the Scheme of Delegation which make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. | Director of Nursing, Quality & Patient Experience and Director of Finance | Head of Hywel Dda Health Charities and Senior Finance Business Partner Head of Accounting and Statutory Reporting |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2a | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: a) up to £1,000; | Senior Nurse Manager, Service Delivery Manager, Heads of Service or Managers at equivalent level | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2b | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: b) £1,001 to £10,000; | Clinical or Service Director, -Service General Manager, Head of Nursing or Managers at equivalent level | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2c | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: c) £10,001 to £50,000; | Charitable Funds Sub-Committee | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2d | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: d) £50,001 to £100,000 | Charitable Funds Committee | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 20.2.2e | FUNDS HELD ON TRUST (CHARITABLE FUNDS) | Accountability to Charity Commission and the Welsh Ministers | Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: e) Over £100,000 | Corporate Trustee | N/A |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 21.1.1 | RETENTION OF RECORDS | Responsibilities of the Chief Executive | Maintain archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the Data Protection Act 1998 (c.29) and the Freedom of Information Act 2000 (c.36) | Chief Executive and Director of Finance | Assistant Director of Corporate Legal Services and Public Affairs (FOI only) |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 21.1.2 | RETENTION OF RECORDS | Responsibilities of the Chief Executive | Records held in archives shall be capable of retrieval by authorised persons | Chief Executive and Chief Operating Officer | Acute records - Acute Records Manager Mental Health records - MHA Administrator Community – Community & Integrated Medicine Clinical Care Group Service Director |
| STANDING FINANCIAL INSTRUCTIONS (SFI) | 21.1.2 | RETENTION OF RECORDS | Responsibilities of the Chief Executive | Records held in accordance with regulation shall only be destroyed at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed | Chief Executive and Chief Operating Officer and Director of Finance | Acute records - Acute Records Manager Mental Health records - MHA Administrator Community records – Community & Integrated Medicine Clinical Care Group Service Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Medical Professional Leadership and Engagement | a) Maintain a refreshed clinical leadership model | Medical Director | Medical Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Nursing | b) Maintain a refreshed clinical leadership model | Director of Nursing, Quality and Patient Experience | Director of Nursing, Quality and Patient Experience |
| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Medical Education | a) Liaison with Deanery and Royal Colleges | Medical Director | Associate Medical Director – Medical Education |
| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Research & Governance | a) Authorisation of Research projects | Medical Director | Director of Research, Innovation and Value |
| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Research & Governance | b) Authorisation of sponsorship deals in relation to research projects | Medical Director | Director of Research, Innovation and University Partnerships |
| SCHEME OF DELEGATION FROM OTHER | N/A | CLINICAL LEADERSHIP | Research & Governance | Accountable for the effective set-up, delivery, governance, financial management and strategic leadership of research and development activities | Medical Director | Director of Research, Innovation and Value |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | Management of Concerns/Complaints/Patient Feedback a) Overall responsibility for ensuring that all complaints are dealt with effectively; | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | b) Recording, receipt and initial acknowledgement of concern/complaint | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) (supported by Concerns Department) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | c) Grading of concern/complaint | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | d) Identification of an Investigating Officer | Director of Nursing, Quality & Patient Experience | Dependent on Grade Grades 1-3 – coordinated by Patient Support Services with the Service Lead Grade 4 – Service Clinical Director/General Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | e) Investigation of complaint | Director of Nursing, Quality & Patient Experience | Grade 1-3 - Complaint Investigation Team with Service Manager Grade 4/5 – Complaint Investigation Team with Service Director/General Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | f) Maintaining regular contact with the complainant with regard to the processing of the concern | Director of Nursing, Quality & Patient Experience | Grades 4 & 5 – Investigation Officer/Patient Support Services |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | g) Maintaining regular contact with the complainant with regard to the matters raised in the concern | Director of Nursing, Quality & Patient Experience | Patient Support Service with Investigating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | h) Preparing final draft response (all Grades of Concern) | Director of Nursing, Quality & Patient Experience | Service (the service is provided with the findings of the investigation by Patient Support Services or Investigating Officer) Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | i) Checking of final draft prior to submission to Chief Executive/Deputy Chief Executive/relevant Clinical ED for signature | Director of Nursing Quality & Patient Experience | Assistant Director (Legal and Patient Support) |

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| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | j) Final check and sign of response to complainant | Chief Executive | Chief Executive/Deputy Chief Executive/relevant Clinical Executive Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Concerns/ Complaints/ Patient Feedback | k) Sending final response to complainant | Director of Nursing, Quality & Patient Experience | Complaint Investigation Team/Patient Support Service |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | a) Overall responsibility for ensuring that all incidents are dealt with effectively | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing, Assurance & Safeguarding |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | b) Completion of Incident Form | Staff member involved in incident or in immediate area | Staff member involved in incident or in immediate area |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | c) Initial Investigation of Incident | Manager of staff member/person in charge of area | Manager of staff member/person in charge of area |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | d) Reporting of incidents meeting criteria for nationally reporting to NHS Executive | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing, Assurance & Safeguarding |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | e) Arranging serious patient safety incident (SI) management meeting | Director of Nursing, Quality & Patient Experience | Nominated Investigation Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | f) Investigation of incidents (severe, catastrophic, or those that meet criteria to report nationally) | Director of Nursing, Quality & Patient Experience | Nominated Investigation Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | g) Preparation of final report (severe, catastrophic, or those that meet criteria to report nationally) | Director of Nursing, Quality & Patient Experience | Nominated Investigation Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | h) Agreement of final report prior to submission to the Director of Nursing, Quality, and Patient Experience | Nominated Investigation Officer | Nominated Investigation Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | i) Sign off of final report and closure of investigation (severe, catastrophic, or those that meet criteria to report nationally) | Director of Nursing, Quality & Patient Experience (Grade 5's only) Chief Operating Officer (other) | Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | j) Reporting of incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) | Director of Allied Health Professions and Health Science | Head of Health, Safety & Security |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | k) Reporting of breaches under the Ionising Radiation (Medical Exposure) Regulations to Health Inspectorate Wales (HIW) | Director of Allied Health Professions and Health Science | Patient Safety & Assurance Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Incident Reporting & Investigation | l) Reporting of Data Protection breaches to Information Commissioners Office (ICO) | Director of Finance | Head of Information Governance |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Approval of compensation for staff and patients personal effects, clinical negligence and personal injury (also see SFI 17.2.2) | Director of Finance | Deputy Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Submission of 'No Surprises' notifications to Welsh Government | Chief Executive | All Executive Directors/ Directors |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Improving Patient Experience | Developing a Patient Experience Strategy | Director of Nursing, Quality & Patient Experience | Assistant Director of Patient Experience- Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Clinical Governance | Joint responsibility for Clinical Governance (Clinical Directors) | Director of Nursing, Quality & Patient Experience/Medical Director/Director of Allied Health Professions and Health Science | Director of Nursing, Quality & Patient Experience /Medical Director/Director of Allied Health Professions and Health Science |

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| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Patient Safety Alerts | a) Maintaining a record of patient safety alerts and monitoring compliance | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing Quality & Governance- Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Patient Safety Alerts | b) Responding to the requirements of safety alerts and providing assurance/information on the ability to meet requirements | Relevant Heads of Service | Relevant Heads of Service |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Health and Care Standards Assessment | a) Completing assessment and compliance with the standards | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing Quality & Governance- Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of the Clinical Audit Function | a) Coordination and participation in national audits and development of a Hywel Dda Clinical Audit Plan | Medical Director | Clinical Audit Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of the Clinical Audit Function | b) Approval of Hywel Dda Clinical Audit Plan | Quality, Safety & Experience Committee | Quality, Safety & Experience Committee |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Ethics & Clinical Trials | a) Lead for Ethics and the establishment of an Ethics Committee | Medical Director | Committee |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Ethics & Clinical Trials | b) Authorisation of clinical trials | Medical Director | Director of Research, Innovation and Value |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | National Institute of Clinical Excellence (NICE) | a) Maintaining a record of publications and recording compliance | Medical Director | Clinical Effectiveness Co-ordinator |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | National Institute of Clinical Excellence (NICE) | b) Responding to requirements and providing information regarding ability to meet requirements | All Executive Directors/Directors | Directors for Corporate Departments/Clinical Care Group Service Directors/General Managers for Operational Directorate |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | a) Performing the role of the NCEPOD Ambassador and collation and provision of information to contribute to NCEPOD audit findings | Director of Nursing, Quality & Patient Experience- Medical Director | Assistant Director - Medical Directorate of Nursing for Planned & Specialist Care Clinical Care Group/Heads of Service |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | b) Maintaining record of publications and recording compliance | Medical Director | Head of Effective Clinical Practice and Quality Improvement |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | c) Responding to requirements and providing information regarding ability to meet requirements | All Executive Directors/Directors | Directors for Corporate Departments/Clinical Care Group Service Directors/General Managers for Operational Directorate |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | HM Coroner | a) Maintaining relationship and ensuring appropriate response to requests for information | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal & Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | HM Coroner | b) Sending response to HM Coroner | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Safeguarding of Adults and Children | a) Implementation of policy and procedures | Director of Nursing, Quality & Patient Experience | Head of Safeguarding/Assistant Director of Nursing for Planned & Specialist Care Clinical Care Group/Assistant Director of Nursing for Community & Integrated Medicine Clinical Care Group/Heads of Service/Designated Lead Managers/Assistant Director of Nursing MHLD |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Safeguarding of Adults and Children | b) Investigation in accordance with POVA requirements | Director of Nursing, Quality & Patient Experience | Head of Safeguarding |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Safeguarding of Adults and Children | c) Safeguarding supervision | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing Quality & Governance- Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Safeguarding – Deprivation of Liberties | a) Supervising Authority | Director of Primary Care, Community Strategy and Long Term Care- Chief Operating Officer | Community and Integrated Medicine Clinical Care Group Service Director / Head of Long Term Care |

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| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Safeguarding – Deprivation of Liberties | b) Managing Authority | Chief Operating Officer | Deputy Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Management of Infections, Diseases & Notifiable Outbreaks | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing Quality & Governance Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Coordination of Welsh Risk Pool Assessments | a) A&E Services | Chief Operating Officer | Community and Integrated Medicine Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Coordination of Welsh Risk Pool Assessments | b) Claims & Complaints | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Coordination of Welsh Risk Pool Assessments | c) Maternity Services | Chief Operating Officer | Planned and Specialist Care Clinical Care Group Service Director/Children, Women and Family Health Clinical Service Group General Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Coordination of Welsh Risk Pool Assessments | d) Surgical Pathway | Chief Operating Officer | Planned and Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Coordination of Welsh Risk Pool Assessments | e) Theatres | Chief Operating Officer | Planned and Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional Standards, Revalidation and Regulation – Medical & Dental | a) Deliver in-year requirements for medical revalidation | Medical Director | Associate Medical Director – Professional Standards |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional Standards, Revalidation and Regulation – Medical & Dental | b) Referral to General Medical Council (GMC)/General Dental Council (GDC) | Medical Director | Associate Medical Director – Professional Standards |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional Standards, Revalidation and Regulation – Medical & Dental | c) Monitoring of registration (GMC/GDC regulatory compliance) | Medical Director | Associate Medical Director – Primary Care & Workforce |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional Standards, Revalidation and Regulation – Medical & Dental | d) Referrals to any professional body for any Primary care contractor including Medical and Dental | Director of Primary Care, Community Strategy and Long Term Care Medical Director | Director of Primary Care, Community Strategy and Long Term Care Medical Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Nurse Development, Revalidation and Practice Standards | a) NMC revalidation process | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing (Nursing Practice) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Nurse Development, Revalidation and Practice Standards | b) Referral to Nursing & Midwifery Council (NMC) | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing (Nursing Practice) |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Management of Nurse Development, Revalidation and Practice Standards | c) Monitoring of registration (NMC regulatory compliance) | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing (Nursing Practice) |

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| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional leadership for Therapies and Health Science | a) Health and Care Professions Council (HCPC) registration, education and standards | Director of Allied Health Professions and Health Science | Assistant Director of Allied Health Professions/Deputy Director of Health Sciences |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | Professional leadership for Therapies and Health Science | b) Referral to appropriate Professional Body | Director of Allied Health Professions and Health Science | Assistant Director of Allied Health Professions/Deputy Director of Health Sciences |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Develop a Health & Well-being Strategy & Health Needs Analysis for Hywel Dda population | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Accountable Officer for Controlled Drugs | Medical Director | Head of Medicines Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Value Based Healthcare | Medical Director/Director of Finance | Director of Research, Innovation and Value |
| SCHEME OF DELEGATION FROM OTHER | N/A | QUALITY, SAFETY AND EXPERIENCE | N/A | Community Health Pathways Platform | Medical Director | Medical Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | N/A | Development of a Community by Design Strategic Plan Primary Care Strategy | Director of Primary Care, Community Strategy and Long Term Care Director of Strategy and Planning | Director of Primary Care, Community Strategy and Long Term Care Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | a) Approval to commission new healthcare services from NHS, private, third sector or independent organisations | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care or through the Chief Operating Officer | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care or through the Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | b) Agreement to provide services and payments in accordance with Medicines Management Incentive Scheme | Director of Primary Care, Community Strategy and Long Term Care Medical Director | Head of Medicines Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | c) Maintaining a register of commissioning contracts | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | d) Ensuring every commissioning contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | e) Agreement of annual contract with existing providers and within existing budgets - NHS, third sector, independent or private | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | f) Agreement of contract variations | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer | Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care/Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | g) Signing contracts of value < £50,000 and contract variations > £25,000 | As per Scheme of Delegation and Authorised Limits | N/A |

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| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | h) Signing contracts of value < £125,000 and contract variations > £50,000 | As per Scheme of Delegation and Authorised Limits | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | i) Signing contracts of value < £500,000 and contract variations > £125,000 | As per Scheme of Delegation and Authorised Limits | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | j) Signing of contracts of value >£1,000,000 | As per Scheme of Delegation and Authorised Limits | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | k) Agreement of changes to contracts where this would place a cost pressure on the organisation which cannot be funded within existing budgets | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | l) Agreement of changes to contracts where this would place a cost pressure on the organisation which would have a significant impact on the delivery of outcomes | Director of Strategy & Planning/Director of Finance | Director of Strategy & Planning/Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | m) Ensuring there is a commissioning framework in place which sets out expectations around what will be included in documentation and approach to management including meetings | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | n) Ensuring there is a contracting framework in place which sets out expectations around what will be included in documentation and approach to management including meetings | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | o) Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | p) Ensuring that there are regular meetings in place to monitor performance against commissioning contracts, that recovery plans are agreed where there are performance or finance issues and that matters of concern are escalated appropriately | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | q) Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs) | Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | As per Scheme of Delegation and Authorised Limits |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning (including Primary Care Services) | r) Authorisation of invoices against NHS LTAs | Director of Finance | As per Scheme of Delegation and Authorised Limits |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | All above sections in primary care commissioning section apply to this area - these are supplementary | N/A | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | a) Approving new care packages in line with HB policy and procedures | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Head of Long Term Care / Service Director for Community & Integrated Medicine |

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| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | b) Authorising emergency care packages or changes to care packages outside panel | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Head of Long Term Care / Service Director for Community & Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | c) Authorising of invoices against agreed packages of care | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Service Director for Community & Integrated Medicine Clinical Care Group for high cost/exceptional packages of care/General Manager for routine packages of care within their delegated budget level |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | d) Authorising CHC retrospective claims including Powys and UHB claims | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Primary Care, Community Strategy and Long Term Care Service Director for Community & Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of Continuing Healthcare and Funded Nursing Care | e) Decision to go to arbitration or take legal action in relation to any commissioning or provider contract | Chief Executive | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | a) Attending NHS Wales Joint Commissioning Committee meetings | Chief Executive | Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | b) Input to NHS Wales Joint Commissioning Committee commissioning decisions and agreement to Joint Commissioning Committee policies | Chief Executive | Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | c) Dissemination of NHS Wales Joint Commissioning Committee commissioning policies throughout the organisation | Chief Executive | Director of Strategy & Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | d) Approving and signing the annual contract with the NHS Wales Joint Commissioning Committee as commissioner | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | e) Agreeing contract variations with the NHS Wales Joint Commissioning Committee | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | Commissioning of cross border secondary and tertiary services for population | f) Hywel Dda University Health Board representative on the Joint Commissioning Committee Collaborative Commissioning Leadership Group | Director of Strategy & Planning | Director of Strategy & Planning |

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| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | IPFR Process and Prior Approval (in line with HB policy & Procedures) | a) Screening of IPFR requests submitted by patient/ clinicians | Medical Director | IPFR Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | IPFR Process and Prior Approval (in line with HB policy & Procedures) | b) Chairing of the IPFR Panel | Medical Director | IPFR Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | IPFR Process and Prior Approval (in line with HB policy & Procedures) | c) Decisions on clinically urgent IPFR requests which cannot wait for screening and panel process | Medical Director | IPFR Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | IPFR Process and Prior Approval (in line with HB policy & Procedures) | d) Arrangements for Review panels of IPFR screening process and/or panel decision | Medical Director | IPFR Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | IPFR Process and Prior Approval (in line with HB policy & Procedures) | e) Communication with patient and referring clinician | Medical Director | IPFR Manager/Team |
| SCHEME OF DELEGATION FROM OTHER | N/A | COMMISSIONING | N/A | Provision of Low Vision Service for HDdUHB population. | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | a) Scheduled Care | Chief Operating Officer | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | b) Cancer & Oncology | Chief Operating Officer | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | c) Children, Women & Family Health | Chief Operating Officer | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | d) Community Services | Chief Operating Officer | Community & Integrated Medicine Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | e) Mental Health & Learning Disability Services | Chief Operating Officer | Mental Health & Learning Disabilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | e) Therapy Services | Chief Operating Officer | Allied Health and Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | f) Primary Care | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Primary Care Clinical Care Group Service-Director Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | g) Estates & Facilities | Director of Allied Health Professions and Health Science | Estates & Facilities Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | h) Delivery on targets as per operation delivery plan | Chief Executive | All Executive Directors/Directors |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | i) Organ Donation | Chief Operating Officer | Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | j) Falls | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | k) Deconditioning | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | l) WGH Creche | Chief Operating Officer | Women & Family Health Clinical Service Group General Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | m) Out of Hours Service | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | n) Management of School Nursing & Health Visiting Service | Chief Operating Officer | Community & Integrated Medicine Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | o) Establish revised children's partnership arrangements | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | p) Providing assurance on screening services | Director of Public Health | Consultant in Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | q) Management of Substance Misuse Service | Chief Operating Officer | Commissioning Manager – Substance Misuse |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Delivery of: | r) Hospital Helicopter Landing Sites (HHLS) - Accountable Manager | Chief Operating Officer | Service Director for Community & Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Designated Education Clinical Lead Officer (DECLO) | Director of Allied Health Professions and Health Science | Regional DECLO with Powys & SBUHB |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Emergency planning, readiness & resilience (including business continuity) | a) Compliance with Emergency Planning & Major Incidents – Civil Contingencies Act 2004 | Director of Public Health | Head of Health Emergency Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Emergency planning, readiness & resilience (including business continuity) | b) Maintaining the organisation's Major Incident Plan | Director of Public Health | Head of Health Emergency Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Emergency planning, readiness & resilience (including business continuity) | c) Ensure all Directorates/Services/Departments have up to date Business Continuity Plans in place | Director of Public Health | Head of Health Emergency Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Emergency planning, readiness & resilience (including business continuity) | Responsibility for oversight of CONTEST (Counter-Terrorism Strategy) | Director of Public Health | Director of Allied Health Professions and Health Science, Director of Nursing, Quality and Patient Experience and the Director of Finance for the sub-parts of CONTEST i.e. PREVENT, PURSUE, PROTECT AND PREPARE |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Health and Safety, Security | a) Compliance with health and safety legislation requirements including control of substances hazardous to health regulations | Director of Allied Health Professions and Health Science | All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Health and Safety, Security | b) Management of security issues | Director of Allied Health Professions and Health Science | All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Health and Safety, Security | c) Responsibility for fire safety management | Director of Allied Health Professions and Health Science | Estates & Facilities Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Health and Safety, Security | Responsibility for Annual Health and Safety Report | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Additional Learning Needs | Additional Learning Needs (ALN) arrangements | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Medical Records | Responsibility for Medical Records Directorate | Director of Finance | Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | a) Physiotherapy Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | b) Occupational Therapy Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | c) Speech and Language Therapy Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | d) Dietetics Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | e) Podiatry Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | f) Orthoptic Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | g) Audiology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | h) Cardio Physiologist Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | i) Neurophysiology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | j) OOH Clinical Service Records | Director of Primary Care, Community-Strategy and Long Term Care-Director of Finance | Primary Care Clinical Care Group Service-Director Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | k) Acute Medical Records | Chief Operating Officer-Director of Finance | Health Records Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | l) Primary Care | Chief Operating Officer-Director of Finance | Primary Care Clinical Care Group Service-Director-Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | m) District Nursing | Chief Operating Officer-Director of Finance | Primary Care Clinical Care Group Service-Director-Clinical Care Group Service Director – Community and Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | n) Community, district nursing and Primary Care Records (not Children's Services) | Chief Operating Officer-Director of Finance | Primary Care Clinical Care Group Service-Director Clinical Care Group Service Director – Community and Integrated Medicine |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | o) Outpatient service records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | p) Palliative Care Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | q) Nursing Records | Chief Operating Officer-Director of Finance | Assistant Director (Operations, Quality and Nursing) |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | r) Mental Capacity Records | Chief Operating Officer-Director of Finance | Assistant Director (Operations, Quality and Nursing) |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | s) Specialist Nurse (tissue viability records) | Chief Operating Officer-Director of Finance | Assistant Director (Operations, Quality and Nursing) |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | t) Cancer Services Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | u) Community Paediatric Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | v) Acute Paediatric and Neonates Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | w) Community Children's Service Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | x) Midwifery and Women's Health Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | y) Obstetrics and Gynaecology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | z) Pathology Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aa) Radiology Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director Radiology Services Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ab) Cardiology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ac) Renal Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ad) General Medicine Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ae) Gastroenterology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | af) Neurology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ag) Stroke Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ah) Care of The Elderly | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ai) General surgery, vascular, breast care records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aj) Ophthalmology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ak) Ear, Nose and Throat Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | al) Trauma and Orthopaedics Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | am) Plaster Services Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | an) Dermatology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ao) Rheumatology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ap) Theatres Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aq) Day Surgery Unit Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ar) Pre-assessment Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | as) Endoscopy Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | at) Anaesthetics Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | au) Urology Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | av) Critical Care Records | Chief Operating Officer-Director of Finance | Planned & Specialist Care Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aw) Mental Health and Learning Disability Records | Chief Operating Officer-Director of Finance | Mental Health & Learning Disabilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ax) Psychology Records | Chief Operating Officer-Director of Finance | Allied Health & Health Sciences Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | ay) Mental Health Subject Access Requests | Chief Operating Officer-Director of Finance | Mental Health Act Administrator |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | az) Acute Subject Access Requests | Chief Operating Officer-Director of Finance | Acute Records Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aaa) Managed Practices records | Director of Primary Care, Community Strategy and Long Term Care-Director of Finance | Assistant Director of Primary Care |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aab) Low Vision records | Director of Primary Care, Community-Strategy and Long Term Care- Director of Finance | Head of Dental and Optometry |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational Health Records Management | aac) Dental services records for specific services and not independent Dental Practices | Director of Primary Care, Community-Strategy and Long Term Care- Director of Finance | Head of Dental and Optometry |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational quality and safety and effectiveness | a) Implementing Hospital Patient Environment audits | Chief Operating Officer | Service Director, Estates & Facilities Group |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational quality and safety and effectiveness | b) Decontamination | Chief Operating Officer | Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational quality and safety and effectiveness | c) Capital equipment renewal & replacement | Chief Operating Officer | Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Operational quality and safety and effectiveness | d) Electro-Bio Medical Engineering (EBME) | Chief Operating Officer | Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Managed Practices | Delivery of Managed Practices Contacts | Director of Primary Care, Community-Strategy and Long Term Care- Chief Operating Officer | Director of Primary Care, Community-Strategy and Long Term Care- Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Managed Practices | Management and service delivery of Health Board Managed Practices (including premises contracts) | Director of Primary Care, Community-Strategy and Long Term Care- Chief Operating Officer | Director of Primary Care, Community-Strategy and Long Term Care- Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Medicines and Healthcare products Regulatory Agency (MHRA) (linking in with the Medical Director for issues relating to medicines/blood as necessary) | Director of Allied Health Professions & Health Science | Director of Allied Health Professions & Health Science/Medical Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Medical Devices | Chief Operating Officer | Deputy Director of Operations |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Medicines Management | Director of Primary Care, Community-Strategy and Long Term Care- Medical Director | Head of Medicines Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Development of a medicines optimisation strategy (primary & secondary care) | Director of Primary Care, Community-Strategy and Long Term Care- Medical Director | Head of Medicines Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | National Contracts for GMS, Dental, Community Pharmacy and Optometry, including implementation, monitoring, performance management and reporting | Director of Primary Care, Community-Strategy and Long Term Care- Chief Operating Officer | Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Performance issues (Medical, dental, pharmacy, optometry) management of performance panels and matters arising from managed practices. | Medical Director | Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | a) Develop an estates strategy and rationalisation plan | Director of Strategy & Planning | Director of Estates & Facilities (Operational)- Programme Director Capital and Major Infrastructure |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | b) Compliance with environmental regulations | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | c) Management of land, buildings, included leased assets | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | d) Authorised holder of deed and controller of property | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | e) District Valuer issues and negotiations | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | f) Delivery of Capital Estates Projects | Director of Strategy & Planning and Director of Allied Health Professions & Health Science | Director of Estates & Facilities and (Operational)- Programme Director Capital and Major Infrastructure and Head of Operations |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Estates | g) Licences and leases for property | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | a) Information Governance (including compliance with the Data Protection Act, Access to Health Records Act and other IG legislation) | Director of Finance (Senior Information Risk Owner) | Head of Information Governance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | b) Data Protection Officer | Director of Finance | Head of Information Governance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | c) Senior Information Risk Owner (SIRO) | Director of Finance | Digital Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | d) Caldicott Standards and Action Plan | Medical Director | Deputy Caldicott Guardian /Head of Information Governance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | e) Development and revision of Information Sharing Protocols | Director of Finance | Head of Information Governance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | f) IG Training Programme | Director of Finance | Head of Counter Fraud |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | g) Data Quality | Director of Finance | Digital Director & all information Asset Owners |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | h) Management and control of computer systems and facilities to ensure achievement and compliance with national standards and IM&T strategy | Director of Finance | Digital Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | i) Purchases/installation of IT software & hardware | Director of Finance | Digital Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Information Management & Technology Strategy | j) Delivery of specific IT projects | Director of Finance | Digital Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Performance Management & Business Intelligence | a) Review & establish the performance management framework which included meaningful performance measures for the totality of the services for the which the Health Board is responsible | Director of Finance | Head of Performance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Performance Management & Business Intelligence | b) Develop the Board Performance Report template on an annual basis, advising on aligning and integrating service, workforce and financial performance matters for sign off by the Strategic Development & Operational Delivery Strategy and Planning Committee | Director of Finance | Head of Performance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Performance Management & Business Intelligence | c) Establish Performance Management Office | Director of Finance | Head of Performance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | Performance Management & Business Intelligence | d) Provide assurance on the overall performance and delivery against Health Board plans and objectives | Director of Finance | Head of Performance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | NHS Shared Services Partnership | a) Attending Joint Committee meetings | Chief Executive | Director of Finance |

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| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | NHS Shared Services Partnership | b) Agreeing actions to be taken where performance is off track | Chief Executive | Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | NHS Shared Services Partnership | c) Ensure robust interface protocols are in place and test efficacy on a planned programme of review | Chief Executive | Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | To oversee the Health Board's contribution to the NHS Wales Decarbonisation Strategic Delivery Plan | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | To oversee the Health Board's contribution for social model for health & well-being | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Responsibility for Biodiversity | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Compliance with Climate Change regulations | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Responsibility for the production of an independent annual report on the health of the population of Hywel Dda University Health Board | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | OPERATIONAL | N/A | Hywel Dda University Health Board representative on the Area Planning Board | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | a) Develop Board Risk Appetite Statement | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | b) Review internal risk management processes | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance & Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | c) Co-ordination & maintenance of Corporate Risk Register | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance & Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | d) Management & maintenance of Operational (Clinical Care Group/Clinical Service Group/Executive Function) Risk Registers | Executive Directors and Directors | Heads of Departments/Heads of Service/Clinical Care Group Service Directors/Clinical Service Group General Managers |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | e) Development of Board Assurance Framework | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance & Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | f) Implement recommendations from external governance reviews | All Executive Directors and Directors | All Executive Directors and Directors |

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| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Corporate Governance, Assurance Framework & Risk Management | Accountable for compliance with Welsh Health Circulars issued by Welsh Government, Ministerial Directions and Consultations | All Executive Directors and Directors | All Executive Directors and Directors |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Policies & Procedures (written control documents) | a) Maintaining a database of all written control documents | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Policies & Procedures (written control documents) | b) Manage the process for developing and reviewing written control documents | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Policies & Procedures (written control documents) | c) Approval of written control documents | Appropriate committee as per Written Control Document Scheme of Delegation *Owning groups & approving committees - clinical written control documentation | As per Written Control Document Scheme of Delegation *Owning groups & approving committees - clinical written control documentation |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Board Secretariat | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Board Development & Committee Management | a) Establish a process for establishment & abolition of committees and groups | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Board Development & Committee Management | b) Establish procedures on the management of committees and groups to ensure consistency and good governance | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Board Development & Committee Management | c) Board and Committee development | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Regulatory and inspections coordination and assurance | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance & Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Legal Advice | a) Engagement of UHB solicitors | Director of Corporate Governance/Board Secretary Director of Workforce & OD for workforce related matters | Assistant Director of Corporate Legal Services and Public Affairs Assistant Director of People Management for workforce related matters |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Legal Advice | b) Authority to seek legal advice – all issues | Director of Corporate Governance/Board Secretary Director of Workforce & OD for workforce related matters | Assistant Director of Corporate Legal Services and Public Affairs Assistant Director of People Management for workforce related matters |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Legal Advice | Legal partnership functions and regionalisation solution discussions with SBUHB | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Working | Partnership Working with SBUHB | Chief Executive | Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Working | Health Board link with Llais | Director of Strategy and Planning | Director of Strategy and Planning / Communications and Engagement Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Arrangements that appropriate insurance/indemnity is in place (Corporate) | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Arrangements that appropriate insurance/indemnity is in place (Nursing and Midwifery) | Director of Nursing, Quality & Patient Experience | Assistant Director-(Legal and Patient Support)/Assistant Director of Nursing (Professional Standards and Regulation) |

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| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Maintenance of the University status of the organisation. | Medical Director | Director for Research, Innovation and Value |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | COVID-19 Inquiry | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Freedom of information Act (FOI) | a) Coordinate the collecting of information to prepare FOI responses within statutory deadlines | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Freedom of information Act (FOI) | b) Sign off of Final Responses | Relevant Lead Executive Director or Director | Assistant Director of Corporate Legal Services and Public Affairs |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Freedom of information Act (FOI) | c) Undertake internal reviews/complaints relating to FOI | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Public Engagement | a) Develop and implement public engagement strategy | Communications and Engagement Director | Head of Engagement |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Public Engagement | b) Ensure public participation in service design and decision making | Communications and Engagement Director | Head of Engagement |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Stakeholder Engagement & Management (excluding armed forces) | a) Organising a continuous programme of stakeholder events across Hywel Dda | Communications and Engagement Director | Head of Engagement |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Stakeholder Engagement & Management (excluding armed forces) | b) Supporting services in engaging with staff, patients and the public during service change | Communications and Engagement Director | Head of Engagement |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Stakeholder Engagement & Management (including armed forces) | c) Engaging with armed forces, carers, staff, refugees, asylum seekers and those with sensory impairment | Director of Workforce & OD | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Communications | a) External Communications including relationships with press, key stakeholders and the public | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Communications | b) Internal communications with staff (Corporate Information) | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Communications | c) Developing and maintaining the organisation's external website, staff intranet, social media and e-Communications | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Communications | d) Responsibility for the effective implementation, delivery and evaluation of the organisation's Communications and Engagement Strategy | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Annual Report | a) Annual Report - Ensure the necessary disclosures on governance and the workings of the Board through the preparation, publication and distribution of the Accountability Report including the Annual Governance Statement | Director of Corporate Governance/Board Secretary | Assistant Director of Assurance and Risk |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Annual Report | b) Annual Report - Performance Report | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Policy Development | a) Accountability for all communications and engagement policies ensuring their application within the organisation and ensuring any joint policies agreed with local partners are also applied consistently amongst key partners, including reference to the Health Board's branding, corporate identity, etc | Communications and Engagement Director | Communications and Engagement Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Sponsorship | a) Sponsorship to attend courses and conferences | Executive Directors/Directors/Clinical Care Group Service/Director/Heads of Service/General Managers | Individual is responsible for completing Gifts, Hospitality & Sponsorship form |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Sponsorship | b) Sponsorship of HB events | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Advertising | a) Relating to recruitment | Director of Workforce & OD | Assistant Director of People Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Advertising | b) Other | Communications and Engagement Director | Assistant Director of Communications -Head of Communications |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Welsh Language | a) Compliance with the Welsh Language Act 1993 and the Welsh Language Standards | Communications and Engagement Director | Welsh Language Service Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Welsh Language | b) Welsh translation services | Communications and Engagement Director | Welsh Language Service Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Welsh Language | c) Welsh Language Strategy and development | Communications and Engagement Director | Welsh Language Service Manager |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Governance | a) Maintain a partnership governance framework to ensure a consistent approach of working across partners | Director of Public Health | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Governance | b) Performance management and monitoring of outcomes of work delivered through partnerships and other inter-organisational arrangements | Director of Public Health / Chief Executive Officer | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion and Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Governance | Regional Partnership Board Governance | Director of Primary Care, Community-Strategy and Long Term Care Chief Executive Officer | Assistant Director of Primary Care |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Partnership Governance | Public Services Board Governance | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | International Health Partnerships (Working Overseas) | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | International Health Partnerships (Volunteering) | Director of Public Health | Director of Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Equality, Diversity and Human Rights | Compliance with the Equality Act 2010 and Public Sector Equality Duty (2016) | Director of Public Health | Director of Public Health Assistant Director of Business, Partnerships and Inclusion / Consultant in Public Health |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | a) Public Board | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | b) Audit and Risk Assurance Committee | Director of Corporate Governance/Board Secretary | Director of Corporate Governance/Board Secretary |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | c) People, Organisational Development & Culture Committee | Director of Workforce & OD | Director of Workforce & OD |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | d) Quality, Safety and Experience Committee | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | e) Charitable Funds Committee | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | f) Mental Health Legislation Committee | Chief Operating Officer | Chief Operating Officer |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | g) Finance and Performance Committee | Director of Finance | Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | h) Health and Safety Committee | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | i) Remuneration and Terms of Service Committee | Chief Executive | Chief Executive |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | j) Strategy and Planning Committee | Director of Strategy and Planning | Director of Strategy and Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | k) Digital, Data and Innovation Committee | Director of Finance | Director of Finance |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | l) Healthcare Professionals Forum | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |

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| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | m) Stakeholder Reference Group | Communications and Engagement Director | Communications and Engagement Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | Committee Lead | n) Staff Partnership Forum | Director of Workforce & OD | Director of Workforce & OD |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Targeted Intervention SRO | Director of Strategy and Planning | Deputy Director of Operational Planning and Commissioning Director of Delivery |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Medical Examiners Service | Medical Director | Medical Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Engagement with Education Providers | Director of Workforce & OD | Assistant Director of People Development |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Staff Engagement and Support | a) Occupational Health Service | Director of Workforce & OD | Assistant Director of People Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Staff Engagement and Support | b) Staff psychological well-being | Director of Workforce & OD | Assistant Director of OD |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Staff Engagement and Support | c) Staff communication (corporate) | Director of Workforce & OD | Communications and Engagement Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Staff Engagement and Support | d) Staff engagement on service change | Director of Workforce & OD | Communications and Engagement Director |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Staff Engagement and Support | e) Speak Up Safely | Director of Workforce & OD | Assistant Director of OD |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Workforce Planning, recruitment and retention | a) Develop & implement a workforce strategy | Director of Workforce & OD | Assistant Director of People Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Workforce Planning, recruitment and retention | b) Establish & implement workforce plans to address key performance measures in sickness reduction, appraisal rates, mandatory training, job planning and employee relations, support & investigation | Director of Workforce & OD | Head of Strategic Workforce Planning – Assistant Director of People Planning |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | N/A | Organisational Development Strategy | Director of Workforce & OD | Assistant Director of OD |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | N/A | Staff Side and Employee Relations | Director of Workforce & OD | Head of Workforce Assistant Director of People Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | N/A | Workforce Equality and Diversity | Director of Workforce & OD and Director of Public Health | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Medical Staffing | a) Authorisation above medical and locum cap | Medical Director | Assistant Director (Medical Directorate) |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Medical Staffing | b) Job Planning | Medical Director | Assistant Director (Medical Directorate) |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Medical Staffing | c) Monitoring and quality assurance of job plans | Medical Director | Assistant Director (Medical Directorate) |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Disciplinary investigations and dismissal of staff | a) Chief Executive i) Suspension/ Exclusion ii) Dismissal | Chair of the Board | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Disciplinary investigations and dismissal of staff | b) Director i) Suspension/ Exclusion ii) Dismissal | Chief Executive | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Disciplinary investigations and dismissal of staff | c) All Other Staff (excluding Medical and Dental) i) Suspension/ Exclusion ii) Dismissal | Appropriate Line Manager (must be minimum of Band 7) Appropriate Senior Manager (normally will be minimum of Band 8) | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Disciplinary investigations and dismissal of staff | d) Medical and Dental Staff i) Suspension/ Exclusion ii) Dismissal | See UPSW (or any subsequent policy which replaces UPSW) Medical Director (or nominated deputy) | N/A |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | Disciplinary investigations and dismissal of staff | Dismissal of Primary Care contracted Medical and Dental staff (and other Contractor professionals) i.e Optometry and Community Pharmacy | Director of Primary Care, Community Strategy and Long Term Care - Medical Director | Director of Primary Care, Community Strategy and Long Term Care - Medical Director |

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| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | N/A | Workforce policies and procedures | Director of Workforce & OD | Head of Workforce - Assistant Director of People Management |
| SCHEME OF DELEGATION FROM OTHER | N/A | WORKFORCE | N/A | Finance Professional Leadership | Director of Finance | Assistant Directors of Finance and Head of Service Modernisation |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Responsibility for Quality Impact Assessment | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |
| SCHEME OF DELEGATION FROM OTHER | N/A | CORPORATE | N/A | Responsibility for Integrated Impact Assessment | Director of Nursing, Quality & Patient Experience | Director of Nursing, Quality & Patient Experience |
| LEGISLATION COMPLIANCE | N/A | Concerns | N/A | NHS Redress (Wales) Measure 2008 (2008 nawm1) - Measures of the Welsh Director of Nursing, Quality & Patient Experience Assistant Director (Legal & Patient Experience) Government to make provision about arrangements for redress in relation to liability in connection with services provided as part of the health service in Wales | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) |
| LEGISLATION COMPLIANCE | N/A | Concerns | N/A | The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 - National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023 | Director of Nursing, Quality & Patient Experience | Assistant Director (Legal and Patient Support) |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Well-being of Future Generations (Wales) Act 2015 | Director of Public Health | Director of Public Health |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | Social Services and Well-being (Wales) Act 2014 | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Partnership Arrangements (Wales) Regulations 2015 | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Assistant Director of Primary Care |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | Charities Act 2011 | Director of Nursing, Quality & Patient Experience | Head of Hywel Dda Health Charities |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | Charities Act 2022 | Director of Nursing, Quality & Patient Experience | Head of Hywel Dda Health Charities |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The National Health Service Act 1977 | Chief Executive | All Executives |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The National Health Services (Wales) Act 2006 | Chief Executive | All Executive Directors/Directors |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Health and Social Care (Wales) Act 2025 | Chief Operating Officer | Chief Operating Officer |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Health and Social Care (Quality and Engagement) (Wales) Act 2020 | Director of Nursing, Quality & Patient Experience | All Executive Directors/Directors |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 | Chief Executive | Director of Corporate Governance/Board Secretary |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 as amended | Chief Executive | Director of Corporate Governance/Board Secretary |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Local Health Boards (Directed Functions) (Wales) Regulations 2009 | Chief Executive | Director of Corporate Governance/Board Secretary |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009 | Chief Executive | Director of Corporate Governance/Board Secretary |
| LEGISLATION COMPLIANCE | N/A | Corporate | N/A | The Local Health Boards (Establishment and Dissolution) (Wales) (Amendment) Order 2013 | Chief Executive | Director of Corporate Governance/Board Secretary |
| LEGISLATION COMPLIANCE | N/A | Equality | N/A | Equality Act 2010 - A legal framework to protect the rights of individuals and advance equality of opportunity for all | Director of Workforce & OD | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion |
| LEGISLATION COMPLIANCE | N/A | Equality | N/A | Human Rights Act 1998 - Codifies the protections in the European Convention on Human Rights into UK law | Director of Workforce & OD | Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion |
| LEGISLATION COMPLIANCE | N/A | Equality | N/A | Welsh Language Act 1993 – Establishes the principle that Welsh and English languages should be treated on the basis of equality, in the conduct of public business in Wales | Communications and Engagement Director | Communications and Engagement Director |
| LEGISLATION COMPLIANCE | N/A | Equality | N/A | Welsh Language (Wales) Measure 2011 | Communications and Engagement Director | Communications and Engagement Director |
| LEGISLATION COMPLIANCE | N/A | Estates | N/A | Pollution Prevention and Control Act 1999 & Environmental Permitting Regulations 2010 (previously The Radioactive Substances Act 1993) - Inspections regarding Radioactive Waste, etc. Under Radioactive Substance Act 1993. Registration to keep radioactive substances and authorisation to store and dispose of radioactive waste to comply with the requirements | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |

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| LEGISLATION COMPLIANCE | N/A | Estates | N/A | Energy Act 2008 (c.32) - Combined Heat and Power Quality Assurance (CHPQA) | Director of Allied Health Professions and Health Science | Estates & Facilities Clinical Care Group Service Director |
| LEGISLATION COMPLIANCE | N/A | Health & Safety | N/A | Health and Safety at Work Act 1974 & Secondary Legislation (Regulations) | Director of Allied Health Professions and Health Science | All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer |
| LEGISLATION COMPLIANCE | N/A | Health & Safety | N/A | Fire & Rescue Services Act 2005 & Regulatory Reform (Fire Safety) Order 2005 | Director of Allied Health Professions and Health Science | All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer |
| LEGISLATION COMPLIANCE | N/A | Health & Safety | N/A | Ionising Radiation (Medical Exposure) Regulations 1999 | Director of Allied Health Professions and Health Science | Head of Radiology |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | General Data Protection Regulations 2018 - Protection of personal information | Director of Finance | Digital Director and Head of Information Governance |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | General Data Protection Regulations 2018 - Non Medical Subject Access Requests | Director of Finance | Digital Director and Head of Information Governance |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | General Data Protection Regulations 2018 - Acute Subject Access Requests | Chief Operating Officer | Acute Records Manager |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | General Data Protection Regulations 2018 - Mental Health Subject Access Requests | Chief Operating Officer | Mental Health Administrator |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | Access to Health Records Act 1990 - Access to the health records of a deceased person | Chief Operating Officer | Health Records Manager/ Mental Health Administrator |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | Common Law duty of Confidentiality | Director of Finance | Digital Director |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | Computer Misuse Act 1990 – Securing computer material against unauthorised access or modification; and for connected purposes | Director of Finance | Digital Director |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | Freedom of Information Act 2000 - Provides public access to information held by public authorities | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| LEGISLATION COMPLIANCE | N/A | Information Governance | N/A | Environmental Information Regulations 2004 | Director of Corporate Governance/Board Secretary | Assistant Director of Corporate Legal Services and Public Affairs |
| LEGISLATION COMPLIANCE | N/A | Medicines Management | N/A | Health Act 2006 (c.28) & Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 (under Health Act 2006) | Medical Director | Head of Medicines Management |
| LEGISLATION COMPLIANCE | N/A | Medicines Management | N/A | Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 (under Health Act 2006) - Regulations on the management of Controlled Drugs (Jan 2009) | Medical Director | Head of Medicines Management |
| LEGISLATION COMPLIANCE | N/A | Medicines Management | N/A | Misuse of Drugs Act 1971 (c.38) & Misuse of Drugs Act 2001- Restriction relating to production, supply, possession and destruction of controlled drugs | Medical Director | Pharmaceutical & Prescribing Manager, Head of Medicines Management |
| LEGISLATION COMPLIANCE | N/A | Mental Health | N/A | Mental Health Act 1983 | Chief Operating Officer | Mental Health & Learning Disabilities Clinical Care Group Service Director |
| LEGISLATION COMPLIANCE | N/A | Mental Health | N/A | Mental Health (Wales) Measure 2010 | Chief Operating Officer | Mental Health & Learning Disabilities Clinical Care Group Service Director |
| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Human Tissue Act 2004 – Corporate Licence Holder | Director of Allied Health Professions and Health Science | Director of Research, Innovation and University Partnerships and Consultant Histopathologist (Pathology Lead) Clinical Care Group Service Director - Allied Health Professions and Health Sciences Designated Individual - Consultant Pathologist |
| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Human Transplantation (Wales) Act 2013 | Chief Operating Officer | Consultant Histopathologist (Pathology Lead) |

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| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing for Quality, Assurance & Professional Regulation Assistant Director of Nursing, Assurance and Safeguarding (Grade 5 only) Operation Team (other) |
| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Nurse Staffing Levels (Wales) Act 2016 | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing (Nursing Practice) |
| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Quality | Director of Nursing, Quality & Patient Experience | Deputy Director Nursing, Quality & Patient Experience/ Assistant Director of Nursing - Quality & Governance / Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) |
| LEGISLATION COMPLIANCE | N/A | Patient Safety | N/A | Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Candour | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing - Quality & Governance Assistant Director of Nursing Assurance & Safeguarding |
| LEGISLATION COMPLIANCE | N/A | Public Health | N/A | Public Health (Control of Diseases) Act 1984 (c.22) & Health Protection (Notification) (Wales) Regulations 2010 - Cases of notifiable diseases, death and disposal of bodies | Director of Public Health | Head of Health Emergency Planning |
| LEGISLATION COMPLIANCE | N/A | Public Health | N/A | Smoke-Free Premises (Wales) Regulations 2007 | Director of Public Health | Public Health Officer (Tobacco) |
| LEGISLATION COMPLIANCE | N/A | Public Involvement | N/A | Local Government and Public Involvement in Health Act 2007 (c.28) – Disclosure of information, ethical standards, patient and public involvement | Director of Public Health | Communications and Engagement Director |
| LEGISLATION COMPLIANCE | N/A | Public Safety | N/A | Civil Contingencies Act 2004 - Establishes a coherent framework for emergency planning | Director of Public Health | Head of Health Emergency Planning |
| LEGISLATION COMPLIANCE | N/A | Safeguarding | N/A | Children's Act 1989, 2004 - Provides the legislative framework for child protection in Wales | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing for Quality, Assurance & Professional Regulation Assistant Director of Nursing Assurance & Safeguarding |
| LEGISLATION COMPLIANCE | N/A | Safeguarding | N/A | Care Standards Act 2000 - Provides for the administration of a variety of care institutions, including, independent hospitals, nursing homes and residential care homes | Director of Primary Care, Community Strategy and Long Term Care Chief Operating Officer | Head of Long Term Care / Clinical Care Group Service Director - Community & Integrated Medicine |
| LEGISLATION COMPLIANCE | N/A | Safeguarding | N/A | Protecting Vulnerable Groups Act 2006 - Provides the legislative framework for the new Vetting and Barring scheme | Director of Nursing, Quality & Patient Experience | Assistant Director of Nursing for Quality, Assurance & Professional Regulation Assistant Director of Nursing Assurance & Safeguarding |
| LEGISLATION COMPLIANCE | N/A | Safeguarding | N/A | Mental Capacity Act 2005 - Provides a statutory framework for people who lack capacity to make decisions for themselves | Chief Operating Officer | Head of Consent & Mental Capacity |
| LEGISLATION COMPLIANCE | N/A | Finance | N/A | Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026 | Chief Operating Officer | Clinical Care Group Service Director – Community and Integrated Medicine /Head of Long Term Care |
| LEGISLATION COMPLIANCE | N/A | Finance | N/A | Health Service Procurement (Wales) Act 2024 | Director of Finance | Director of Finance |
| LEGISLATION COMPLIANCE | N/A | Finance | N/A | The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024). | Director of Finance | Director of Finance |
| LEGISLATION COMPLIANCE | N/A | Partnerships | N/A | The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024). | Director of Public Health | Director of Public Health |
| LEGISLATION COMPLIANCE | N/A | Childrens | N/A | Corporate Parenting Charter 2024 | Chief Operating Officer | Community and Integrated Medicine Clinical Care Group Service Director |
| LEGISLATION COMPLIANCE | N/A | Childrens | N/A | Additional Learning Needs and Education Tribunal (Wales) Act 2018 | Director of Allied Health Professions and Health Science | Director of Allied Health Professions and Health Science |
| CAPITAL SCHEMES | N/A | N/A | N/A | Women & Children's Phase 2. GGH | Director of Acute Services (SRO) | Project Director - General Manager, Children, Women and Family Health Clinical Service Group |
| CAPITAL SCHEMES | N/A | N/A | N/A | Fire Enforcement Work WGH | Director of Strategy and Planning (SRO) | Project Director - Director of Estates, Facilities & Capital Management - Programme Director of Capital and Major Infrastructure |
| CAPITAL SCHEMES | N/A | N/A | N/A | Fire Enforcement Work GGH | Director of Strategy and Planning (SRO) | Project Director - Director of Estates, Facilities & Capital Management - Programme Director of Capital and Major Infrastructure |
| CAPITAL SCHEMES | N/A | N/A | N/A | Diagnostic Imaging – All Schemes | Chief Operating Officer (SRO) | Project Director - Clinical Care Director for Radiology |

| | | | | | | |
|-----------------|-----|-----|-----|---|--|---|
| CAPITAL SCHEMES | N/A | N/A | N/A | Carmarthen Hwb | Director of Strategy and Planning (SRO) | Project Director - Senior Delivery Manager for System Flow & Urgent Care |
| CAPITAL SCHEMES | N/A | N/A | N/A | Cross Hands Health & Wellbeing Centre, Cross Hands, Carmarthenshire | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Project Director - General Manager, Carmarthenshire Integrated System Service Group |
| CAPITAL SCHEMES | N/A | N/A | N/A | Aseptic Unit, Withybush General Hospital | Director of Primary Care, Community-Strategy and Long Term Care Medical Director | Project Director - Clinical Director, Pharmacy & Medicines Management |
| CAPITAL SCHEMES | N/A | N/A | N/A | Business Continuity Programme Business Case | Director of Strategy and Planning (SRO) | Project Director – Director of Estates, Facilities & Capital Management Programme Director of Capital and Major Infrastructure |
| CAPITAL SCHEMES | N/A | N/A | N/A | Cylich Caron, Tregaron | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Clinical Care Group Service Director – Community and Integrated Medicine |
| CAPITAL SCHEMES | N/A | N/A | N/A | Aberystwyth Integrated Care Centre | Chief Operating Officer (SRO) | Clinical Care Group Service Director – Community and Integrated Medicine |
| CAPITAL SCHEMES | N/A | N/A | N/A | Fishguard Wellbeing Centre | Director of Primary Care, Community-Strategy and Long Term Care Chief Operating Officer | Project Director - General Manager, Pembrokeshire Integrated System Service Group |
| CAPITAL SCHEMES | N/A | N/A | N/A | Llandovery Health and Wellbeing Hub | Director of Strategy and Planning (SRO) | Project Director – TBC |
| CAPITAL SCHEMES | N/A | N/A | N/A | Chemotherapy Day Unit Bronglais | Chief Operating Officer (SRO) | Project Director - Clinical Care Group Service Director – Community and Integrated Medicine |
| CAPITAL SCHEMES | N/A | N/A | N/A | Sexual Assault Referral Centre (SARC) | Project Director – Clinical Care Group Service Director – Community and Integrated Medicine Director of Strategy and Planning (SRO) | Project Director - General Manager, Children, Women and Family Health Clinical Service Group |

3 - Audit Wales

3.1

10:00, 5 Mins

3.1 - Audit Wales Update Report

*Anne Beegan, Urvisha
Perez,
david.williams@audit.wales*

| For assurance

Attachments

[3.1 Audit Wales ARAC Update \(February 2026\).pdf](#)

Hywel Dda University Health Board – Audit Risk and Assurance Committee Update

Date issued: February 2026



Contents

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For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Introduction

This document provides the Audit Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Hywel Dda University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in April 2025.

We also provide additional information on:

- other relevant examinations and studies published by the Auditor General; and
- relevant corporate documents published by Audit Wales (e.g., fee schemes, annual plans, annual reports), as well as details of any consultations underway.

Accounts audit update

Audit of the 2024-25 Health Charities Annual Report and Accounts

- **Executive Lead:** Director of Finance
- **Focus of the work:** To provide an audit opinion on the 2024-25 Health Charities Annual Report and Accounts
- **Status:** Complete – the audit opinion is due to be signed on 30 January 2026
- **Expected committee date:** January 2026

Audit of the 2025-26 Health Board's Annual Report and Accounts

- **Executive Lead:** Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** In progress – audit planning has commenced
- **Expected committee date:** June 2026

Performance audit update

Review of the management of outpatients

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work has examined the management of outpatients, including assessing the Health Board's progress on the recommendations made in our 2015 and 2018 Review of Follow-up Outpatient Appointments.
- **Status:** Draft report issued for clearance
- **Expected committee date:** April 2026

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Finance
- **Focus of the work:** This work has examined digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** In progress – draft reporting phase.
- **Expected committee date:** April 2026

Review of radiology services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work has examined the effectiveness of arrangements to manage current and future demand for the Health Board's radiology services and will assess the extent of progress made in implementing the recommendations from our 2017 radiology service review.
- **Status:** In progress – draft reporting phase.
- **Expected committee date:** April 2026

Structured assessment 2025 - deep dive review of the arrangements to manage estates

- **Executive Lead:** Director of Allied Health Professions and Health Science
- **Focus of the work:** This work will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** In progress – planning phase.
- **Expected committee date:** June 2026

Review of cancer services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. The work will focus on whether the Health Board is taking the necessary action to provide timely and equitable access to cancer diagnosis and treatment, in line with national targets, standards and plans.
- **Status:** Not yet started – project brief due to be issued in February.
- **Expected committee date:** June 2026

Other relevant publications

Since the last committee update, the Auditor General has published other relevant outputs which have relevance to the NHS. These are set out below.

| | |
|--|---------------|
| <u>Checking the patients. Results from a pilot data matching exercise on GP patient lists</u> | January 2026 |
| <u>Positive action on fraud and error in community pharmacy but more analysis could reap rewards</u> | December 2025 |
| <u>Facing the Future – Auditor General for Wales Podcast – Episode 4</u> | November 2025 |
| <u>Opportunities for Change – Auditor General for Wales Podcast – Episode 3</u> | November 2025 |
| <u>Under Pressure – Auditor General for Wales Podcast – Episode 2</u> | November 2025 |
| <u>A Unique Perspective – Auditor General for Wales Podcast – Episode 1</u> | November 2025 |

Since the last committee update, Audit Wales has also published the following corporate documents.

| | |
|---|---------------|
| <u>Fee Scheme 2026-27</u> | January 2026 |
| <u>Biodiversity and Resilience of Ecosystems Duty Report for 2023-2025 and Plan for 2026-2028</u> | December 2025 |

There are no relevant Audit Wales consultations currently underway.

Further information

Audit Wales has a range of other information to support the scrutiny of Welsh public bodies and to continue to improve the services provided to the people of Wales.

Visit our website to find:



Our publications which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for performance audit.



Data tools to help you better understand public spending trends.



Details of our Good Practice work and events including the sharing of emerging practice and insights from our audit work.



Our newsletter which provides you with regular updates on our public service audit work, good practice, and events.



Audit Wales

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.



3.2

10:05, 0 Mins

3.2 - Review of Investment in Digital Systems

*Anne Beegan,
Urvisha Perez, Huw
Thomas (Hywel Dda
UHB - Director of
Finance)*

DEFERRED to 14 April 2026 meeting

| For assurance

3.3

10:05, 0 Mins

3.3 - Review of the Management of Outpatients

*Anne Beegan,
Urvisha Perez,
Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)*

DEFERRED to 14 April 2026 meeting

| For assurance

3.4

10:05, 0 Mins

3.4 - Review of Radiology Services

*Anne Beegan,
Urvisha Perez,
Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)*

DEFERRED to 14 April 2026 meeting

| For assurance

4 - NWSSP – Audit and Assurance Services -
Internal Audit

4.1

10:05, 5 Mins

4.1 - Internal Audit Plan Progress Report

James Johns
(NWSSP - Internal
Audit)

| For assurance

Attachments

[4.1 SBAR IA Plan Progress Report February 2026.pdf](#)

[4.1 IA Plan Progress Report February 2026.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

| | |
|--|--|
| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 10 February 2026 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Audit & Assurance Services Progress Report |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Head of Internal Audit |
| SWYDDOG ADRODD: REPORTING OFFICER: | Head of Internal Audit |

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

The Audit & Assurance Services progress report provides the Audit & Risk Assurance Committee (ARAC) with an update in relation to the delivery of the approved Internal Audit Plan for 2025/26 and outcomes from audit work.

Cefndir / Background

The work undertaken by Internal Audit is in accordance with its annual plan, which is prepared following a detailed planning process and subject to Committee approval.

The progress report provides the Committee with information regarding the progress of Internal Audit work in accordance with the agreed plan, amendments to the agreed plan and outcomes of any audits completed since the previous meeting of the committee.

Asesiad / Assessment

The findings and assurance ratings from the Internal Audit Reports provides the Committee with a level of assurance as to the adequacy of the risk, governance and control environment in the areas audited.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to take assurance with regard to the delivery of the Internal Audit plan and from the outcomes of the finalised audit reports. The Audit & Risk Assurance Committee is asked to approve the update to the plan.

| Amcanion: (rhaid cwblhau) Objectives: (must be completed) | |
|--|---|
| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | <p>3.16 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.</p> <p>3.17 This will be achieved by:</p> <p>3.17.1 review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;</p> <p>3.17.2 review of the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;</p> <p>3.17.3 Regular consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;</p> <p>3.17.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and</p> <p>3.17.5 annual review of the effectiveness of internal audit.</p> |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Internal Audit reports cover a range of organisational risks. |
| Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Amcanion Cynllunio Planning Objectives | All Planning Objectives Apply |

| | |
|---|--------------------|
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |
|---|--------------------|

| Gwybodaeth Ychwanegol: Further Information: | |
|--|--|
| Ar sail tystiolaeth: Evidence Base: | Internal Audit Plan & Charter. Individual Internal Audit reports. Evidence gathered from the Health Board as part of the delivery of audit assignments. Health Board Risks. |
| Rhestr Termau: Glossary of Terms: | Contained within the reports. |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee: | Director of Corporate Governance Executive Directors and Senior Managers relevant to the individual audits. |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|-----|
| Ariannol / Gwerth am Arian: Financial / Service: | n/a |
| Ansawdd / Gofal Claf: Quality / Patient Care: | n/a |
| Gweithlu: Workforce: | n/a |
| Risg: Risk: | n/a |
| Cyfreithiol: Legal: | n/a |

| | |
|------------------------------------|-----|
| Enw Da: Reputational: | n/a |
| Gyfrinachedd: Privacy: | n/a |
| Cydraddoldeb: Equality: | n/a |

Hywel Dda University Health Board Audit & Risk Assurance Committee

February 2026

Audit & Assurance Services Internal Audit Progress Report

CONTENTS

1. Introduction
2. Outcomes from Finalised Audits
3. Internal Audit plan 2025-26 - Delivery and Planning Update

Appendix A - Assignment Status Schedule



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Please note

This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit & Risk Assurance Committee.






Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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 Hywel Dda 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.

1. Introduction and Background

1.1 This progress report provides the Audit & Risk Assurance Committee (ARAC) with the current position in relation to the delivery of the 2025/26 Internal Audit Plan. The report also includes details of the progress with the delivery of individual audits, outcomes from finalised audits and any updates required to the plan.

2. Outcomes from Finalised Audits

2.1 The Internal Audit Reports finalised since the previous meeting of the Committee are highlighted in the table below along with the allocated assurance ratings, where applicable. The full versions of these reports are included on the agenda as separate items.

| ASSIGNMENT | ASSURANCE RATING |
|--------------------------------|---|
| Vaccinations and Immunisations |  <p>Limited</p> |
| Patient Experience |  <p>Reasonable</p> |
| Managed Practices |  <p>Reasonable</p> |
| Escalation governance |  <p>Substantial</p> |
| Cyber |  <p>Substantial</p> |

3. Planning and Delivery Update

- 3.1** The assignment status schedule for the 2025/26 plan is set out at Appendix A. The schedule includes at this stage an initial timeline for audit assignments as we look to use a flexible approach with our delivery through the year in order to ensure effective management of the available resources.
- 3.2** The current position of the audits that have not made the Committee deadline are summarised in the table below.

| Audit | Current status | Current Position/ comments |
|----------------------------------|----------------|--|
| Operational Governance | WIP | A knock-on effect of the additional work required on the other audits together with the delays in being provided with all required documentation, and the volume of audit work required. |
| Level 3/4 Directorate Escalation | Draft | Some delays in receipt of required documentation, together with the audit field work taking longer than planned due to its complexity. |
| Space Utilisation | Draft | Further discussion required with management on draft report. |

- 3.3** As a result of ongoing planning discussions with the Health Board, including with the Director of Corporate Governance, it has been requested that the audit of IRMER is deferred due to operational pressures. The Committee is asked to approve the amendment to the plan.
- 3.4** Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and senior managers in relation to audits currently being planned and delivered. The UHB Board meetings and some Committees have been observed. Ongoing liaison meetings with Audit Wales and Health Inspectorate Wales have also continued.
- 3.5** The planning process for the 26/27 Internal Audit Plan has commenced, with the draft plan scheduled to be presented to the Committee in April.

Appendix A – HDUHB Internal Audit Plan 2025/26 – Assignment Status Schedule

| Audit Output | Planned start | Planned ARAC | Executive Lead/Responsible Director | Progress Status | Assurance | H | M |
|---|----------------------|---------------------|--|------------------------|--------------------|----------|----------|
| Joint Committee with SBUHB | Q3/4 | Apr | Corporate Governance | planning | | | |
| Operational Governance Arrangements | Q2/3 | Dec | Chief Operating Officer | WIP | | | |
| Escalation Governance | Q3/4 | Feb | Corporate Governance /CEO | Final | Substantial | - | - |
| Level Three / Four Directorates | Q2/3 | Dec | Chief Operating Officer | Draft | | | |
| Nursing Management | Q1/2 | Aug | Nursing, Quality Safety & Experience | FINAL | Limited | 1 | 2 |
| Cleaning Standards | Q3/4 | May | Allied Health Professionals & Health Science | planning | | | |
| Medical Workforce Stabilisation | Q3/4 | April | Medical | planning | | | |
| Validation of Emergency Departments performance and waiting time data | Q1/2 | Oct | Chief Operating Officer | FINAL | Limited | 2 | 4 |
| Staff Sickness Management | Q1/2 | Aug | Workforce & OD | FINAL | Limited | 1 | 2 |
| Commissioning– Long Term Agreement | Q2 | Oct | Strategy & Planning | FINAL | Reasonable | 1 | - |

Audit & Risk Assurance Committee Progress Report

| | | | | | | | |
|---|-------------|------------|---|------------------|-------------------|----------|----------|
| Commissioning – Third Sector | Q3/4 | May | Chief Operating Officer | Planning/ wip | | | |
| Decision making for high-cost drugs | Q2/3 | Feb | Finance | Planning/ wip | | | |
| GP Out of Hours | Q3/4 | Apr | Chief Operating Officer | planning | | | |
| Corporate Risk Ophthalmology | Q1/2 | Aug | Chief Operating Officer | Final | Reasonable | - | 2 |
| Vaccination & Immunisation | Q1/2 | Oct | Public Health | Final | Limited | 5 | 4 |
| Patient Experience | Q3/4 | Feb | Nursing, Quality Safety & Experience | FINAL | Reasonable | 1 | 4 |
| Infection Prevention & Control | Q3/4 | Apr/may | Nursing, Quality Safety & Experience | WIP/QA | | | |
| Theatre Stock System Implementation | Q3 | Apr | Chief Operating Officer | | | | |
| Human Tissue Authority | Q2 | Oct | Allied Health Professionals & Health Science | FINAL | Limited | 2 | 4 |
| IRMER | Q3/4 | Apr/may | Allied Health Professionals & Health Science | Defer | | | |
| Medical Devices Regulations | Q2/3 | Dec | Chief Operating Officer | FINAL | Substantial | | 1 |
| Managed Practices | Q1/2 | Dec | Chief Operating Officer | Final | Reasonable | 2 | 4 |
| Follow up and agreed Action Implementation Tracking - | | | Corporate Governance | wip | | | |

Audit & Risk Assurance Committee Progress Report

| | | | | | | | |
|--|-------------|------------|--|--------------|--------------------|---|----------|
| ED Data Validation re audit | Q4 | | Chief Operating Officer | planning | | | |
| Human Tissue Authority – recommendation follow up | Q4 | | Allied Health Professionals & Health Science | planning | | | |
| Sickness Management - recommendation follow up | Q4 | | Nursing/Workforce | planning | | | |
| Cyber Security | Q2/3 | Dec | Finance | Final | Substantial | | 1 |
| Departmental / Local IT systems management | Q3 | Feb | Finance | WIP | | | |
| Estates Assurance - Space Utilisation | Q2/3 | Feb | Strategy & Planning | draft | Advisory | | |
| Major Infrastructure Investment Plan (MIIP) | Q3/4 | April | Strategy & Planning | planning | | | |
| Control of Contractors | Q1/2 | Oct | Chief Operating Officer | Final | Advisory | - | - |
| Capital Governance | Q1 | Oct | Strategy & Planning | Final | Advisory | - | - |
| Integrated Audit & Assurance Plans (SSU)- Withybush General Hospital Fire – Phase 2. | IAAPs | | Strategy & Planning | | | | |



Office details: [Audit & Assurance Services West Team](#)

Contact details: james.johns@wales.nhs.uk

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

4.2

10:10, 10 Mins

4.2 - Escalation Governance (Substantial Assurance)

*James Johns
(NWSSP - Internal Audit), Philip Kloer
(Hywel Dda UHB - Chief Executive),
Joanne Wilson
(Hywel Dda UHB - Director of Corporate Governance/Board Secretary)*

| For assurance

Attachments

[4.2 Escalation Governance Final IA Report.pdf](#)

Escalation Governance

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Substantial Assurance

Contents

| | |
|-------------------------------------|---|
| Executive Summary | 1 |
| Findings & Agreed Action Plan | 2 |
| Appendix A | 4 |

Review Reference

HDU-2526-24

Fieldwork

August – December 2025

Executive Sign Off

5 February 2026

Audit Committee

February 2026

Executive Lead

Phil Kloer, Chief Executive Officer

Audit Team

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit



Executive Summary

Purpose

The overall objective of this review was to assess and provide independent assurance over the effectiveness of governance arrangements in place for the closure of escalation actions.

Overview

Escalation arrangements continue to be embedded within the Health Board’s operational and assurance governance structure with clear lines of reporting from sub-groups and formal reporting groups via the organisation’s assurance level approach. During 2025, new statutory committees of the Board and Clinical Care Groups were established with criterion accurately realigned to ensure assigned responsibilities and escalation continuity were maintained.

The formal reporting groups and statutory committees continue to review the progress and performance levels of allocated targeted intervention (TI)/escalation criteria with the Audit and Risk Assurance Committee providing overarching scrutiny of TI/ escalation action progress. Given the maturity of current reporting arrangements, an opportunity to streamline reports to focus on key actions requiring immediate attention should be considered and is highlighted for management information.

The monitoring and reporting of the performance measures at the appropriate committee was evident and a review of the source data confirmed the accuracy of the figures reported to the Health Board and submitted to Welsh Government to support their progress against de-escalation. Whilst positive steps and actions have resulted in some domains being de-escalated during 2025; challenges still face the Health Board in the delivery of level 4 (finance and A&E performance) and level 3 (planned care and cancer) TI actions.

We have therefore concluded **substantial** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives

| | | Related Findings | Assurance |
|---|--|------------------|--------------------|
| 1 | Appropriate governance arrangements have been established to manage the six domains of the <i>NHS Wales Escalation and Oversight Framework</i> | - | Substantial |
| 2 | Targeted Intervention actions are only closed on approval of the Targeted Intervention Coordination Group on the basis that they are (i) supported by sufficient and appropriate evidence demonstrating completion, or (ii) subject to alternative 'business as usual' monitoring arrangements with mechanisms in place to provide assurance over progress and completion. | - | Substantial |

Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements have been established to manage the six domains of the *NHS Wales Escalation and Oversight Framework*

Substantial

Overview / Summary of Observations

The Health Board has an established governance structure in place to monitor and manage the delivery of TI/escalation actions in line with the Welsh Government (WG) *Escalation Framework 2025/26* document. The Director of Delivery continues to play a key role within the escalation governance process having responsible for collecting and validating evidence for each TI criterion, demonstrating the impact of remedial measures, assess outcomes against set indicators and working closely with directorates and WG.

Operational Governance Arrangements

The Executive Team is supported by three formal reporting groups – Integrated Quality, Finance and Performance Delivery (IQFPD), A Healthier Mid & West Wales (AHMWW) and Value & Sustainability – in addition to an overarching TI Coordination Group. Terms of reference (ToR) are in place and are supported by designated sub-groups for each reporting group.

In April 2025, a reorganisation within the Operations Directorate resulted in the formation of five Clinical Care Groups (CCGs) that report into the IQFPD Group. The reporting arrangements of the CCGs was reflected in the revised ToR for IQFPD Group. Testing confirmed regular update papers were submitted by all sub-groups and CCGs into the formal reporting groups for the period April to December 2025 – detailed testing on the content of update papers was undertaken in the Operational Governance Arrangements (HDU-2526-02) and Internal Escalation Level 3/4 (HDU-2526-03) Internal Audit reports.

A review of update papers to the formal reporting groups and Executive Team provided a clear progress and implementation of each TI/ escalation action within through the '3A' assurance level approach.

Assurance Governance Arrangements

The statutory committees of the Board were restructured in April 2025 with the Strategic Development and Operational Delivery Committee and Sustainable Resources Committee being stood down and replaced with the following committees:

- Digital, Data and Innovation Committee
- Finance and Performance Committee
- Strategy and Planning Committee

A mapping exercise confirmed that following the restructure, TI/ escalation criterion was realigned to the new committees ensure assigned responsibilities and continuity were maintained. To enhance the monitoring and capture of evidence of actions, all criterion aligned against the statutory committees are recorded on the AMAT system.

A review of the statutory committee minutes and papers for the period April to December 2025 confirmed evidence of (i) regular TI/ escalation progress and update reports, (ii) scrutiny of the reports by members of the committees, and (iii) decisions or actions noted in minutes being recorded in the action log for addressing.

Objective 2: Targeted Intervention actions are only closed on approval of the Targeted Intervention Coordination Group on the basis that they are (i) supported by sufficient and appropriate evidence demonstrating completion, or (ii) subject to alternative 'business as usual' monitoring arrangements with mechanisms in place to provide assurance over progress and completion.

Substantial

Overview / Summary of Observations

TI/ escalation criteria are allocated a formal reporting group and statutory committee that are responsible for reviewing the progress and performance levels with the aim of de-escalation. The Audit and Risk Assurance Committee continue to receive regular update reports on the de-escalation progress of criteria.

An escalation update paper submitted to the Executive Briefing meeting in July 2025, highlighted the following criteria that had been de-escalated due to meeting their required targets:

- Criterion 21: Enhanced Monitoring 60% performance maintained for three months against SCP target
- Criterion 36: 80% of LPMHSS mental health assessments within 28 days
- Criterion 37: 70% of therapeutic interventions started within 28 days
- Criterion 38: 85% of residents in receipt of secondary mental health services with valid care treatment plan
- Criterion 42: A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care
- Criterion 44: Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny
- Criterion 46: A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care
- Criterion 47: Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity
- Criterion 48: Positive staff engagement in NHS Wales surveys

We can confirm the monitoring and reporting of the above performance measures at the appropriate committee, whilst a review of the source data confirmed the accuracy of the figures reported to the Health Board and submitted to WG to support their progress against de-escalation.

On 16 December 2025, the WG confirmed that Hywel Dda had been de-escalated to level 1 (routine) for Leadership and Governance.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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



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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 Hywel Dda 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.

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Public Sector Internal Audit Standards

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4.3

10:20, 0 Mins

4.3 - Operational Governance Arrangements

*James Johns
(NWSSP - Internal
Audit)*

DEFERRED to 14 April 2026 meeting

| For assurance

4.4

10:20, 10 Mins

4.4 - Managed Practices (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)

| For assurance

Attachments

[4.4 Managed Practices Final IA Report.pdf](#)

Managed Practices

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead
Audit Team

HDU-2526-25
September – November 2025
3 February 2026
10 February 2026
Andrew Carruthers, Chief Operating Officer
James Johns, Head of Internal Audit
Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

Health boards have a statutory duty to ensure the delivery of primary care medical services to their resident population. In the absence of a GP partner contract, it is sometimes necessary for the Health Board to directly manage a practice to ensure service continuity. This is a broad scope, high level review to assess the arrangements in place for the management of key systems and risk areas in relation to Health Board managed practices.

Overview

It was pleasing to note that operational governance arrangements introduced in April 2025 have been adopted, with a Managed Practice Integrated Governance Group holding regular Business, Planning, Performance & People and Quality Health & Safety meetings following the recommended agenda template. These meetings incorporate risk, finance, workforce and quality/safety matters. Engagement with finance business partners has improved during 2024/25, and workforce metrics are positive.

We have concluded **Reasonable** assurance overall. The matters requiring management attention include:

1. Inconsistent risk management practices, with some risks recorded and managed via Datix and others recorded and managed via practice-level registers which in some cases do not follow the Boards risk management methodology. **[Finding 1]**
2. Risk is a standing agenda item for the Managed Practice governance groups and there was evidence of discussion of a specific risk, but there was no evidence that risk registers have been presented and discussed. **[Finding 2]**
3. Budgets are based on historic GMS allocations at the point of transfer to the Health Board and do not reflect actual requirements. **[Finding 3]**
4. Complaints registers were not available for three practices, and those that were do not follow a consistent format. Complaints received and managed by the practices are not graded in line with PTR. **[Finding 4]**
5. A small number of incidents dated prior to March 2025 remain open. **[Finding 5]**
6. The strategic vision for managed practices presented to the Board in March 2023 requires updating. **[Finding 6]**

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

Scope & Assurance Summary

| Objectives | Related Findings | Assurance |
|---|------------------|--------------------|
| 1 Risks are identified, monitored and managed. | 1, 2 | Reasonable |
| 2 Budgets are determined in line with the GMS contract and financial performance monitored. | 3 | Limited |
| 3 Incidents, complaints and claims are managed and monitored to assess and ensure quality and safety of services to patients. | 4,5 | Reasonable |
| 4 Staff absence, training and performance is managed and monitored. | - | Substantial |
| 5 Performance measures have been defined and are regularly monitored and reported within the Health Board. | - | Substantial |
| 6 A strategy for transitioning managed practices back to commissioned services via the GMS contract has been developed and progress reported to the Health Board. | 6 | Limited |

Management Actions



High Priority



Medium Priority

Themes



- Finance Management & Control
- Information, Data Quality & Data Accuracy
- Quality, Safety & Patient Experience
- Risk Management
- Strategy

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Risks are identified, monitored and managed **Reasonable**

There are eight risks related to managed practices recorded on Datix, including six amber and one red all of which are above tolerance with mitigating actions identified and evidence of regular review. Most risks are generic and applicable to all practices.

In addition to the risks on Datix, the managed practices within Pembrokeshire also maintain a separate risk register with more operational, practice specific risks recorded. A number of issues were identified with these registers. Separate registers are not maintained for the Carmarthenshire practices. **[Finding 1]**

Whilst risk features as a standing agenda item for the *Managed Practices Integrated Governance Group (IGG)* meetings, risk registers (Datix or otherwise) have not been presented and discussed. However, there is evidence of regular discussion of one Datix risk and escalation to the Primary Care CCG IGG. **[Finding 2]**

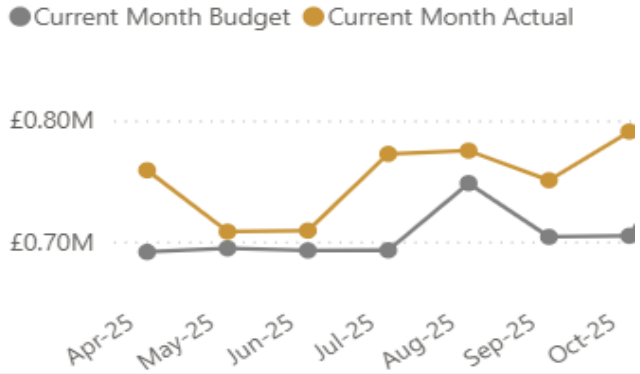
| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|--|
| <p>1 Inconsistent Risk Management Practices</p> <p>Risk management practices are inconsistent, with practice-level risk registers are maintained by practices in Carmarthenshire but not by those in Pembrokeshire.</p> <p>The risks on these registers are not recorded on Datix. In addition:</p> <ul style="list-style-type: none"> • Target scores have not been identified so it is not clear whether the risks are within or above tolerance (and therefore whether further action and/or escalation is required). • In some cases the risk assessment matrix had not been correctly applied to determine the current risk assessment score and RAG rating, which could cause confusion and misinterpretation of the risk significance. • Ashgrove risks had not been reviewed since April 2025 | <p>Materialisation of risks due to improper management/mitigation.</p> | <p>Agreed Action:</p> <p>Risks for all MPs will be reviewed, streamlined and captured and managed via the Datix system.</p> <p>All risks will be reviewed and discussed through the Managed Practice IGG QHS meeting escalating as appropriate into the Primary Care CSG IGG QHS meeting.</p> <p>Expected Evidence of Implementation:</p> <p>Evidence of risk review (e.g. date of last review, progress update) and all open risks recorded on Datix.</p> <p>Evidence (e.g. minutes/papers) of review/discussion of risks at the Managed Practice IGG QHS meeting, with onwards escalation to Primary Care CSG IGG QHS meeting (where appropriate).</p> |
| <p>Theme: Risk Management</p> | <p>Medium Priority</p> | <p>Officer: Anna Swinfield, Head of GMS Sustainability</p> <p>Target Implementation Date: 31 March 2026</p> |
| <p>2 Risk Monitoring & Reporting</p> <p>Risk a standing agenda item for the Managed Practices Integrated Governance Group meetings and there is evidence of discussion of a specific risk (Tenby Surgery water ingress).</p> | <p>Materialisation of risks due to improper management/mitigation.</p> | <p>Agreed Action:</p> <p>The individual MP risk register will be presented and discussed at each Managed Practice IGG meeting. Managed Practices will be reminded that they are responsible for their individual Practice risk monitoring and reporting.</p> |

| | | |
|---|---|--|
| However, risk registers (Datix or otherwise) have not been presented and discussed. | | Expected Evidence of Implementation: Managed Practice IGG agendas/papers/action notes demonstrating review of risks. |
| Theme: Risk Management | Medium Priority Control Operation | Officer: Anna Swinfield, Head of GMS Sustainability Target Implementation Date: 31 March 2026 |

Objective 2: Budgets are determined in line with the GMS contract and financial performance monitored **Limited**

The core budget component for practices operating under the GMS contract is the Global Sum, calculated based on a per-patient capitation formula adjusted for practice list size and demographics. For health board managed practices, the annual budgets are based on the historic GMS allocation at the time the practice transferred to the health board. We are advised that there are difficulties in operating managed practices within the global sum allocation due in part to variation in pay costs, and there have been limited adjustments to account for capitation changes or inflation increases (with the exception of pay awards). Workforce establishment reviews were ongoing at the time of audit. **[Finding 3]**

We were advised that finance meetings did not take place during 2024/25. However, with effect from April 2025, financial performance is now monitored via the monthly *Managed Practice IGG Business, Planning, Performance and People (BPPP)* meetings, with Finance Business Partner representation. Although no reports were taken to the meetings held April – August, a formal finance report covering in month overview, budget statement, staff analysis and savings was taken to the September and October 2025 meetings.



| 2025-26 | Budget | Forecast | Variance Y/E |
|--------------|-------------------|-------------------|--------------|
| Pay | £7,059,929 | £1,029,220 | 15% |
| Non-Pay | £940,445 | £46,330 | 5% |
| Total | £8,000,374 | £1,052,662 | 13% |

Figure 1 Financial Position as at M5

| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|--|
| <p>3 Budget Setting</p> <p>Budgets are based on historic GMS contract allocations at the point of becoming a managed practice, in some cases many years ago, and are therefore require review and updating to reflect actual requirements. Workforce establishment reviews</p> | <p>Budgets are inaccurate and outdated potentially resulting in under/overspend, inability to effectively</p> | <p>Agreed Action:</p> <p>Managed practice budgets will be reviewed and updated where appropriate to achieve better alignment with GMS contract funding arrangements, and incorporate the outcomes of the ongoing workforce establishment reviews.</p> |

| | | |
|--|---|--|
| were ongoing at the time of audit with an anticipated completion date of March 2026. | manage financial performance, and poor decision-making. | Expected Evidence of Implementation: Outcome of budget review / updated budgets. |
| | High Priority | Officer: Anna Swinfield, Head of GMS Sustainability |
| Theme: Finance Management & Control | Control Design | Target Implementation Date: 30 June 2026 |

| | |
|--|-------------------|
| Objective 3: Incidents, complaints and claims are managed and monitored to assess and ensure quality and safety of services to patients | Reasonable |
|--|-------------------|

Complaints

There is no single central record of complaints relating to managed practices. **[Finding 4]**

Complaints received direct to the practice are managed by the Practice Manager and recorded on local, manual complaints registers – they are not recorded on Datix. Review of the complaints registers for Minafon, Sarn and Tenby noted inconsistent format, and complaints are not graded in line with the Putting Things Right guidance. A total of 29 complaints are recorded across the three practices since March 2025, seven (24%) of these remain open. Registers were also requested but not received for Ashgrove, Penrhyn or Neyland. **[Finding 4]**

Complaints made directly to the Health Board are recorded on Datix. Review of Datix identified 19 complaints received since January 2023, three of which remain open. All closed complaints were graded 1 (“low to medium harm or service disruption” as per PTR guidance) at outcome stage.

Incidents

Incidents are reported by the Practice to the Datix Team for recording on the Datix system. There are 22 incidents recorded since March 2025; 68% have a ‘reporters initial harm assessment’ of ‘Low’ or ‘None’ and 77% are closed. A small number of incidents reported prior to March 2025 (with one dating back as far as November 2023) remain open. **[Finding 5]**

Claims

Four claims were opened during 2024, all managed by the Health Board legal team. No claims have been opened in 2025. Concerns are a standing agenda item on the *Managed Practice IGG – Quality Health & Safety (QHS)* meetings.

| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|
| <p>4 Complaints Registers</p> <p>We were unable to confirm whether complaints registers are maintained for Ashgrove, Penrhyn or Neyland practices.</p> <p>The registers maintained by Minafon, Sarn and Tenby do not follow a consistent format – the registers used in Minafon and Sarn are more comprehensive.</p> | <p>Lack of oversight of complaints. Signs of systemic issues (such as repeated or serious complaints) may be missed. Non-compliance with PTR.</p> | <p>Agreed Action:</p> <p>A standard template will be issued to managed practices for recording complaints received by the practice.</p> <p>All formal complaints will be captured on Datix to ensure there is appropriate oversight and support provided (where required) to ensure that the complaint is managed and responded to in accordance with the PTR regulations.</p> |

| | | |
|---|--|--|
| <p>Complaints received and managed by the practices are not graded in line with Putting Things Right guidance.</p> | | <p>All complaints will be reviewed by the Managed Practice IGG QHS meeting</p> <p>Expected Evidence of Implementation: Consistent complaints registers for all managed practices, recording the Datix reference number as confirmation of it has been captured on the system. Evidence (e.g. minutes/papers) of complaints reviewed/discussed at CSG IGG QHS.</p> |
| <p>Theme: Information, Data Quality & Data Accuracy</p> | <p>Medium Priority</p> <p>Control Design</p> | <p>Officer: Anna Swinfield, Head of GMS Sustainability</p> <p>Target Implementation Date: 31 March 2026</p> |
| <p>5 Open Incidents</p> <p>A datix report of all incidents recorded for managed practices for the period October 2023 – September 2025 identified five incidents (two severe, three moderate) reported prior to March 2025 that remain open.</p> | <p>Failure to learn from incidents resulting in recurrence.</p> <p>Patient harm / negative experience.</p> <p>Non-compliance with PTR.</p> | <p>Agreed Action: Open incidents will be reviewed by the individual Practice Manager to ensure that they have been concluded, and subsequently closed on Datix.</p> <p>Expected Evidence of Implementation: Aged incidents closed (where appropriate).</p> |
| <p>Theme: Quality, Safety & Patient Experience</p> | <p>Medium Priority</p> <p>Control Operation</p> | <p>Officer: Anna Swinfield, Head of GMS Sustainability</p> <p>Target Implementation Date: 31 March 2026</p> |

Objective 4: Staff absence, training and performance is managed and monitored

Substantial

Sickness Absence

Managed practices utilise the All Wales Managing Attendance at Work Policy for the management of sickness absence. As of October 2025, the sickness absence rates for Pembrokeshire and Carmarthenshire managed practices was 3.53% and 7.82% respectively. The higher sickness rate in Carmarthenshire exceeds the Health Board aspiration <6.6% and is attributed to long-term illness.

Statutory & Mandatory Training

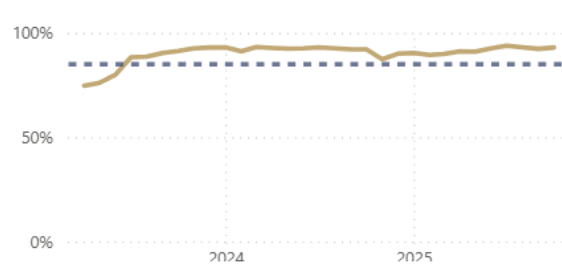
Mandatory training compliance exceeds the Health Board target of 85% with compliance rates for Pembrokeshire and Carmarthenshire practices at 98.5% and 92.6% respectively.

Performance

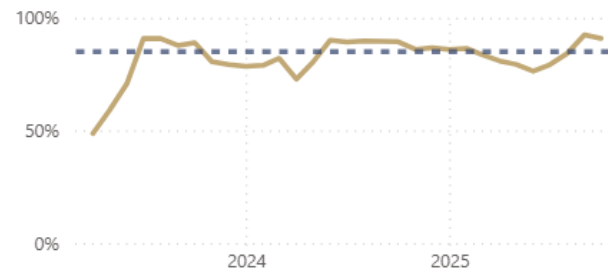
Managed practices utilise the standard Health Board template for PADR, and compliance exceeds the Health Board target. Sample review of PADR confirmed that they had been completed, using the appropriate template and had been completed to a high standard.

Workforce matters, including absence training and performance, are a standing agenda item for the *Managed Practice IGG BPPP* meetings.

% staff compliance with the Core Skills Training



% staff who have had a PADR in past 12 months



Objective 5: Performance measures have been defined and are regularly monitored and reported within the Health Board

Substantial

Workforce and finance performance is monitored through the Health Board IRIS Power BI dashboards and discussed at the Managed Practice IGG meetings, which are aligned to the standard agenda templates for Clinical Care/Service Group governance meetings. These are covered in more detail under each objective.

Objective 6: A strategy for transitioning managed practices back to commissioned services via the GMS contract has been developed and progress reported to the Health Board

Limited

A paper to the Health Board in March 2023 set out the strategic vision for managed practices, acknowledging the challenges faced in securing GMS contracts but also recognising the benefits and opportunities that Health Board managed practices can present.

There have been no further updates following this paper and it is not clear what the current strategic plans are for managed practices, with one exception - we understand that the Vacant Practice Panel met is due to convene to consider expressions of interest received in relation to one practice, with a view to making a recommendation to the Board in this regard.

| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|---|
| <p>6 Managed Practices Strategy</p> <p>The strategic vision for managed practices presented to the Board in March 2023 requires updating to reflect the current position and strategic intentions for the future of managed practices. This is important for determining the extent to which a practice is integrated into Health Board operations, future financial and service planning.</p> | <p>Lack of strategic direction for managed practices. Increased strategic risk regarding future GMS contract management.</p> | <p>Agreed Action:</p> <p>A recommendation following a Vacant Practice Panel for Meddygfa'r Sarn will be considered by Board in January 2026.</p> <p>The commitment has been given to establishing an annual review process for Managed Practices which will start in 2026/27.</p> <p>The Primary and Community Services Strategic Plan will take into consideration the future delivery model for General Medical Services which may include Managed Practices</p> <p>Expected Evidence of Implementation:</p> <p>Outcome of Board discussion in January 2026. Implementation of a Managed Practice annual review process Evidence of reporting to Board.</p> |
| <p>Theme: Strategy</p> | <p style="background-color: red; color: white; text-align: center;">High Priority</p> <p>Control Design</p> | <p>Officer: Anna Swinfield, Head of GMS Sustainability</p> <p>Target Implementation Date: 31 May 2026</p> |

Appendix A

Assurance Opinion

| | | |
|--|-----------------------|--|
| | Substantial | Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure. |
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4.5

10:30, 0 Mins

4.5 - Theatre Stock System Implementation

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 14 April 2026 meeting

| For assurance

4.6

10:30, 20 Mins

4.6 - Vaccination and Immunisation (Limited Assurance)

*James Johns
(NWSSP - Internal
Audit), Ardiana Gjini
(Hywel Dda UHB -
Executive Director of
Public Health),
Bethan Lewis (Hywel
Dda UHB - Assistant
Director of Public
Health Strategic
Business and
Operations)*

| For assurance

Attachments

[4.6 Vaccination & Immunisation Final IA Report.pdf](#)

Vaccination & Immunisation

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Limited Assurance

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Review Reference

HDU-2526-15

Fieldwork

July – November 2025

Executive Sign Off

21 January 2026

Audit Committee

February 2026

Executive Lead

Dr Ardiana Gjini, Executive Director of Public Health

Audit Team

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit



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Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Audit and Assurance Services



Executive Summary

Purpose

To assess the arrangements in place to monitor and promote the uptake of vaccination and immunisation programmes amongst the eligible population covered by the Health Board.

Overview

The Welsh Government's (WG) 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 \(NIF\)](#), launched in October 2022 by the Minister for Health & 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 the WGs commitment](#) to ensuring equitable access to vaccinations for every citizen as a core priority.

At the outset of our review Hywel Dda did not have an overarching strategic immunisation plan. Whilst this is not a Welsh Government requirement, we have observed strategic plans in place at two other health boards and the findings of this review indicate that the Health Board would benefit from having one. At the time of reporting, a *West Wales Regional Health Protection Strategic Plan* was in development and includes a very high-level strategic immunisation plan. **[Finding 1]**

The Health Board published its [Immunisation Equity Strategic Plan \(2024-2026\)](#) (IESP) in May 2024. Whilst an implementation plan has been developed, actions are not consistently SMART and there were inconsistencies between the 'master' and 'easy view' versions of the document **[Finding 2]**. There is no evidence of progress in implementing actions within the plan, and no evidence of implementation monitoring since its inception in July 2024 as the Vaccine Equity Steering Group was not established until July 2025. **[Finding 3]**

Over 80% of vaccination for the eligible population of the HDUHB are delivered by GP practices. Whilst the Health Board has an annual delivery plan for influenza and COVID-19, there are no delivery programmes in place for other routine vaccinations. **[Finding 4]**

A governance structure has been designed to provide oversight, monitoring and assurance in relation to delivery of immunisation programmes and the IESP. However, the structure is not fully operational with most groups in the early stages of development, infrequent meetings and issues with member engagement and attendance. **[Findings 3 & 5]** Furthermore, the Population Health & Oversight Subgroup has not been established and this is not reflected in the A Healthier Mid & West Wales (Executive Team) Group governance. There is however evidence of periodic reporting on immunisations to AHMWW. **[Finding 6]**

Engagement between the Immunisations Team, Primary Care and primary care contractors can be improved and there is lack of clarity regarding roles and responsibilities for delivery and monitoring **[Finding 7]**

Whilst there is some evidence of community outreach activity to raise awareness and extend vaccination access, this is not borne out of a data-driven and co-ordinated programme of activity linked to the IESP. **[Finding 8]** Furthermore, there is limited evidence to demonstrate outcomes monitoring to evaluate the impact of engagement on immunisation uptake, to inform future activity. **[Finding 9]**

Noting the issues identified, we have concluded **Limited** assurance overall. Full details of the matters arising are detailed within the Findings and Agreed Action Plan. The following opportunities for enhancement have also been identified that do not impact the overall opinion and are highlighted for management information:

- The Immunisation Equity Strategic Plan is broadly aligned with the five core principles set out within the NIF, although comparison with the plans for other Welsh health boards highlighted opportunity to make this alignment more explicit by structuring the document in line with the core principles.
- A vaccination equity strategic plan peer review has recently been completed by the Welsh Clinical Leadership Fellowship Project, led by Welsh Government and Public Health Wales. The findings of this review were communicated to health boards in September 2025 and offers opportunity to refresh and enhance the IESP.

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

| | Objectives | Related Findings | Assurance |
|---|--|------------------|----------------|
| 1 | The Health Board has suitable strategic and operational plans in place to improve vaccination uptake and address inequalities in uptake. | 1, 2, 3, 4 | Limited |
| 2 | Appropriate structures, resources and processes are in place to ensure accountability for effective delivery of strategic/operational plans, with regular monitoring and assurance reporting to the Board. | 3, 4, 5, 6 | Limited |
| 3 | The Health Board works closely with partners to ensure effective communication and engagement with the population, including vulnerable people and underserved communities. | 7, 8, 9 | Limited |

Management Actions



High Priority



Medium Priority

Themes



- Communication & Engagement
- Governance
- Lessons Learnt
- Planning, Delivery & Deadline Management
- Reporting
- Strategy

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

At a Glance: National Immunisation Surveillance Data

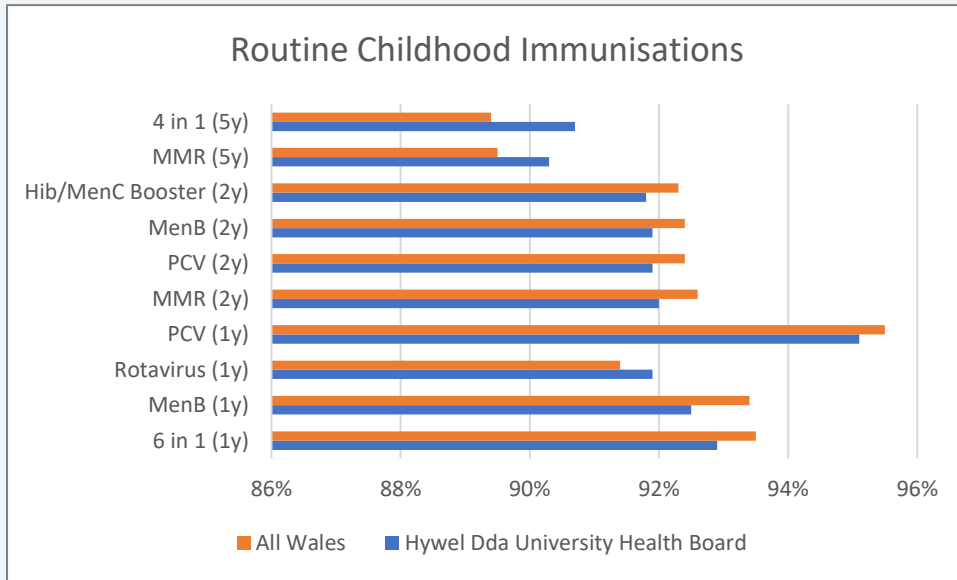


Chart 1: Uptake of routine childhood immunisations in children Q1 2025-26

Welsh Government Target: 95%

Source: [PHW Childhood Immunisation Uptake Report Q1 2025-26](#)

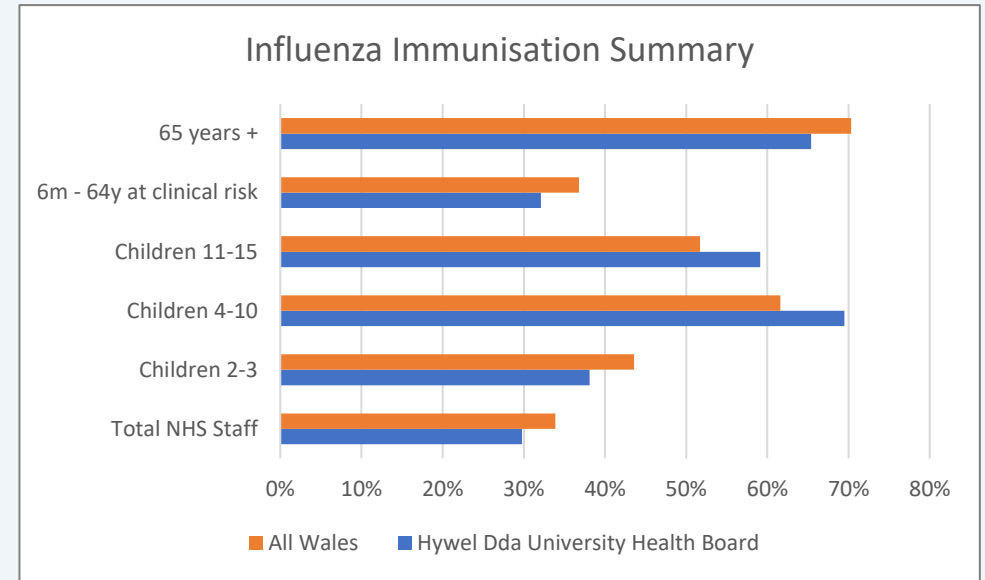


Chart 2: Uptake of influenza in eligible population in 2024-25

Welsh Government Target: 75%

Source: [National Influenza Immunisation Summary - 2024-25 \(27 Mar 2025\)](#)

The data demonstrates that whilst Hywel Dda is not an outlier in terms of vaccination uptake, the Health Board is falling short of Welsh Government targets.

Findings & Agreed Action Plan

Objective 1: The Health Board has suitable strategic and operational plans in place to improve vaccination uptake and address inequalities in uptake

Limited

Strategic Plans

The Health Board's commitment to improving population health (Planning Objective 10), reducing health inequalities and increasing the uptake of routine immunisations is conveyed within the 2025-26 Annual Plan. Included are specific targets for increasing immunisation rates for HPV from 78% to 81%; MMR2 by age 5 from 88.2% to 91.2%; and flu vaccination in priority populations by 5%. See *Objective 2 for further detail on monitoring and reporting*.

The NIF outlines six priority areas of focus: Vaccination Equity; Digitally Enabled Vaccination; Eligibility; Public Vaccination Literacy; Deployment; and Governance. Whilst not a specific requirement of the NIF, we note that two Welsh health boards have overarching strategic immunisation plans aligned to each of the six priority areas. There is no overarching strategic immunisation plan in place within Hywel Dda. The Health Board is however developing a *West Wales Regional Health Protection Strategic Plan 2025-2028* (a draft version was presented at the end of audit fieldwork). This document outlines the health priorities of West Wales including priorities and arrangements for immunisation and vaccine equity. A 'strategic immunisation plan' is included within the appendices setting out the vaccination programmes (including target groups, delivery model and expected uptake rates) and community vaccination and outreach 'mop-up' arrangements (including triggers, criteria and associated response). The document is yet to be completed, finalised and implemented. **[Finding 1]**

Aligned to the first priority area and in response to a specific requirement of the NIF, Hywel Dda has developed an [Immunisation Equity Strategic Plan \(2024-2026\)](#) (IESP) which outlines the organisations commitment and high-level strategies to address inequities in vaccination access and improve uptake. The strategic plan, approved in May 2024, outlines the current position (as at 2024), the long-term aim to achieve 95% uptake of vaccines and also identifies the challenges in achieving optimal immunisation uptake rates for the Health Board's population groups.

The plan is broadly aligned with the five core principles set out within the NIF, although comparison with the plans for other Welsh health boards highlighted opportunity to make this alignment more explicit by structuring it in line with the core principles. A vaccination equity strategic plan peer review has recently been completed by the Welsh Clinical Leadership Fellowship Project, led by Welsh Government and Public Health Wales. The findings of this review were communicated to health boards in September 2025 (during the audit) and offers opportunity to refresh and enhance the IESP where appropriate to reflect learning. This has been highlighted to management as an area for potential enhancement.

Operational Plans

The IESP identifies the key objectives and goals aligned to the three-year strategy and these are replicated in an Immunisation & Vaccination Workplan. However, the associated actions are not consistently SMART in nature **[Finding 2]** and implementation has not been progressed or monitored since its inception in July 2024. **[Finding 3]** We understand that the workplan was to be the focus of a new Vaccine Equity Steering Group (VESG), but this was not established until July 2025 (*see objective 2 for further detail on governance arrangements*).

An 'easy view' version of the workplan has been developed at the request of the VESG, to aid monitoring and review at the group. However, comparison with the original workplan identified inconsistencies. **[Finding 2]**

The Immunisation Schedule & Monitoring document outlines the timing, primary and secondary delivery routes and governance monitoring arrangements for each vaccination. The Seasonal Influenza & COVID-19 Vaccination Programmes Delivery Plan 2025/26 was presented to the Strategic Planning & Delivery Group in August 2025. We were not provided with any evidence of Health Board-wide delivery plans in place for other routine vaccination programmes (these have been observed at another health board). **[Finding 4]**

| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|
| <p>1 West Wales Regional Health Protection Strategic Plan</p> <p>Hywel Dda does not have an overarching strategic immunisation plan aligned to the six priorities set out within the NIF.</p> <p>The <i>West Wales Regional Health Protection Strategic Plan 2025-2028</i> includes a very high level 'strategic immunisation plan' within the appendices, setting out the vaccination programmes and community vaccination and outreach 'mop-up' arrangements. The document is yet to be completed, finalised and implemented.</p> <p>Theme: Strategy</p> | <p>Lack of strategic plan resulting in public health objectives not being achieved.</p> <p>Medium Priority</p> <p>Control Operation</p> | <p>Agreed Action:</p> <p>The West Wales Regional Health Protection Strategic Plan will be finalised, approved by the Health Protection Oversight Group/A Healthier Mid & West Wales Group and implemented.</p> <p>Expected Evidence of Implementation:</p> <p>Final, approved plan. Evidence of approval.</p> <p>Officer: Glenna Jones, Head of Health Protection Service</p> <p>Target Implementation Date: 31 May 2026</p> |
| <p>2 Immunisation & Vaccination Workplan - Design</p> <p>Actions within the Immunisation & Vaccination Workplan are not consistently SMART in nature.</p> <p>An easy view version of the workplan has recently been developed (to aid monitoring at the VESG – see finding 3), however:</p> <ul style="list-style-type: none"> • Four amber actions have been omitted from the easy view version, the reason for this is not clear • One red action has been changed to amber, the reason for this is not clear as the actions are otherwise identical. • Two actions (rated red and amber on the original) have no RAG rating. <p>We were advised that the intention is to maintain both documents, which is inefficient and risks inconsistency. The key difference between the 'master' and 'easy view' versions is the omission of objectives and green RAG rated actions (there are only three) in the latter.</p> <p>Theme: Strategy</p> | <p>Actions that are not SMART in nature can cause ambiguity and limits progress tracking and impact evaluation.</p> <p>Failure to deliver the IESP.</p> <p>High Priority</p> <p>Control Design</p> | <p>Agreed Action:</p> <p>Actions will be reviewed and updated to ensure that they are SMART in nature.</p> <p>A single document will be maintained and filtered as necessary for the purpose of monitoring and reporting to the VESG.</p> <p>Expected Evidence of Implementation:</p> <p>Updated actions that are SMART in nature.</p> <p>Officer: Glenna Jones, Head of Health Protection Service</p> <p>Target Implementation Date: 31 March 2026</p> |

| | | |
|---|---|--|
| <p>3 Immunisation & Vaccination Workplan – Monitoring & Delivery</p> <p>There is no evidence of progress in implementing the actions within the plan, and implementation of the plan has not been monitored since inception in July 2024. We are advised that this is due to lack of Consultant capacity – this is reflected on the risk register (1844).</p> <p>The VESG was established in July 2025 and minutes of the September 2025 meeting indicate that the workplan was discussed, but it is not clear whether the plan itself was presented.</p> <p>There are 31 actions in the most recent version (easy view) of the implementation plan, with three red actions, 26 amber and two with no rating. Deadlines for nearly 60% of the actions have passed (Q2 24/25 – Q2 25/26).</p> | <p>Failure to deliver the IESP.</p> | <p>Agreed Action:</p> <p>A public health Consultant has now been appointed, responsibility includes leading on implementation of the IESP workplan.</p> <p>Action deadlines will be revised and the workplan will be routinely monitored at the VESG, which reports to the Immunisation Oversight Group.</p> |
| <p>Theme: Planning, Delivery & Deadline Management</p> | <p style="background-color: red; color: white; text-align: center;">High Priority</p> <p>Control Design</p> | <p>Expected Evidence of Implementation:</p> <p>Revised action deadlines. Evidence of monitoring at VESG e.g. meeting papers/minutes.</p> <p>Officer: Dr Jo McCarthy, Consultant in Public Health</p> <p>Target Implementation Date: 30 April 2026</p> |
| <p>4 Vaccine Delivery Plans</p> <p>The Health Board has an annual delivery plan for influenza and COVID-19, but there are no delivery programmes in place for other routine vaccination programmes.</p> <p>Whilst recognising the availability of national guidance (such as Patient Group Directions) and frameworks (such as the Healthy Child Wales Programme and School Nursing Framework) which guide delivery of immunisation programmes, terms of reference for the planning & delivery groups (see objective 2) identify these groups as responsible for providing delivery plans for their respective vaccination areas. <i>See also Finding 5.</i></p> | <p>Lack of clarity regarding vaccine programme delivery, potentially resulting in duplication or omission, and negative impact on partner engagement.</p> | <p>Agreed Action:</p> <p>Vaccine specific delivery plans will be developed and monitored by the respective governance groups.</p> |
| <p>Theme: Planning, Delivery & Deadline Management</p> | <p style="background-color: red; color: white; text-align: center;">High Priority</p> <p>Control Operation</p> | <p>Expected Evidence of Implementation:</p> <p>Vaccine specific delivery plans. Evidence of monitoring at respective governance groups e.g. meeting papers/minutes.</p> <p>Officer: Glenna Jones, Head of Health Protection Service; Dr Jo McCarthy, Consultant in Public Health</p> <p>Target Implementation Date: 30 April 2026</p> |

Objective 2: Appropriate structures, resources and processes are in place to ensure accountability for effective delivery of strategic/operational plans, with regular monitoring and assurance reporting to the Board

Limited

Vaccination programmes are issued nationally through Public Health Wales (PHW) Routine Immunisation Schedule for Wales and Welsh Government Welsh Health Circulars (such as the National Influenza Immunisation Programme 2025-26). PHW play a central role in surveillance and performance monitoring through robust mechanisms such as the COVER (Coverage of Vaccination Evaluated Rapidly) reports, which provide detailed uptake data at national and health board levels.

Operational Resources

The NIF committed to establishing central immunisation resource within health boards, including a core team of specialist immunisation nurses to provide a robust local commissioning function. Hywel Dda has an Immunisation Team led by a Head of Nursing, Senior Nurse and Lead Nurse for Health Protection and Immunisations. The Head of Nursing reports to the Assistant Director of Public Health Strategic Business and Operations. The Consultant Lead for immunisations is currently on secondment – we are advised that this has impacted on delivery of the IESP.

Operational Governance Arrangements

The governance structure in figure 1 is intended to provide oversight, monitoring and assurance in relation to delivery of immunisation programmes and the IESP. However, the structure is not fully operational with most of the five Immunisation Planning & Delivery Groups (IPDGs) and the Vaccination Equity Steering Group still in the early stages of development, some groups not yet established, infrequent meetings and issues with member engagement and attendance. **[Findings 3 & 5]**

Whilst the Immunisation Oversight Group has been meeting regularly since 2024, the *Health Protection Coordination Oversight Group (HPCOG)* has only met twice (January and July 2025) and current reporting arrangements from the HPCOG to the Executive Team's *A Healthier Mid & West Wales (AHMWW)* Group are not in line with terms of reference for the latter. AHMWW action notes demonstrate that periodic high-level updates have been provided in relation to vaccination and immunisation, these are mostly verbal and not supported with papers to the Group. **[Finding 6]**

Assurance Reporting to Board

Progress against the deliverables within Planning Objective 10 is regularly reported to the *Strategic Planning Committee* by the Director of Public Health. The Winter Vaccination Programme (Influenza and COVID-19) was presented to SPC in August 2025.

Figure 1: Immunisation Governance Structure



| Key Findings | Risk & Impact | Agreed Management Action |
|---|---|--|
| <p>5 Immunisation Planning & Delivery Groups / Vaccine Equity Steering Group</p> <ul style="list-style-type: none"> The <i>Occupational IPDG</i> has not been established. The <i>Adult IPDG</i> has only met to discuss terms of reference, and has not met since May 2025. The <i>Infant & Pregnancy IPDG</i> and Vaccine Equity Steering Group were established during audit fieldwork. The <i>School Age IPDG</i> has not met since May 2025. <p>Based on the meeting minutes provided to us, none of the IPDGs are discharging their responsibilities as set out within their respective terms of reference.</p> <p>Meeting minutes demonstrate notable challenges with engagement and meeting attendance across all IPDGs, particularly with Primary Care representatives who cite capacity as an issue.</p> <p>Theme: Governance</p> | <p>Lack of oversight and monitoring of immunisation programme delivery potentially resulting in immunisation targets not being achieved.</p> <p>High Priority</p> <p>Control Operation</p> | <p>Agreed Action:</p> <p>The existing governance structure, terms of reference and membership will be reviewed and streamlined, in consultation with Primary Care colleagues, to achieve a more efficient structure that better supports operational needs. Guidance will be sought from the Corporate Governance Team where needed.</p> <p>Expected Evidence of Implementation:</p> <p>Refined governance structure. Updated Terms of Reference. Meeting minutes demonstrating that meetings for all IPDGs are taking place and with appropriate attendance.</p> <p>Officer: Glenna Jones, Head of Health Protection Service</p> <p>Target Implementation Date: 31 March 2026</p> |
| <p>6 Reporting to AHMWW</p> <p>The <i>Health Protection Coordination Oversight Group (HPCOG)</i> should report to the <i>Population Health & Oversight Subgroup (PHOSG)</i> – a subgroup of the Executive Team’s <i>A Healthier Mid & West Wales Group (AHMWW)</i>.</p> <p>However, the PHOSG has not been established. Instead, the HPCOG (and three other groups within Public Health that should report to the PHOSG) report directly to AHMWW via respective members of the Public Health Senior Leadership Team. This is not reflected in the AHMWW governance.</p> <p>Whilst there is evidence of periodic, high-level updates provided to AHMWW in relation to vaccination and immunisation, these are predominantly verbal with papers rarely included in meeting packs.</p> <p>Theme: Reporting</p> | <p>Reporting and escalation is not in line with defined governance arrangements.</p> <p>Medium Priority</p> <p>Control Design</p> | <p>Agreed Action:</p> <p>Terms of Reference for the AHMWW will be updated to reflect the current governance structure and reporting arrangements.</p> <p>Papers will be included in the AHMWW meeting packs to support information flows and discussion.</p> <p>Expected Evidence of Implementation:</p> <p>Updated terms of reference for AHMWW</p> <p>Public Health update papers included within the AHMWW meeting packs.</p> <p>Officer: Lee Davies, Director of Strategy & Planning; Ardiana Gjini, Director of Public Health</p> <p>Target Implementation Date: 31 March 2026</p> |

Objective 3: The Health Board works closely with partners to ensure effective communication and engagement with the population, including vulnerable people and underserved communities.

Limited

Whilst the Health Board has overall responsibility for achieving immunisation uptake targets to safeguard and improve population health, a significant proportion (~80%) of immunisation programmes are delivered in the primary care setting by independent GP and pharmaceutical contractors, with the Primary Care Clinical Care Group responsible for commissioning arrangements (outside the scope of this review).

We were advised that the Immunisation Team utilises national vaccine surveillance data to monitor uptake trends and identify vaccines with low coverage. Data is analysed at GP level to identify underserved populations and inform targeted interventions. There was evidence of monitoring and use of this data in relation to RSV, influenza and COVID-19.

In cases where uptake is lower than expected, the Immunisation Team will intervene to support delivery efforts (for example by focusing on the harder to reach population such as housebound patients and underserved communities) and improve vaccination uptake. However, the circumstances or triggers for instigating intervention and the form that this will take are not defined. Minutes of the Respiratory IPDG note lack of clarity over arrangements for influenza and COVID-19, and friction between the Health Board and primary care contractors over the approach for 2- & 3-year-old flu. Informal observations during the audit also indicate that there is scope to improve engagement between Public Health and Primary Care. **[Finding 7]**






Vaccination equity means tailoring support for specific groups that are affected by inequalities in vaccine uptake. The Immunisation Team cited numerous examples of community outreach activity such as mobile and pop-up clinics and participation in community events to raise awareness, improve vaccination literacy and extend vaccination access to individuals with mobility issues, anxiety, transport deprivation, socioeconomic disadvantage or those not registered with a GP. However, efforts are not borne out of a data-driven and co-ordinated programme of activity linked to the IESP. **[Finding 8]** Furthermore, there is limited evidence of outcomes monitoring to evaluate the impact of engagement and interventions on vaccination rates and equity outcomes, to inform future engagement activity. **[Finding 9]**

| Key Findings | Risk & Impact | Agreed Management Action |
|--|--|--|
| <p>7 Engagement with Primary Care</p> <p>The circumstances or triggers for instigating intervention and the form that this will take are not defined and anecdotal comments shared during the audit suggest that this is a source of dissatisfaction among GP contractors.</p> <p>Informal observations during the audit indicate that there is scope to improve engagement between Public Health and Primary Care.</p> <p>Furthermore, minutes of the Respiratory IPDG in September 2025 note:</p> <ul style="list-style-type: none"> “lack of clarity over who is delivering what” in relation to the influenza and COVID-19 programmes “making it difficult to plan clinics”. | <p>Lack of clarity over roles and responsibilities. Ineffective engagement between Health Board teams and primary care contractors, potentially impacting on vaccine programme delivery.</p> | <p>Agreed Action:</p> <p>Roles and responsibilities for monitoring and driving vaccination uptake, including triggers for instigating intervention and the form that this will take, will be agreed between the Immunisation Team and Primary Care and formally defined.</p> <hr/> <p>Expected Evidence of Implementation:</p> <p>Documented roles and responsibilities. Documented triggers and consequential actions for intervention in primary care vaccination programme delivery. Evidence that these are agreed by both the Immunisation Team and Primary Care.</p> |

| | | | |
|-------------------------|--|--|--|
| | <ul style="list-style-type: none"> “there has been a lot of friction and upset over the approach [for 2- & 3-year-old flu] between primary care and the Health Board”. | <p align="center">Medium Priority</p> | <p>Officer: Dr Jo McCarthy, Consultant in Public Health; Rhian Bond, Assistant Director of Primary Care; Sion James, Deputy Medical Director Primary Care & Community Services</p> |
| | <p>Theme: Communication & Engagement</p> | <p align="center">Control Operation</p> | <p>Target Implementation Date: 31 May 2026</p> |
| <p align="center">8</p> | <p>Approach to Targeted Interventions / Community Outreach</p> <p>The Immunisation Team cited numerous examples of community outreach activity to raise awareness, improve vaccination literacy and extend vaccination access. However, efforts are not borne out of a data-driven and co-ordinated programme of activity linked to the IESP.</p> | <p>Interventions intended to improve vaccination uptake may not be focused in the right areas and therefore may not have the desired outcome in improving equity and uptake.</p> | <p>Agreed Action:</p> <p>Vaccination uptake data will be used to inform and develop a planned programme of community outreach activity to ensure that resources are focused in the right areas. This will link in with the IESP Workplan.</p> <p>Expected Evidence of Implementation:</p> <p>Documented programme of community outreach activity, demonstrating focus on priority areas identified in vaccine uptake data.</p> |
| | | <p align="center">High Priority</p> | <p>Officer: Marie Evans, Health Protection Manager; Wesley Spencer, Senior Public Health Practitioner</p> |
| | <p>Theme: Strategy</p> | <p align="center">Control Design</p> | <p>Target Implementation Date: 30 April 2026</p> |
| <p align="center">9</p> | <p>Evaluating the Impact of Interventions</p> <p>Whilst there is anecdotal evidence of proactive approaches to improve vaccine uptake and equity, there is limited evidence to demonstrate outcomes monitoring to evaluate the impact of engagement on immunisation uptake, to inform future engagement activity</p> | <p>Opportunities to improve the effectiveness of interventions may be missed.</p> <p>Continued use of ineffective methods resulting in wasted resources.</p> | <p>Agreed Action:</p> <p>Develop and implement tools to capture service user experienced (e.g. surveys, focus groups, interviews).</p> <p>Design and carry out regular monitoring to assess how targeted interventions affect vaccine uptake rates and equity outcomes across different population groups.</p> <p>Embed evaluation activities and feedback loops into both the strategic and implementation plans.</p> <p>Expected Evidence of Implementation:</p> <p>Evaluation framework outlining the methods, data sources, frequency of analysis, roles and responsibilities.</p> <p>Defined reporting framework for the outcome of the evaluations undertaken; and agenda/notes to support the same.</p> |
| | | <p align="center">Medium Priority</p> | <p>Officer: Marie Evans, Health Protection Manager</p> |
| | <p>Theme: Lessons Learnt</p> | <p align="center">Control Design</p> | <p>Target Implementation Date: 30 June 2026</p> |

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 Hywel Dda 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 Hywel Dda 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.



4.7

10:50, 0 Mins

4.7 - Level 3 and 4 Directorates

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 14 April 2026 meeting

| For assurance

4.8

10:50, 0 Mins

4.8 - Decision Making for High Cost Drugs

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 14 April 2026 meeting

| For assurance

4.9

10:50, 0 Mins

4.9 - Departmental / Local IT systems management

*James Johns
(NWSSP - Internal
Audit)*

DEFERRED to 14 April 2026 meeting

| For assurance

4.10

10:50, 10 Mins

4.10 - Patient Experience (Reasonable Assurance)

*James Johns
(NWSSP - Internal Audit), Sharon Daniel
(Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience),
Louise O'Connor
(Hywel Dda Health Board - Assistant Director)*

| For assurance

Attachments

[4.10 Patient Experience Final IA Report.pdf](#)

Patient Experience

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Reasonable Assurance

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| Appendix A | 8 |

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2526-16

October - November 2025

December 2025

February 2026

Sharon Daniel, Executive Director of Nursing,
Quality and Patient Experience

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the arrangements and processes in place within Hywel Dda University Health Board (the Health Board) for capturing and utilising patient experience.

Overview

Patients and carers have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected, and their dignity maintained. The Welsh Government's 'People's Experience Framework' (the Framework - previously known as the 'Framework for Assuring Service User Experience') was updated in 2024 to reflect changes in service provision following the Covid-19 pandemic, incorporate recent legislative developments, and broaden its scope to be more inclusive beyond traditional definitions of patient and service user. This updated Framework came into effect on 1 April 2025 and includes a comprehensive set of tools and measures designed to evaluate and improve the quality of health services across Wales.

The Health Board demonstrates commitment to patient experience through established processes and governance forums. However, improvements are needed to formalise strategic intent, strengthen consistency in data collection and analysis at Clinical Care Group level, and enhance system functionality and engagement. Implementing the agreed actions will support alignment with national expectations and continuous improvement.

The audit is taking place during a transitional year, and future developments will be shaped by national directives and internal restructuring. While some current processes are manual and fragmented, we are advised that strategic improvements are planned, guided by the new People's Experience Framework and local self-assessment.

We have concluded **Reasonable** assurance on this area. The matters requiring management attention, to strengthen existing arrangements and support continuous improvement, include:

- The Improving People and Community Experience Charter requires updating to reflect the new Peoples Experience Framework, which recommends that all NHS organisations have in place a People's Experience Strategy. A self-assessment tool to guide the refresh has been developed but is yet to be distributed to services for completion. There are no timelines in place for completion of these tasks.
- There is variation in Civica system engagement at service level and no means of assessing the extent to which the system is used to monitor feedback.
- Some system functionality, including poor feedback escalation protocols and action logging, is not utilised by the Health Board. Whilst there are examples of where feedback is used to drive improvement, there is no mechanism for gaining Health Board-wide assurance that action is taken, where appropriate, in response to feedback.
- Whilst there is demonstrable evidence of analysis of patient experience feedback and triangulation with concerns data at a corporate level (and reported to Board). However, there is limited evidence to demonstrate analysis and discussion of patient experience data (over and above Patient Story) at CCG/CSG level.
- Responsibilities and expectations on services in relation to interpreting and acting upon patient experience feedback are not clearly defined.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. We have also highlighted the following opportunities for enhancement:

- Ensuring that more compliments are captured within Civica and shared to provide a balanced view of patient experience
- The format and content of the Improving People and Community Experience report varies, and whilst in some cases this is appropriate, there is opportunity to standardise reporting to ensure consistent and concise reporting, which may be more informative for the reader for example by enabling comparison with previous periods.

Scope & Assurance Summary

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

| | | Related Findings | Assurance |
|---|--|------------------|-------------------|
| 1 | The Health Board has a patient experience strategy in place, detailing its commitment and approach to listening and learning from patient experience | 1 | Reasonable |
| 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 | 2, 3, 4 | Reasonable |
| 3 | Feedback is used to inform and drive improvement throughout the organisation, with evidence of action taken to address identified issues and share good practice | 5 | Reasonable |
| 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 | 4 | Reasonable |

Management Actions

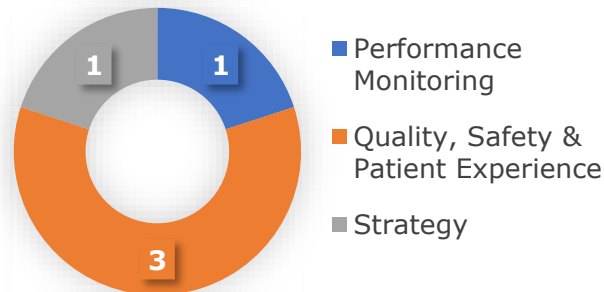


High Priority



Medium Priority

Themes



Risk Types

Quality or Safety Issues
Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Health Board has a patient experience strategy in place, detailing its commitment and approach to listening and learning from patient experience Reasonable

The Health Board has an *Improving People and Community Experience Charter* approved by the Board in March 2024. The document, developed in alignment with the previous Welsh Government 'Framework for Assuring Service User Experience', is aligned to strategic objectives and clearly sets out what patients can expect when using Health Board services and receiving care. The Charter is yet to be refreshed in light of the new 'Peoples Experience Framework' which came into effect in April 2025 and recommends that all NHS Wales organisations have in a place a People's Experience Strategy. **[Finding 1]**

The Framework recommends that all NHS Wales bodies complete a local self-assessment RAG rating score for each element of the framework as a basis for local quality improvements. This is yet to be completed. **[Finding 1]**

Nevertheless, our review has found that existing patient experience arrangements demonstrate alignment with several key elements of the new Framework, including the consistent use of the national core question set and All-Wales scoring structure in surveys issued through Civica.

| Key Findings | Risk & Impact | Agreed Management Action |
|---|--|--|
| <p>1 Peoples Experience Framework: The Peoples Experience Strategy</p> <p>The <i>Improving People and Community Experience Charter</i> requires updating to reflect the new People's Experience Framework (2025), which recommends that all NHS Wales organisations have in place People's Experience Strategy.</p> <p>Whilst the Charter outlines what patients can expect when using Health Board services, a strategically endorsed document would provide a structured plan and set measurable objectives to enable the Health Board to drive improvements and monitor progress in achieving these.</p> <p>The Health Board has developed a self-assessment tool which has been endorsed by the <i>Listening & Learning Sub-Committee</i> but this is yet to be distributed for completion at service level (in part due to the recent operational restructure).</p> <p>Theme: Strategy</p> | <p>Without a structured and strategic approach to understanding and improving patient experience, the Health Board may miss valuable insights into how care is perceived and delivered. This could limit opportunities for learning, improvement, and responsiveness to service patient needs.</p> <p style="background-color: yellow; text-align: center;">Medium Priority</p> <p>Control Design</p> | <p>Agreed Action:</p> <p>The self-assessment tool will be distributed to CCGs for completion at service level and the outcome used to inform the refresh of the Charter and set the patient experience workplan for the Health Board.</p> <p>As part of the refresh, we will consider the merits of replacing the Charter with a formal strategy. Regardless, we will ensure that the revised document satisfies the requirements of the new Framework and it will be strategically endorsed.</p> <p>A workplan will be developed to support delivery of the refreshed Charter/Strategy, these will be replicated at CCG level</p> <hr/> <p>Expected Evidence of Implementation:</p> <p>Dissemination of self-assessment tool to CCGs. Updated Charter/Strategy to reflect the new Framework, approved by Board.</p> <hr/> <p>Officer: Jeff Bowen, Head of Patient Experience</p> <p>Target Implementation Date: CCG dissemination - 31 January 2026. Charter refresh - 30 June 2026 (<i>engagement and coproduction will be required following self assessment analysis and prioritisation process</i>)</p> |

Objective 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

Reasonable

The Health Board utilises the Civica system, a 'once for Wales' digital platform designed to collect and analyse real-time feedback from patients, relatives and service users. The system develops and presents surveys for service users, using multiple contact methods including SMS, interactive voice recognition (IVR) and web tools.

Cursory review of the Civica user access list found generally good coverage across CCGs, although some gaps were evident. Civica offers ad hoc and push reporting, and bespoke dashboards although the onus is on individual service areas to engage with the system and tailor it to their requirements, with the support of the Patient Experience Team where necessary. Whilst this encourages ownership and accountability at service level, there is no way of determining the extent to which service areas use the system and we were unable to confirm which areas are in receipt of regular push reports. Services we spoke with during the review also demonstrated variation in system engagement and use of patient experience data. **[Finding 3]**

The system also has automated escalation protocols for poor/negative feedback however, these are not currently in use in Hywel Dda. **[Finding 2]**

Whilst patient story is a standing agenda item for the Clinical Care/Service Group *Integrated Governance Group (Quality Health & Safety)* meetings, review of papers identified limited evidence to demonstrate analysis and discussion of patient experience data at CCG/CSG level. Older Adults MHL D CSG was an exception to this, with evidence of Civica reports presented at IGG meetings. Paediatrics also demonstrated patient experience data presented at IGG. **[Finding 4]**

Conversely, there is demonstrable evidence of analysis of patient experience data and triangulation with concerns data at a corporate level, at the *Listening & Learning Sub-Committee* and within the *Improving People Experience* reports presented to the *Quality, Safety & Experience Committee* and the *Board*. This is covered in more detail under Objective 4.

| Key Findings | Risk & Impact | Agreed Management Action |
|--|--|--|
| <p>2 Civica System Functionality</p> <p>Civica has automated escalation protocols for notification and escalation of poor/negative feedback received. Whilst this functionality is used in other NHS Wales organisations, it is not currently in use in Hywel Dda.</p> <p>Civica also has functionality to capture follow-up actions and outcomes through its Action Log feature, which is designed to support progress tracking and accountability. This tool enables the recording of actions arising from feedback and assigns responsibility to relevant staff or departments, and monitors completion status and deadlines, thereby enhancing management oversight. This functionality is not in use in Hywel Dda.</p> | <p>Poor or very poor feedback not being acted on promptly.</p> <p>Limited evidence to demonstrate learning and action taken in response to patient feedback.</p> <p style="text-align: center;">Medium Priority</p> | <p>Agreed Action:</p> <p>The benefits of using the real-time alerts function for poor and very poor feedback will be explored and a decision taken as to whether this will be implemented within Hywel Dda.</p> <p>We will pilot use of the action logging functionality within Outpatient Services by the end of March 2026, with a view to wider implementation across the whole Health Board by December 2026 if this proves successful. Consideration will be given to how this aligns with other systems such as Datix for the purposes of triangulation and overall improvement planning.</p> <p>Expected Evidence of Implementation:</p> <p>Escalation protocol and action logging functionalities implemented throughout the Health Board (or rationale to support consideration of benefits and decision not to implement).</p> <p>Officer: Jeff Bowen, Head of Patient Experience</p> |

| | | | |
|---|--|---|--|
| | Theme: Quality, Safety & Patient Experience | Control Design | Target Implementation Date: 1 April 2026 |
| 3 | <p>Civica System Engagement</p> <p>There are no Civica users within the Estates & Facilities Service Group.</p> <p>It is not possible to assess system use at service level and we were unable to confirm which areas are in receipt of push reports.</p> <p>Service areas spoken with during the review demonstrated variation in system engagement. Engagement with and use of the system at service level varies.</p> <p><i>See Also Key Finding 5</i></p> | Feedback is not analysed and acted upon, or used to inform learning and service improvements. | <p>Agreed Action:</p> <p>Civica user access list will be reviewed to identify and address any gaps in service coverage.</p> <p>Standard push reports will be established for all service areas to ensure consistency. 'How to' guides will be developed to support service areas in engaging with and building confidence in using the system more efficiently and effectively, including establishing bespoke dashboards and reports.</p> <p>Expected Evidence of Implementation:</p> <p>Evidence (e.g. emails, system settings/parameters confirming that push reports are issued to all service areas on a regular basis.</p> <p>Guidance documents developed and communicated with Clinical Care/Service Groups.</p> |
| | | Medium Priority | Officer: Jeff Bowen, Head of Patient Experience |
| | Theme: Quality, Safety & Patient Experience | Control Design | Target Implementation Date: 1 April 2026 |
| 4 | <p>Governance</p> <p>Whilst patient story is a standing agenda item for IGG QHS meetings, patient experience data including themes and trends is not. Only two of the service areas reviewed demonstrated reporting of patient experience data at their respective IGGs, this included identification of themes and trends and triangulation with concerns/incidents data.</p> | Feedback is not analysed and acted upon, or used to inform learning and service improvements. | <p>Agreed Action:</p> <p>Patient experience will be incorporated into the Concerns element of the QHS agenda to ensure triangulation with concerns data and identification of key themes and trends.</p> <p>Expected Evidence of Implementation:</p> <p>Updated QHS agenda and evidence of communication with CCG/CSGs.</p> <p>CCG/CSG meetings evidencing review of patient experience data and triangulation with other concerns data.</p> |
| | | Medium Priority | Officer: Gareth Rees - Deputy Director of Operations (to update master agenda template) / CCG Directors (to implement within respective CCGs) |
| | Theme: Performance Monitoring | Control Operation | Target Implementation Date: 1 April 2026 |

Objective 3: Feedback is used to inform and drive improvement throughout the organisation, with evidence of action taken to address identified issues and share good practice

Reasonable

Responsibility for interpreting and acting upon patient experience feedback rests with individual services although roles, responsibilities and expectations in this regard are not clearly defined. **[Finding 5]**

Civica has functionality to record and track actions in response to feedback although this is not currently used. Consequently, there is no mechanism in place for gaining Health Board-wide assurance that action is taken, where appropriate, in response to feedback. **[Finding 2]**

Nevertheless, there are examples of evidence that feedback is being used to drive improvement:

- The Health Board's *You Said We Did* initiative shares action taken in response to feedback received – this is shared on notice boards, the intranet page and reported to the Board
- The Big Thank You shares positive patient experience and feedback
- The Listening & Learning Sub-Committee established a working group to address communication issues – a key theme in negative feedback
- Patient Stories concluding with the learning and action taken

Compliments received via cards, e-mails, letters and gifts can be uploaded to Civica and shared with wider team members during meetings as well as up to Board level. It was noted that not all service areas consistently upload or share compliments received. Ensuring that positive feedback is captured and communicated could enhance staff morale, support service improvement and provide a more balanced view of patient experience.

| Key Findings | Risk & Impact | Agreed Management Action |
|--|--|---|
| <p>5 Clarity of Expectations of Service Areas in Managing Patient Experience Data</p> <p>Responsibility for interpreting and acting upon patient experience feedback rests with individual services. Roles and responsibilities in this regard are not clearly defined - there is no guidance on expected actions from service areas, and nothing setting out how service areas will analyse, action and use feedback to inform service improvements.</p> | <p>Feedback is not analysed and acted upon, or used to inform learning and service improvements.</p> <p style="text-align: center;">High Priority</p> | <p>Agreed Action:</p> <p>Roles, responsibilities and expectations will be documented in guidance.</p> <p>As part of the self-assessment process, service areas will be required to develop plans setting out their commitment and local arrangements for ensuring and demonstrating that feedback is analysed, acted on and used to drive improvement.</p> <hr/> <p>Expected Evidence of Implementation:</p> <p>Document setting out roles, responsibilities and expectations of CCG/CSGs.</p> <p>CCG/CSG level patient experience plans.</p> <hr/> <p>Officer: Jeff Bowen, Head of Patient Experience</p> <p>Target Implementation Date:</p> <p>Document outlining roles and responsibilities – 1 March 2026</p> |

Objective 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

Reasonable

Civica is the primary mechanism for capturing and monitoring patient experience data. A total of 3,969 patient feedback responses were collected via Civica in October 2025. 23,788 targeted contacts (surveys sent via SMS, IVR and email) were made during the month and 3650 responses were received representing a response rate of 15.34%. During the same period, 319 passive responses (completed surveys collected via all other delivery methods such as QR codes, paper surveys and survey links) were received.

The governance structure demonstrates commitment to transparency and oversight. The *Listening and Learning Sub-Committee (LLSC)* operates as a multi-professional forum, enabling the identification and scrutiny of learning from concerns and good practice. Patient experience is also reported to the *Quality, Safety & Experience Committee (QSEC)* via the *Quality Assurance Report* and the *Improving People and Community Experience* report which provides statistical analysis, themes, and priority actions for monitoring improvements. The same report is also presented to *Board*.

These reports highlight the mechanisms in place for capturing and collating feedback, summary of response rates and positive responses, analysis of themes and trends and triangulation with concerns data (incidents, complaints, claims). The format and content of reports varies, and whilst in some cases this is appropriate, there is opportunity to standardise reporting to ensure consistency and more concise reporting, enabling comparison with previous periods.

As highlighted in Objective 1, whilst patient story is a standing agenda item for the Clinical Care/Service Group *Integrated Governance Group (Quality Health & Safety)* meetings, review of papers identified limited evidence to demonstrate analysis and discussion of patient experience data at CCG/CSG level. Older Adults MHL D CSG was an exception to this, with evidence of Civica reports presented at IGG meetings. Paediatrics also demonstrated patient experience data presented at IGG. **[Finding 4]**

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda 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 Hywel Dda 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.



4.11

11:00, 0 Mins

4.11 - Estates Assurance – Space Utilisation

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 14 April 2026 meeting

| For assurance

5

11:00, 10 Mins

5 - BREAK

6 - Financial Focus

6.1

11:10, 10 Mins

6.1 - Financial Assurance Report

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

| For assurance

Attachments

[6.1 SBAR Financial Assurance Report ARAC February 2026.pdf](#)

[6.1 Financial Assurance Report ARAC February 2026.pdf](#)

[6.1 Appendices 1-3 - Financial Assurance Report ARAC February 2026.pdf](#)



**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

| | |
|--|--|
| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 10 February 2026 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Financial Assurance Report |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Huw Thomas, Executive Director of Finance |
| SWYDDOG ADRODD: REPORTING OFFICER: | Tim John, Head of Accounting and Statutory Reporting |

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

The Audit and Risk Assurance Committee (ARAC) requires assurance on a number of financial areas as outlined in the body of the report.

Cefndir / Background

The Standing Orders require that ARAC provides assurance to the Board that the University Health Board's assurance processes are operating effectively. Critical to this is Financial Assurance, which cannot be measured only by the UHB's main finance report and requires further information in order to assess the control environment in place; the risk assessment and management process; and the control activities.

Asesiad / Assessment

This report outlines the issues which require the Committee to action and monitor (Alert and Advise respectively) and the issues from which the Committee can take assurance around the actions being undertaken (Assure).

Alert: Whilst recognising that staff overpayments are referenced below under matters to advise the Committee of, the Committee is reminded that a short report on immaterial over and underpayment of salaries will be discussed In-Committee.

Advise:

- a) The Committee is advised of the breaches of Standing Financial Instructions (SFIs), in respect of retrospective purchase orders, which are reported in Appendix 1b. Where these breaches occur, they are reviewed by local NWSSP Procurement for appropriate re-education and the relevant director is informed.
- b) While the level of staff overpayments decreased, the average recovery period has increased from 5 to 14 months. This increase is attributed to the conclusion of seven historic debt repayment plans, details of which are provided on Schedule 3 of the Report. The target is to have no overpayments; however, the total overpaid during

November and December 2025 represents 0.22% of the average monthly net pay costs (September and October 2025 – 0.23%).

- c) There was one individual loss exceeding £5,000 in November and December 2025 in respect of drugs wastage (£5.3k); details are provided on Schedule 4 of the Report. In addition, there were losses and write offs less than £5,000 in the period totalling £27,590, a significant decrease on the previous two month period.

Assure:

a) Purchase To Pay (P2P)

- i. No PO, No Pay. The Health Board actively enforces the No PO, No Pay policy and whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure that proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH).
- ii. Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year – the target is to pay 95% of all non-NHS invoices within 30 days. Budget holders are continually pursued to authorise invoices promptly, as e-mail requests from NWSSP Accounts Payable are often ignored.

To improve compliance across all aspects of the P2P process, a Task and Finish group between the Core Accounting Team, local Procurement team and NWSSP Accounts Payable has been established to review and triangulate a cohesive approach in conjunction with NWSSP's national IOH initiatives.

In addition, training is provided to areas where there are frequently high numbers of failures. This is in addition to contacting suppliers with invoices on hold without a PO and/or contacting the service users to raise a PO if required.

- b) Single Tender Actions (STAs) and contracts awarded are carefully controlled. No STAs have been made since March 2024.
- c) Health Board income is reviewed and appropriate training is provided to staff raising invoices to ensure the correct VAT treatment is applied.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **SCRUTINISE** the award of contracts listed in Appendix 1a
- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1b
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded
- **NOTE** that a short report on immaterial over and underpayment of salaries will be discussed In-Committee
- **DISCUSS** losses as detailed in Appendix 3 and **APPROVE** the loss in excess of £5,000
- Take **ASSURANCE** from the actions taken to:
 - a) Improve Purchase To Pay (P2P) compliance
 - b) Manage Single Tender Actions (STAs)
 - c) Ensure compliance with VAT requirements

| Amcanion: (rhaid cwblhau) Objectives: (must be completed) | |
|---|---|
| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | BAF SO9-PR20 BAF SO10-PR33 |
| Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | Not Applicable |
| Amcanion Cynllunio Planning Objectives | Not Applicable |
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

| Gwybodaeth Ychwanegol: Further Information: | |
|--|--|
| Ar sail tystiolaeth: Evidence Base: | Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system. |

| | |
|--|--|
| Rhestr Termiau: Glossary of Terms: | <p>AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital CAT – Core Accounting Team CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year ERs NI – Employers National Insurance GGH – Glangwili General Hospital HMRC – His Majesty’s Revenue and Customs IFRS – International Financial Reporting Standards NWSSP – NHS Wales Shared Services Partnership PID – Patient Identifiable Data PO – Purchase Order POL – Probability of Loss PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – Worthybush General Hospital WRP – Welsh Risk Pool</p> |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee: | <p>UHB’s Finance Team UHB’s Management Team</p> |

| | |
|---|--|
| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
| Ariannol / Gwerth am Arian: Financial / Service: | Financial implications are inherent within the report. |
| Ansawdd / Gofal Claf: Quality / Patient Care: | Risk to our financial position affects our ability to discharge timely and effective care to patients. |
| Gweithlu: Workforce: | Overpayments are reported within this report. |
| Risg: Risk: | Financial risks are detailed in the report. |
| Cyfreithiol: Legal: | The UHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year. |
| Enw Da: Reputational: | Adverse variance against the UHB’s financial plan will affect our reputation with Welsh Government, Audit Wales and with external stakeholders. |
| Gyfrinachedd: Privacy: | Not Applicable |
| Cydraddoldeb: Equality: | Not Applicable |



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University Health Board



6.1 Financial Assurance Report for the period 1 November to 31 December 2025 Audit and Risk Assurance Committee

10 February 2026

Compliance requirements for ARAC - Overview



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| Requirement | Reporting | Frequency | Status | Reference |
|--|--|---|------------------|------------------|
| Scheme of delegation changes | <ul style="list-style-type: none"> Exception reporting for approval | As and when | Compliant | N/a – no changes |
| Compliance with Purchase to Pay requirements | <ul style="list-style-type: none"> Breaches of the No PO, No Pay policy/Instructions for noting | Bi-monthly | Assure Committee | Schedule 2a |
| | <ul style="list-style-type: none"> Public Sector Payment Policy (PSPP) compliance | Bi-monthly | Assure Committee | Schedule 2a |
| | <ul style="list-style-type: none"> Tenders awarded for noting | Bi-monthly | Assure Committee | Schedule 2b |
| | <ul style="list-style-type: none"> Single tender action | Bi-monthly | Assure Committee | Schedule 2b |
| | <ul style="list-style-type: none"> Breaches of Standing Financial Instructions (SFIs) | Bi-monthly | Advise Committee | Schedule 2b |
| Compliance with Income to Cash requirements | <ul style="list-style-type: none"> Overpayments of staff salaries and recovery procedures for noting | Bi-monthly | Advise Committee | Schedule 3 |
| Losses & Special payments and Write offs | <ul style="list-style-type: none"> Write off schedule Approval of losses and special payments | Bi-monthly | Advise Committee | Schedule 4 |
| Compliance with Capital requirements | <ul style="list-style-type: none"> Scheme of delegation approval for capital | Following approval of annual capital plan | Compliant | N/a – no changes |
| Compliance with Tax requirements | <ul style="list-style-type: none"> Compliance with VAT requirements | Bi-monthly | Assure Committee | Schedule 5 |
| | <ul style="list-style-type: none"> Compliance with employment taxes | Bi-monthly | Compliant | N/a – no changes |
| Compliance with Reporting requirements | <ul style="list-style-type: none"> Changes in accounting practices and policies Agree final accounts timetable and plans Review of annual accounts progress Review of audited annual accounts and financial statements | Annually | Compliant | N/a – no changes |

2a. Compliance with Purchase to Pay requirements



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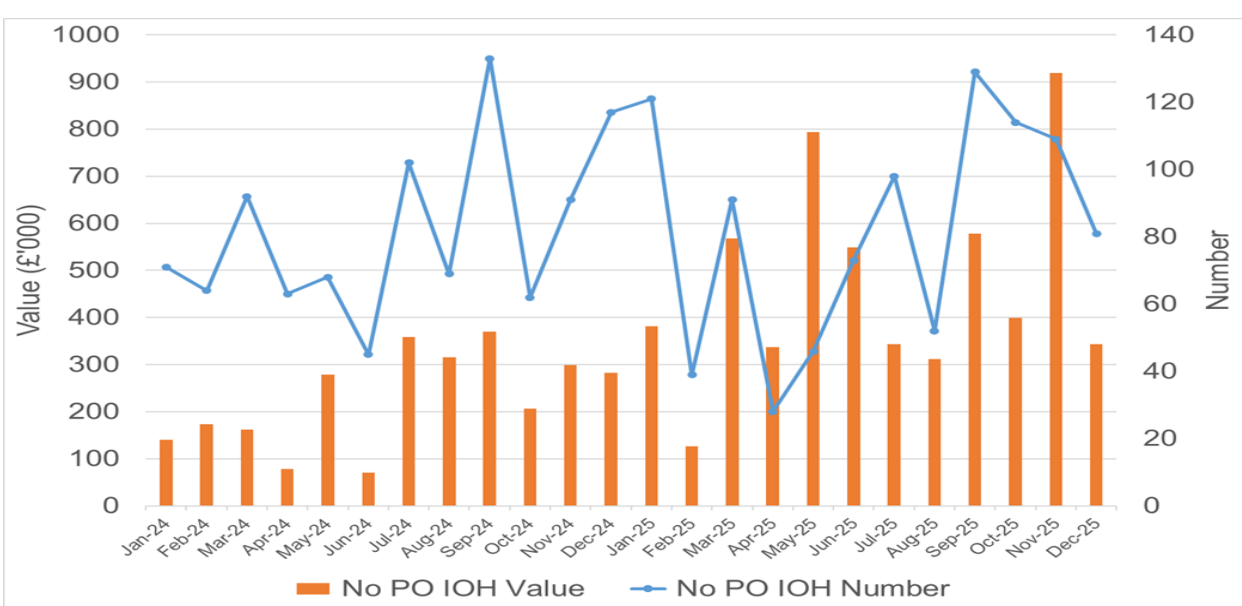
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| | | |
|------------|--|---|
| IOH | November and December 2025 | Cumulative to end October 2025 |
| | No. 190; Value £1,262k* | No. 96; Value £350k |
| | <i>September and October 2025 No. 243; Value £977k</i> | <i>Cumulative to end of October 2025 No. 127; Value £282k</i> |

| | | |
|-------------|--|--|
| PSPP | Non – NHS (statutory target > 95%) | NHS (no statutory target) |
| | November 2025 – 96.2% December 2025 – 98.0% | November 2025 – 92.7% December 2025 – 95.7% |
| | Cumulative to 31 December 2025 96.6% | Cumulative to 31 December 2025 88.3% |

*Includes one invoice for £248,852 in respect of an annual subscription for Adastra Wales. PO number was not detailed on the invoice and the PO value was less than the invoice value

IOH (invoices on hold) awaiting a purchase order or credit note (including disputed invoices)



Reducing invoices on hold

| Supplier and Health Board Non-Compliance exceeding £50,000 | No. of invoices | Value £ |
|--|-----------------|---------|
| Suppliers | | |
| OneAdvanced Limited | 1 | 248,852 |
| Carmarthenshire County Council | 8 | 167,429 |
| Ricoh UK Ltd | 1 | 87,917 |
| The Priory Group | 6 | 86,142 |
| Safestyle Security Services Ltd | 7 | 75,592 |
| Siemens Healthcare Diagnostics Ltd | 4 | 63,169 |
| Securitas Technology Ltd | 1 | 61,272 |
| Clinical Care Groups/Executive function | | |
| COO; Primary Care (GMS OOH) | 1 | 248,852 |
| COO; MH & LD (In patient) | 11 | 91,159 |
| Digital (Carms Medical Records) | 1 | 87,917 |

Improvements
A joint improvement plan between Finance, Local Procurement and Accounts Payable to decisively reduce non-compliance with P2P

2b. Compliance with Purchase to Pay requirements



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| | | | | | |
|------------|--|-----------------------------------|--|--------------------|---|
| STA | November and December 2025 No. 0; Value £0 <i>September and October 2025</i> <i>No. 0; Value £0</i> | Tenders Awarded (>£25k) | November and December 2025 No. 16; Value £5,406,262 <i>September and October 2025</i> <i>No. 29; Value £9,784,834</i> | Consultancy | November and December 2025 No. 0; Value £0 <i>September and October 2025</i> <i>Number = 0; Value = £0</i> |
|------------|--|-----------------------------------|--|--------------------|---|

Top 5 Tenders Awarded (>£25k)

| Supplier | Description | Value £ | Department |
|---|---|------------------|--------------|
| Leica Microsystems Uk Limited | NHS Supply Chain (NHSSC) Laboratory Diagnostics, Point of Care Testing and Pathology Managed Services | 2,536,757 | Pathology |
| Circle Healthcare Group (BMI Werndale Hospital) | 3-month contract for Vasectomy Outsourcing | 775,000 | Planned Care |
| Allocate Software TA RLDatix | E-Job Planning Software Licences | 345,306 | Digital |
| Patients Know Best Limited | Online Platform: Patients Know Best | 297,606 | Digital |
| Medstrom Limited | Rental of Plus Sized Patient Beds and Equipment | 228,286 | Operations |
| Total | | 4,182,955 | |

Contracts awarded (>£25k) and breaches of SFIs

| Contracts Awarded | Number | Value £ | Details |
|---|-----------|------------------|--------------------|
| Post competitive tender | 8 | 1,434,632 | Appendix 1a |
| Direct awards via Framework agreement | 7* | 3,469,159 | Appendix 1a |
| VEAT | 2 | 539,631 | Appendix 1a |
| Total* | 17 | 5,443,422 | |
| Consultancy Contracts | - | - | - |
| Breaches of SFIs | 6 | 141,517 | Appendix 1b |
| Contract Awards reported retrospectively | 1 | 228,286 | Appendix 1a |

* Includes contract awards reported retrospectively

3. Compliance with Income to Cash



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Salary Overpayments

November and December 2025
No. 39; Value £39,373
(Appendix 2)

September and October 2025
No. 43; Value £75,974

Debt balance at 31 December 2025: £294k; average recovery period of 14 months*

31 October: £316k; average recovery period of 5 months

| | Dec-25 | Oct-25 |
|---------------------------|---------------|--------|
| Avg no of invoices raised | 23 | 22 |
| Avg value | £33.5k | £33k |
| Avg no paid | 19 | 18 |
| Avg value | £30k | £30k |

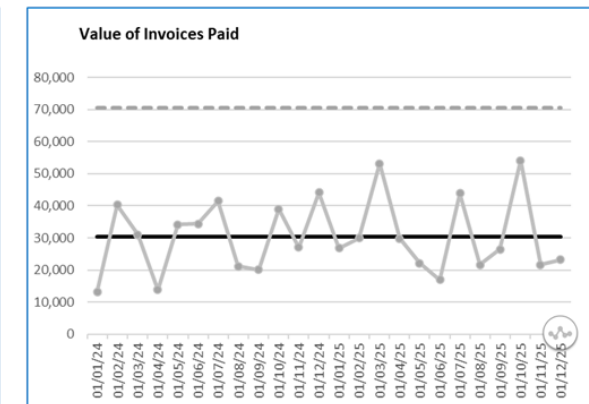
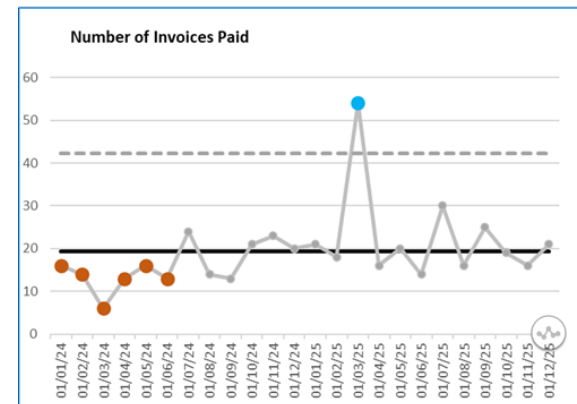
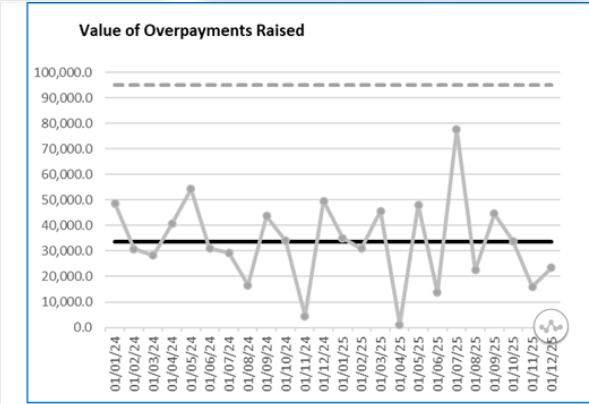
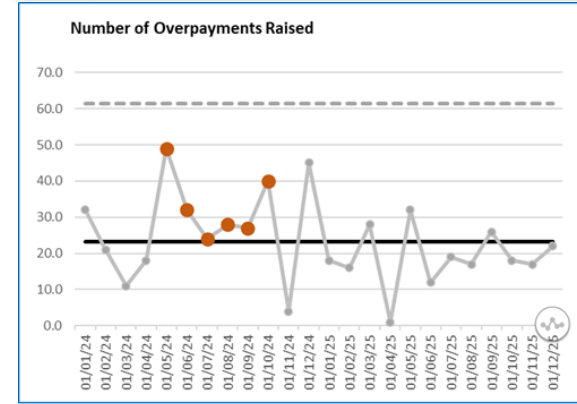
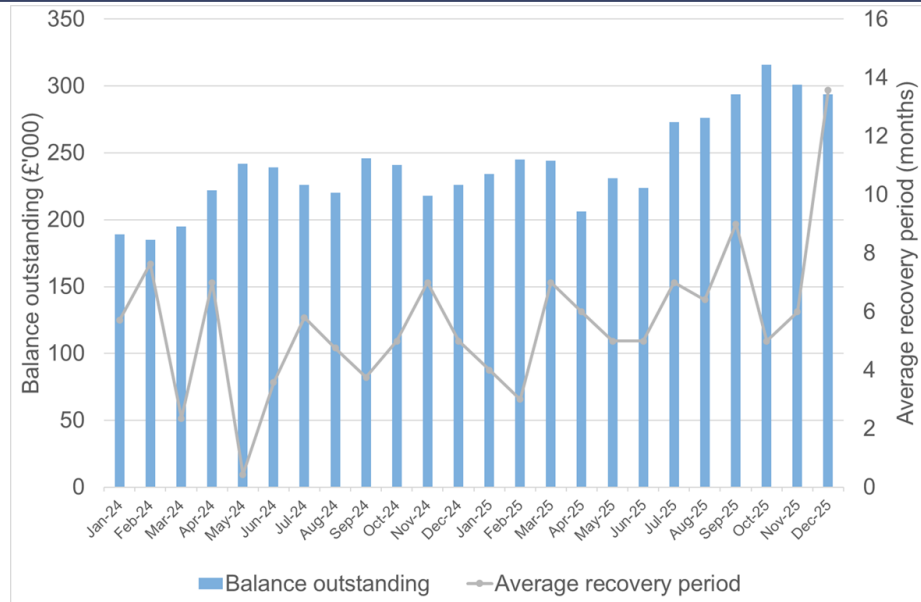
Underpayments November and December 2025 - £22,511

September and October 2025 - £12,546

*The increase in average recovery period from 5 to 14 months can be attributed to the conclusion of the following historic debt repayment plans:

- 4 x repayment plan with repayment terms of 14 to 18 months
- 2 x repayment plan with repayment terms of 3.5 to 4 years
- 1 x repayment plan with repayment terms of 4.5 years

Trend of aged overpayments and recoveries



4. Losses and Special Payments



| | | | |
|--|---|---|---|
| Losses £5k and over requiring ARAC Approval | November and December 2025 £5,316 <i>September and October 2025</i> £35,480 | Losses under £5k approved by DoF and CEO | November and December 2025 £27,590 (Appendix 3) <i>September and October 2025</i> £41,452 |
|--|---|---|---|

| Losses – Requiring Approval from ARAC | £ |
|---|--------|
| Pharmacy wastage – WGH ITU patient specific product not required; alternative use not possible | 5,316 |
| All Other Losses | |
| Ex gratia | 609 |
| Overpayments of salaries, salary sacrifice, accommodation, Wagestream, private patient income etc | 1,329 |
| 4b Other causes* - expired stock, wastage, breakages | 25,652 |
| Total Losses | 32,906 |

*** 4b Other causes**

In accordance with the Health Board’s Losses and Special Payments Procedure (Procedure number: 066) category 4b is defined as:

4) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:

- a. culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness
- b. other causes

5. Other Areas



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Compliance with Capital Requirements

Project Bank Account (PBA)

The Withybush Fire Upgrade Phase 2 project meets the criteria for use of a Project Bank Account (PBA). The contractor for the project has proposed Barclays as their provider, which has been confirmed by WG as a compliant provider. The process to open the PBA has therefore started with Barclays. It is expected that the PBA will be operational in time for the first payment, due in February 2026, to be made to that account. Progress in arranging the PBA is being monitored by the project team. The construction phase commenced at the beginning of January 2026.

Compliance with Tax Requirements

Compliance with VAT Requirements

VAT over-charged on supplies of pathology services

In November 2025, the Health Board notified HMRC that it had incorrectly charged VAT totalling £130k to its customer, Circle Health Group Ltd, in respect of pathology services provided to the company. The VAT was refunded to the Health Board in January 2026 and a credit note has been issued to the customer to refund the over-charged VAT. This matter has now concluded. Internal reviews subsequently undertaken show that this was an isolated case and there was no financial loss to the Health Board.

Compliance with Employment Tax Requirements

No updates to report.

Compliance with Reporting requirements

No updates to report.



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6.1 Financial Assurance Report for the period 1 November to 31 December 2025 Audit and Risk Assurance Committee

10 February 2026

Appendices

Appendix 1a: Contracts awarded

Contracts Awarded Post Competitive Tender:

| | |
|---|---|
| P Reference & Title | P0353 – Vasectomy Outsourcing |
| Supplier | Circle Healthcare Group (BMI Werndale Hospital) |
| Contract Period | 01/01/2026 to 31/03/2026 |
| Value | £775,000.00 |
| Department | Planned Care |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, Circle Healthcare Group (BMI Werndale Hospital) were awarded a 3 month contract for Vasectomy Outsourcing. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0401 – Audio Visual Equipment at Picton Terrace |
| Supplier | Hospital Services Limited |
| Contract Period | 21/11/2025 to 21/11/2030 |
| Value | £135,115.07 |
| Department | Digital |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, Hospital Services Limited were awarded a 60 month contract for Audio Visual Equipment at Picton Terrace. This contract award does not allow for an extension. |

| P0427A – Single Point of Access (SPOA) Transport (Winter Pressures) - Pembrokeshire & Ceredigion | |
|---|--|
| P Reference & Title | |
| Supplier | St John Ambulance Cymru |
| Contract Period | 01/11/2025 to 31/03/2026 |
| Value | £122,972.20 |
| Department | Community |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a PSR award, St John Ambulance Cymru were awarded a 5 month contract for Single Point of Access (SPOA) Transport (Winter Pressures) - Pembrokeshire & Ceredigion. This contract award does not allow for an extension. |

| P0361B – Project Management (PM) Professional Services for the Energy Performance Contract | |
|---|---|
| P Reference & Title | |
| Supplier | Atkins Réalis |
| Contract Period | 01/11/2025 to 31/03/2027 |
| Value | £111,000.00 |
| Department | Capital Planning / Estates |
| Professional Services (Yes/No) | Yes |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, Atkins Réalis were awarded a 17 month contract for PM Professional Services for the Energy Performance Contract. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0361C – Quantity Surveyor (QS) Professional Services for the Energy Performance Contract |
| Supplier | Atkins Réalis |
| Contract Period | 01/11/2025 to 31/03/2027 |
| Value | £98,600.00 |
| Department | Capital Planning / Estates |
| Professional Services (Yes/No) | Yes |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, Atkins Réalis were awarded a 17 month contract for QS Professional Services for the Energy Performance Contract. This contract award does not allow for an extension. |

| | |
|---|--|
| P Reference & Title | P0361D – Mechanical & Electrical Technical Advisor Professional Services for the Energy Performance Contract |
| Supplier | DRAC Consulting Limited |
| Contract Period | 01/11/2025 to 31/03/2027 |
| Value | £85,285.00 |
| Department | Capital Planning / Estates |
| Professional Services (Yes/No) | Yes |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, DRAC Consulting Limited were awarded a 17 month contract for Mechanical & Electrical Technical Advisor Professional Services for the Energy Performance Contract. This contract award does not allow for an extension. |

| | |
|---|--|
| P Reference & Title | P0361A – Construction Design and Management (CDM) Professional Services for the Energy Performance Contract |
| Supplier | Atkins Réalis |
| Contract Period | 01/11/2025 to 31/03/2027 |
| Value | £69,500.00 |
| Department | Capital Planning / Estates |
| Professional Services (Yes/No) | Yes |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a competitive tender, Atkins Réalis were awarded a 17 month contract for CDM Professional Services for the Energy Performance Contract. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0427 – Single Point of Access (SPOA) Transport (Winter Pressures) - Carmarthenshire |
| Supplier | Delta Wellbeing Limited |
| Contract Period | 01/11/2025 to 31/03/2026 |
| Value | £37,160.62 |
| Department | Community |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | Following a Provider Selection Regime (PSR) award, Delta Wellbeing Limited were awarded a 5 month contract for Single Point of Access (SPOA) Transport (Winter Pressures) - Carmarthenshire. This contract award does not allow for an extension. |

Direct awards via Framework Agreements:

| | |
|---|--|
| P Reference & Title | P0305 – Histopathology Managed Service Contract Renewal |
| Supplier | Leica Microsystems UK Limited |
| Framework Utilised | NHS Supply Chain (NHSSC) Laboratory Diagnostics, Point of Care Testing and Pathology Managed Services (2023/S 000-028831) |
| Contract Period | 01/11/2025 to 30/11/2029 |
| Value | £2,536,757.66 |
| Department | Pathology |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | September 2025 |
| Compliant | Y |
| Comment | A direct award via NHS Supply Chain (NHSSC) Laboratory Diagnostics, Point of Care Testing and Pathology Managed Services (2023/S 000-028831) Framework has been awarded to Leica Microsystems UK Limited for a Histopathology Managed Service Contract Renewal for 48 months. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0271A – Online Platform: Patients Know Best |
| Supplier | Patients Know Best Limited |
| Framework Utilised | Crown Commercial Services (CCS) G-Cloud 14 (RM1557.14) |
| Contract Period | 01/12/2025 to 30/11/2027 |
| Value | £297,606.00 |
| Department | Digital |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A direct award via Crown Commercial Services (CCS) G-Cloud 14 (RM1557.14) Framework has been awarded to Patients Know Best Limited for an Online Platform: Patients Know Best for 24 months. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0425 – Cardiology ECG Digital Archive |
| Supplier | GE Medical Systems Limited |
| Framework Utilised | NHSSC Cardiac Diagnostics Equipment, Technologies and Related Equipment and Services (2022/S 000-000127) |
| Contract Period | 01/01/2026 to 31/03/2031 |
| Value | £144,550.00 |
| Department | Digital / Cardiology |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A direct award via NHSSC Cardiac Diagnostics Equipment, Technologies and Related Equipment and Services (2022/S 000-000127) Framework has been awarded to GE Medical Systems Limited for a Cardiology ECG Digital Archive for 72 months. This contract award does not allow for an extension. |

| | |
|---|--|
| P Reference & Title | CAP25-14 – Spacelabs Windows 10 Compatibility Upgrade |
| Supplier | Spacelabs Healthcare Limited |
| Framework Utilised | NHSSC Cardiac Diagnostics Equipment, Technologies and Related Equipment and Services (2022/S 000-000127) |
| Contract Period | 01/01/2026 to 31/03/2026 |
| Value | £117,271.96 |
| Department | Digital / Cardiology |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A direct award via NHSSC Cardiac Diagnostics Equipment, Technologies and Related Equipment and Services (2022/S 000-000127) Framework has been awarded to Spacelabs Healthcare Limited for a Spacelabs Windows 10 Compatibility Upgrade for 3 months. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0360 – Theatres Waste Removal Systems |
| Supplier | Stryker Limited |
| Framework Utilised | All Wales Trauma, Orthopaedics, and Joint Replacement Framework Agreement |
| Contract Period | 01/01/2026 to 31/12/2031 |
| Value | £76,689.36 |
| Department | Theatres |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A direct award via All Wales Trauma, Orthopaedics, and Joint Replacement Framework has been awarded to Stryker Limited for Theatres Waste Removal Systems for 72 months. This contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0430 – Corporate Landlord Model |
| Supplier | PeopleToo |
| Framework Utilised | ESPO Consultancy Services (664_25) |
| Contract Period | 21/12/2025 to 31/03/2026 |
| Value | £68,000.00 |
| Department | Estates |
| Professional Services (Yes/No) | Yes |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A direct award via ESPO Consultancy Services (664_25) Framework has been awarded to PeopleToo for a Corporate Landlord Model for 4 months. This contract award does not allow for an extension. |

Direct awards via VEAT/Transparency Process:

| | |
|---|--|
| P Reference & Title | P0019A – E-Job Planning Software Licences |
| Supplier | Allocate Software TA RLDatix |
| Contract Period | 31/12/2025 to 30/12/2030 |
| Value | £345,306.00 |
| Department | Digital |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A Transparency Notice was issued to confirm that Allocate Software TA RLDatix were awarded a 60 month contract for E-Job Planning Software Licences. The contract award does not allow for an extension. |

| | |
|---|---|
| P Reference & Title | P0195A – Cyber Resilience Phishing Subscription Renewal |
| Supplier | Meta Compliance Limited |
| Contract Period | 01/01/2026 to 31/12/2030 |
| Value | £194,325.00 |
| Department | Digital |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | A Transparency Notice was issued to confirm that Meta Compliance Limited were awarded a 60 month contract for a Cyber Resilience Phishing Subscription Renewal. The contract award does not allow for an extension. |

Awards reported retrospectively:

| | |
|---|--|
| P Reference & Title | P0145A - Rental of Plus Sized Patient Beds and Equipment |
| Supplier | Medstrom Limited |
| Contract Period | 17/10/2025 to 16/10/2026 |
| Value | £228,286.00 |
| Department | Operations |
| Procurement Process | Direct Award via the NHSSC Pressure Area Care and Patient Handling Equipment Framework Agreement (2020/S 129-318007) |
| Professional Services (Yes/No) | No |
| Date of Board Approval (If Applicable) | N/A |
| Compliant | Y |
| Comment | In the month of October 2025, a contract was awarded to Medstrom Limited for a term of 12 months, for the Rental of Plus Sized Patient Beds and Equipment. This contract does not allow for an extension. The procurement process utilised was a Direct Award via the NHSSC Pressure Area Care and Patient Handling Equipment Framework Agreement (2020/S 129-318007). |

Appendix 1b: Breaches of SFIs

| | |
|---------------------|--|
| Title | Security Services at Withybush General Hospital |
| Supplier | Safestyle Security Services Limited |
| Month/Year | December 2025 |
| Value | £96,144.60 |
| Department | Community and Integrated Medicine |
| Comment | In the month of December 2025, a retrospective purchase order was raised to Safestyle Security Services Limited for Security Services at Withybush General Hospital. The total value of the purchase order was £96,144.60. This breach of Standing Financial Instructions sits within the Community and Integrated Medicine Directorate. |
| Action Taken | Escalated for Re-Education, and Relevant Director Informed for Awareness and Action |

| | |
|---------------------|--|
| Title | Supply, Delivery & Installation of a Walk-In Room at Prince Philip Hospital |
| Supplier | Mortuary Equipment Direct Limited |
| Month/Year | December 2025 |
| Value | £14,225.00 |
| Department | Operational Allied Health and Health Sciences |
| Comment | In the month of December 2025, a retrospective purchase order was raised to Mortuary Equipment Direct Limited for the Supply, Delivery & Installation of a Walk-In Room at Prince Philip Hospital. The total value of the purchase order was £14,225.00. This breach of Standing Financial Instructions sits within the Operational Allied Health and Health Sciences Directorate. |
| Action Taken | Escalated for Re-Education, and Relevant Director Informed for Awareness and Action |

| | |
|---------------------|--|
| Title | Cleanroom Services & Workwear |
| Supplier | Elis UK Limited |
| Month/Year | December 2025 |
| Value | £11,306.16 |
| Department | Pharmacy and Medicines Management |
| Comment | In the month of December 2025, a retrospective purchase order was raised to Elis UK Limited for Cleanroom Services & Workwear. The total value of the purchase order was £11,306.16. This breach of Standing Financial Instructions sits within the Primary Care, Community Strategy and Long Term Care Directorate. |
| Action Taken | Breach Added to Procurement Workplan |

| | |
|---------------------|---|
| Title | Rental of Responstor Storage System at Glangwili General Hospital |
| Supplier | Nutwell Logistics Limited |
| Month/Year | November 2025 |
| Value | £7,860.00 |
| Department | Operational Allied Health and Health Sciences |
| Comment | In the month of November 2025, a retrospective purchase order was raised to Nutwell Logistics Limited for the Rental of Responstor Storage System at Glangwili General Hospital. The total value of the purchase order was £7,860.00. This breach of Standing Financial Instructions sits within the Operational Allied Health and Health Sciences Directorate. |
| Action Taken | Breach Added to Procurement Workplan |

| | |
|---------------------|--|
| Title | Payment of Professional Fees |
| Supplier | Thirty Park Place |
| Month/Year | November 2025 |
| Value | £6,031.25 |
| Department | Nursing, Quality and Patient Experience |
| Comment | In the month of November 2025, a retrospective purchase order was raised to Thirty Park Place for the Payment of Professional Fees. The total value of the purchase order was £6,031.25. This breach of Standing Financial Instructions sits within the Nursing, Quality and Patient Experience Directorate. |
| Action Taken | Escalated for Re-Education, and Relevant Director Informed for Awareness and Action |

| | |
|---------------------|--|
| Title | FDA Healthcare Play Specialism Course - Cardiff and Vale College 25-26 |
| Supplier | The University of West London |
| Month/Year | November 2025 |
| Value | £5,950.00 |
| Department | Workforce and Organisational Development |
| Comment | In the month of November 2025, a retrospective purchase order was raised to The University of West London for an FDA Healthcare Play Specialism Course - Cardiff and Vale College 25-26. The total value of the purchase order was £5,950.00. This breach of Standing Financial Instructions sits within the Workforce and Organisational Development Directorate. |
| Action Taken | Escalated for Re-Education, and Relevant Director Informed for Awareness and Action |

Appendix 2: Overpayment of Salaries

| Period covered by this report: 1 November 25 – 31 December 25 | | | |
|---|----------------------------------|------------------|--------------------|
| Ref | Reason for Overpayment | Value (£) | Number of invoices |
| 1 | Processing Error | 2,325.11 | 3 |
| 2 | Late Notification of Changes | 21,330.91 | 20 |
| 3 | Late Notification of Termination | 11,938.30 | 11 |
| 4 | Late Notification of Absence | 3,778.80 | 5 |
| | | | |
| | | 39,373.12 | 39 |

Appendix 3b: Losses and Special Payments less than £1,000

| 2025/2 WRITE OFF LIST | | | |
|--------------------------------------|-----------------|--|--|
| Period covered by this report: | | 1st November to 31 December 2025 | |
| Losses and Special Payments Category | Value (£) | Explanation | |
| OVERPAYMENT OF SALARY | 0.02 | UNDERPAID OF INVOICE | |
| ACCOMMODATION | 0.06 | UNDERPAID OF INVOICE | |
| ACCOMMODATION | 0.06 | UNDERPAID OF INVOICE | |
| ACCOMMODATION | 0.06 | UNDERPAID OF INVOICE | |
| OVERPAYMENT OF SALARY | 0.10 | UNDERPAID OF INVOICE | |
| WAGESTREAM | 11.87 | COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI | |
| WAGESTREAM | 24.38 | COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI | |
| OVERSEAS PATIENT | 35.00 | COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI | |
| SALARY SACRIFICE | 204.47 | CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF | |
| OVERPAYMENT OF SALARY | 282.72 | CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF | |
| PRIVATE PATIENT | 345.89 | CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF | |
| PRIVATE PATIENT | 424.44 | CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF | |
| Total Write Off | 1,329.07 | | |
| 4b Other | - 5.83 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH | |
| 4b Other | - 2.44 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH | |
| 4b Other | - 0.84 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH | |
| 4b Other | - 0.66 | P09-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH | |
| 4b Other | 0.04 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.05 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.06 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.09 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.11 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.14 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.14 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.14 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.16 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.19 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.23 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.26 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.27 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.29 | P08-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH | |
| 4b Other | 0.34 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH | |
| 4b Other | 0.35 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.45 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.46 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.60 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH | |
| 4b Other | 0.61 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.61 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.76 | P08-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 0.80 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH | |
| 4b Other | 0.86 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 0.86 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.87 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 0.96 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.13 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 1.13 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 1.19 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.24 | P09-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH | |
| 4b Other | 1.31 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 1.42 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.44 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH | |
| 4b Other | 1.48 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.56 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.59 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.63 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.77 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.77 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.79 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.79 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 1.87 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH | |
| 4b Other | 1.89 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH | |
| 4b Other | 1.98 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 2.06 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |
| 4b Other | 2.08 | P09-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH | |
| 4b Other | 2.09 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH | |
| 4b Other | 2.28 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH | |
| 4b Other | 2.32 | P08-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH | |
| 4b Other | 2.32 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH | |

| | | |
|--------------|-------|--|
| 4b Other | 2.39 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 2.40 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 2.47 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 2.52 | P09-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH |
| 4b Other | 2.64 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 2.67 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 2.70 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 2.75 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 2.78 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.02 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.08 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.18 | P09-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 3.28 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.60 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 3.71 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 3.74 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.86 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 3.97 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 4.14 | P08-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 4.60 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 5.03 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 5.10 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 5.40 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 5.41 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 5.47 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 5.64 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 5.87 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 5.98 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 6.44 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 6.49 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 6.58 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 6.61 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 11 EX-GRATIA | 7.00 | Travel costs for cancelled appointment - JFF |
| 4b Other | 7.02 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 7.21 | P09-26 WDA - HDUHB~~E EXPIRED STOCK WDA |
| 4b Other | 7.25 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 7.35 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 7.47 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 7.84 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 8.06 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 8.26 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 8.36 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 8.40 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 8.70 | P08-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 8.71 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 9.07 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 9.31 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 9.60 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 10.14 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 10.20 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 10.32 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 10.50 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 11.18 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 11.32 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 11.47 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 12.14 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 12.96 | P09-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH |
| 4b Other | 13.20 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 14.40 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 14.40 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 14.63 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 14.78 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 15.00 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 15.08 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 15.19 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 15.36 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 16.07 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 16.25 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 16.54 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 16.70 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 17.10 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 17.93 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 18.71 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 18.71 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 19.12 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |

| | | |
|--------------|-------|--|
| 4b Other | 19.25 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 19.37 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 20.10 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 20.63 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 20.86 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 21.00 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 21.22 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 21.30 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 22.20 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 22.62 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 22.66 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 22.75 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 22.87 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 23.26 | P09-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH |
| 4b Other | 24.42 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 24.94 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 26.32 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 26.62 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 27.32 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 27.32 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 27.60 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 29.25 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 29.65 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 29.96 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 30.00 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 30.00 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 30.39 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 30.86 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 31.87 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 33.36 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 34.34 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 34.50 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 34.78 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 34.85 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 35.03 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 35.35 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 35.86 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 36.00 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 36.96 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 38.50 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 40.32 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 40.80 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 41.40 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 41.58 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 44.79 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 45.07 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 45.60 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 45.60 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 47.57 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 48.00 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 49.82 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 51.54 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 52.80 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 53.71 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 54.00 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 54.64 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 56.43 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 56.58 | P09-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 57.44 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 57.60 | P08-26 Aseptics - HDUHB~~W EXPIRED STOCK WGH |
| 4b Other | 61.20 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 61.30 | P08-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 63.00 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 66.60 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 11 EX-GRATIA | 70.00 | Ex-Gratia - lost property |
| 4b Other | 70.90 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 74.44 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 74.52 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 77.70 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 79.44 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |

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|------------------|------------------|--|
| 4b Other | 81.13 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 81.36 | P09-26 WDA - HDUHB~~E WASTAGE/BREAKAGES WDA |
| 4b Other | 89.88 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 90.00 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 98.27 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 98.61 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 105.13 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 108.32 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 113.76 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 4b Other | 114.60 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 115.20 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 123.12 | P09-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 131.04 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 134.40 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 134.45 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 141.60 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 158.87 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 162.00 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 163.20 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 11 EX-GRATIA | 163.99 | Ex-Gratia - lost property |
| 4b Other | 166.71 | P08-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH |
| 4b Other | 168.10 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 169.20 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 170.00 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 173.45 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 178.20 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 179.74 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 181.69 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 181.74 | P09-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 183.60 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 189.24 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 210.00 | P08-26 Prince Philip Hospital~~P EXPIRED STOCK PPH |
| 4b Other | 223.17 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 226.80 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 273.60 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 276.50 | P09-26 Bronglais Hospital~~B EXPIRED STOCK BGH |
| 11 EX-GRATIA | 298.00 | Ex-Gratia - lost property |
| 4b Other | 300.00 | P08-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH |
| 4b Other | 306.77 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 356.40 | P08-26 Glangwili Hospital~~G EXPIRED STOCK GGH |
| 4b Other | 364.10 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 379.62 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 466.01 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 480.00 | P09-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 505.34 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 900.00 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| 4b Other | 907.20 | P08-26 Withybush Hospital~~W EXPIRED STOCK WGH |
| Sub total | 14,319.23 | |
| Total | 15,648.30 | |

6.2

11:20, 5 Mins

6.2 - Annual Statement of Financial Procedures *Huw Thomas (Hywel Dda UHB - Director of Finance)*

| For information

Attachments

[6.2 Annual Statement Financial Procedures ARAC February 2026.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

| | |
|--|--|
| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 10 February 2026 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Annual Statement of Financial Procedures |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Huw Thomas, Executive Director of Finance |
| SWYDDOG ADRODD: REPORTING OFFICER: | Tim John, Head of Accounting and Statutory Reporting |

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

Each year, planned reviews are undertaken of the financial procedures operated by the Health Board. The procedures, which set out the main financial system controls, are reviewed in terms of:

- Relevance
- Best practice
- Audit recommendations
- System change
- Health Board policy

Attached is a list of financial procedures for review during 2026/27.

Cefndir / Background

The Financial Procedures of the Health Board, and the maintenance thereof, is a key part of internal governance and financial control.

Asesiad / Assessment

When procedures are reviewed, this is undertaken jointly with the appropriate service managers and stakeholders. Procedures are then formally approved by the Finance and Performance Committee, before they are shared on the intranet and implemented across the Health Board.¹

It is proposed that 10 procedures are reviewed during 2026/27 – see list attached under Appendix 1.

¹ With the exception of the Charitable Funds: Financial Administration and Governance Procedure

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to note the report for information.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

| | |
|---|--|
| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Not Applicable |
| Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | 6. Sustainable use of resources |
| Amcanion Cynllunio Planning Objectives | Not Applicable |
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

Gwybodaeth Ychwanegol:

Further Information:

| | |
|--|--|
| Ar sail tystiolaeth: Evidence Base: | Standing Orders, Standing Financial Instructions and relevant accounting standards. |
| Rhestr Termiau: Glossary of Terms: | Contained within the body of the report. |
| Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee: | UHB's Finance Team UHB's Management Team Executive Team Finance and Performance Committee |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|--|
| Ariannol / Gwerth am Arian: Financial / Service: | Maintaining good systems of financial control helps deliver value for money. |
| Ansawdd / Gofal Claf: Quality / Patient Care: | Not applicable |
| Gweithlu: Workforce: | Not Applicable |
| Risg: Risk: | Maintaining good systems of financial control minimises financial risk. |
| Cyfreithiol: Legal: | Maintaining good systems of financial control minimises potential for legal challenge. |
| Enw Da: Reputational: | Maintaining good systems of financial control aids the good reputation of the UHB. |
| Gyfrinachedd: Privacy: | Not Applicable |
| Cydraddoldeb: Equality: | Not Applicable |

Appendix 1

| Reference | Financial Procedures Review Programme 2026/27 | Planned Review date | Category/Team |
|------------------|---|----------------------------|--|
| 069 | VAT | June 26 | Financial Accounts |
| 090 | Retention of financial records procedure | Aug 26 | Financial Accounts |
| 066 | Losses and Special Leave Payments Financial Procedure | Oct 26 | Financial Accounts |
| 974 | Project bank account procedure | Dec 26 | Capital |
| 1230 | Income Risk Stratification Financial Procedure | Dec 26 | Tritech and Innovation Management Group |
| 1030 | Tax status of workers procedure | Feb 27 | Tax |

6.3

11:25, 5 Mins

6.3 - Counter Fraud Update

Benjamin Rees
(Hywel Dda UHB -
Local Counter Fraud
Specialist)

| For information

Attachments

[6.3 SBAR Counter Fraud Update ARAC February 2026.pdf](#)

[6.3 Counter Fraud Update February 2026.pdf](#)

[6.3 Appendix 1 - Fraud Risk Management Strategy.pdf](#)



**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

| | |
|--|---|
| DYDDIAD Y CYFARFOD: DATE OF MEETING: | 10 February 2026 |
| TEITL YR ADRODDIAD: TITLE OF REPORT: | Counter Fraud Update |
| CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR: | Huw Thomas, Executive Director of Finance |
| SWYDDOG ADRODD: REPORTING OFFICER: | Ben Rees, Head of Counter Fraud |

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 provides to the Audit and Risk Assurance Committee an update on the Counter Fraud work completed within Hywel Dda University Health Board (HDdUHB). This ensures compliance with the Welsh Government Directives for Countering Fraud in the NHS and the NHS Counter Fraud Authority Requirements of the Government Functional Standard GovS 013: Counter Fraud.

The report will present a breakdown as to how resource has been used within Counter Fraud, alongside an overview of key work areas completed against the 4 NHS Counter Fraud Authority standard areas.

Cefndir / Background

Main Report:

To evidence the provision of services within a sound governance framework.

Asesiad / Assessment

Main Report:

The Health Board is compliant with the Welsh Government Directives.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is invited to receive for information the Counter Fraud Update Report and appended items.

| Amcanion: (rhaid cwblhau) Objectives: (must be completed) | |
|---|--|
| Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor: | 3.2 In particular, the Committee will review the adequacy of: 3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score: | Not applicable. |
| Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com) | 3. Effective 4. Efficient |
| Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com) | 4. Learning, improvement and research |
| Amcanion Strategol y BIP: UHB Strategic Objectives: | 1. Striving teams |
| Amcanion Cynllunio Planning Objectives | Not Applicable |
| Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022 | 10. Not Applicable |

| Gwybodaeth Ychwanegol: Further Information: | |
|--|--|
| Ar sail tystiolaeth: Evidence Base: | Counter Fraud Workplan 2025/26 |
| Rhestr Termiau: Glossary of Terms: | LCFS – Local Counter Fraud Specialist/s CF – Counter Fraud CFS Wales – Counter Fraud Services Wales NHS CFA – NHS Counter Fraud Authority NWSSP – NHS Wales Shared Services Partnership LPE – Local Proactive Exercise FRA – Fraud Risk Assessment |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee: | Not applicable. |

| Effaith: (rhaid cwblhau) Impact: (must be completed) | |
|---|-----------------|
| Ariannol / Gwerth am Arian: Financial / Service: | Not applicable. |
| Ansawdd / Gofal Claf: Quality / Patient Care: | Not applicable. |
| Gweithlu: Workforce: | Not applicable. |
| Risg: Risk: | Not applicable. |
| Cyfreithiol: Legal: | Not applicable. |
| Enw Da: Reputational: | Not applicable. |
| Gyfrinachedd: Privacy: | Not applicable. |
| Cydraddoldeb: Equality: | Not applicable. |



HYWEL DDA UNIVERSITY HEALTH BOARD

COUNTER FRAUD UPDATE

For Presentation 10 February 2026

The Counter Fraud workplan has been split into four generic areas for ease of activity reporting:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

| AREA OF ACTIVITY | 2025/26 Resource (days) | Resource Used as at 31/01/2026 | Resource Used (%) as at 31/01/2026) |
|----------------------|-------------------------|--------------------------------|-------------------------------------|
| STRATEGIC GOVERNANCE | 40 | 30 days | 75% |
| INFORM AND INVOLVE | 85 | 68 days | 80% |
| PREVENT AND DETER | 130 | 103 days | 80% |
| HOLD TO ACCOUNT | 185 | 137 days | 75% |
| TOTAL | 440 | 338 days | 77% |

| Work Area | Summary of work areas completed |
|---------------------------|---|
| Inform and involve | <ul style="list-style-type: none"> • All new inductees are required to complete the Health Board’s induction programme and the Counter Fraud mandatory training e-learning package. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme, with an additional 3 sessions / presentations being undertaken in the week prior to Christmas. These additional sessions were aimed at both new starters and Healthcare Support Workers. • In order to raise awareness of the pitfalls of working whilst sick, and NHS fraud in general, a New Year’s Counter Fraud message was circulated to staff via 4 separate channels, reaching over 1700 staff members. A link to the article can be found here: New Years Message from Counter Fraud • A further 4 Viva engage posts were circulated, highlighting emerging fraud trends. More than 3900 employees viewed these posts. • Counter Fraud currently sit on the quarterly HDdUHB Local Intelligence Network (LIN), at which advice is provided on current fraud trends associated with Controlled Drugs. Where applicable, relevant advice, including raising awareness of Fraud in the NHS, is provided. |
| Prevent and deter | <ul style="list-style-type: none"> • In line with the annual plan, a Procurement-based Local Proactive Exercise (LPE) has been completed, which looked at a sample of Standing Financial Instructions breaches. A LPE report has been appended to the In-Committee Counter Fraud report. • Work on a second LPE linked to IR35 compliance associated with Nurse bank agency workers has commenced and is expected to be completed in Quarter 4. • In response to a committee request into the reporting and monitoring of Fraud risks and recommendations, the Counter Fraud team have met with the Assurance and Risk team and the following actions agreed: |

- A Counter Fraud / Assurance and Risk teams' channel has been created, on which all Counter Fraud identified risks and recommendations will be monitored via a live MS Excel document, titled 'Fraud Risk and Recommendations report.' The Head of Counter fraud will ensure that the document is kept up to date with all new material, including risk reports generated throughout the year. In addition, all recommendations and actions undertaken to mitigate the risk will be recorded, noting who has done what and when, with assistance from the Risk and Assurance team being provided when required.

This new process will allow for better monitoring of progress against each risk, outcomes and where applicable, the frequency of risk reviews. A summary of this document will be presented to the In-Committee session throughout the year.
- To assist in the administration of recording and allocated the identified risks to risk owners, Counter Fraud will be exploring the use of AMAT, an incident management system, to track the progress of recommendations made. This process is to commence in full at the beginning of Quarter 1 2026/27; however, Counter Fraud will be testing the system / process in February and March 2026, with a view to assessing the system's effectiveness in managing the administration of Fraud Risk identification Reports.
- In order to migrate all previously identified and reported risks into this new process, Counter Fraud have reviewed all previously recorded matters and migrated each one into the 'Fraud Risk and Recommendations report.' All risks will now go through the new review process as part of the 2026/27 workplan. A summary of the previously identified and reported risks has been appended to the In-Committee report.
- Counter Fraud have developed a Fraud Risk Strategy, which outlines our mission and approach to identifying, assessing, mitigating, and reporting of fraud risks, a copy of this has been appended to this report, Appendix 1 refers.
- The Public Sector Fraud Authority (PSFA) – part of the UK Government's Cabinet Office and HM Treasury – oversees the National Fraud Initiative (NFI) across the UK. Audit Wales leads the exercise in Wales under the

Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales. The Auditor General has mandated that unitary local authorities, NHS bodies, police forces, and fire and rescue authorities participate in the NFI. NFI helps prevent and detect fraud by sharing and matching sets of data electronically. Further information on the initiative can be found here, [National Fraud Initiative | Audit Wales](#).

Final data sets were released in January 2025. Work on the initiative is now nearing completion, with only one match remaining open, due to ongoing enquiries.

To date, the exercise has assisted in the recovery of approximately £33,000. Enquiries associated with the work are nearing completion, with only one report remaining open; a breakdown of each exercise and a summary of activity undertaken has been provided below:

| Match Type | Purpose of the match | Total Matches | Opened | Reviewed and closed | Remaining | Remarks |
|--------------------|---|---------------|--------|---------------------|-----------|--|
| Payroll to Payroll | To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time. The criteria for a match are a person having one full-time post plus at least one other post elsewhere. | 86 | 86 | 85 | 1 | 1 enquiry remains open. This matter is linked to an ongoing investigation into an offence of Fraud by False Representation. NWSSP is leading on the case as the subject concerned is a substantive employee of theirs. |
| Payroll to Pension | To identify cases where employees who have gone back into employment after drawing a pension that could result in an abatement of pension. | 110 | 110 | 110 | 0 | Enquiries undertaken include working with NWSSP Pensions to ensure each entry is valid and compliant. |

| | | | | | | | |
|------------------------|---|--|----|----|----|---|--|
| | | | | | | | No issues have been identified, and all matches are now closed. |
| | Payroll to Creditors | The match identifies instances where an employee and creditor are linked by the same bank account or the same address to identify employees with interests in companies with which your organisation is trading. This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to. | 24 | 24 | 24 | 0 | All matches are now complete, resulting in no concerns being identified. |
| | Payroll to companies' house | To identify potential undeclared interests that have given a pecuniary advantage. To do this NFI have matched payroll data to companies' house information and then to your creditors data. The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with and those where the employees address appears to have links to the company directors or the company. | 49 | 49 | 49 | 0 | All matches are now complete, resulting in no concerns being identified. |
| Hold to Account | <ul style="list-style-type: none"> New referrals have been received into the department over the last two months, with significant work being undertaken. A detailed report of all new, existing, and closed investigations has been provided to the Committee via an In-Committee report. | | | | | | |

Strategic Governance

- Quarterly statistics have been submitted to Counter Fraud Service (CFS) Wales and in compliance with WG directions.
- On 22 January 2026, HDdUHB Counter Fraud were subject to an engagement visit from the NHS Counter Fraud Authority (NHSCFA). Representatives from the NHSCFA met with the Audit and Risk Assurance Committee Chair, Executive Director of Finance, Director of Corporate Governance / Fraud Champion, and the Counter Fraud Team.

The NHSCFA engagement visit aimed to seek assurance on the levels of compliance in NHS provider organisations with regards to GovS 013 NHS Requirements in addition to:

- Exploring opportunities to actively support the LCFS and Hywel Dda University Health Board with the resources NHSCFA and the fraud hub can provide.
- Highlight examples of good practice and communicate the findings across the sector.
- Report on their findings to relevant stakeholders.

Report Provided by:

Ben Rees - Lead Local Counter Fraud Specialist

For presentation; 10 February 2026.

Report agreed by:

Huw Thomas

Director of Finance



LOCAL COUNTER FRAUD SPECIALIST FRAUD RISK MANAGEMENT STRATEGY

Fraud Risk Management Strategy

Our mission is to proactively identify, assess, and mitigate fraud risks across the Health Board, protecting public funds and ensuring resources are used for the delivery of safe and effective patient care. We are committed to maintaining the highest standards of integrity, transparency, and accountability through robust fraud prevention, detection, and response measures aligned with national counter fraud standards.

Purpose

The Fraud Risk Assessment (FRA) provides a structured approach to identifying, evaluating, and documenting fraud risks across the Health Board. It helps build a comprehensive understanding of fraud exposure by assessing individual risks and associated controls, including their limitations.

An FRA is a fundamental component of an effective counter fraud strategy, and supports better decision-making by enabling the Health Board to take proactive steps such as enhancing controls, updating policies, or initiating audit and compliance activities.

While the FRA should align with the Health Board's overall risk management framework, it requires specialised knowledge, tools, and processes specific to fraud. A proactive approach to fraud risk identification helps strengthen Health Board resilience against financial crime and aligns with wider public sector accountability standards.

Methodology:

The template used by the Counter Fraud Team is based on the Government Counter Fraud Profession (GCFP) standard for Fraud Risk Assessment and is aligned with GovS 013, Component 3: Fraud, Bribery, and Corruption Risk Assessment.

The methodology was developed collaboratively by fraud and risk management professions, in consultation with the Institute of Risk Management, and formally endorsed by the GCFP's Board.

It provides a structured and consistent process for identifying fraud risks, assessing their likelihood and impact, evaluating control effectiveness, and prioritising them using the GCFP risk scoring matrix provided in this document. The methodology reflects international best practice and is recognised by partner agencies across sectors.

Approach

FRAs are developed by identifying fraud risks associated with specific operational or functional responsibilities within the Health Board. These risks should be grouped accordingly to reflect the structure of the Health Board and the nature of potential fraud exposers.

The Health Board's Counter Fraud team are expected to assess and score identified risks using the GCFP's standardised risk matrix. The NHS Counter Fraud Authority (NHSCFA) / NHS Counter Fraud Services Wales (NHSCFS Wales) may use these assessments to identify thematic risks and emerging trends across the wider health sector.

FRAs must be maintained as live documents, reviewed regularly, and updated as new risks, data, or typologies emerge.

Under NHS Functional Standards 013, Component 3, organisations are required to work closely with their local risk managers, to ensure FRAs are aligned with their internal risk management policies and frameworks and are appropriately reflected in the corporate risk register.

To that end, Counter Fraud and Assurance and Risk have created a dedicated MS Teams' channel, on which all Counter Fraud identified risks and recommendations will be monitored via a live MS Excel document, titled 'Fraud Risk and Recommendations Report.'

The Head of Counter fraud will ensure that the document is kept up to date with all new material, including risk reports generated throughout the year. In addition, all recommendations and actions undertaken to mitigate the risk will be recorded, noting who has done what and when, with assistance from the Risk and Assurance team being provided when required.

This information will be shared with the Audit and Risk Assurance Committee for ongoing monitoring and assurance.

Note

Although risk assessments will be undertaken using a template based on the Government Counter Fraud Professions (GCFP) standard for Fraud Risk Assessment, all risks that are identified and reported to Health Board risk owners will be done so in line with the Health Board's Risk Management Strategy ([Policy Number 156](#)).

7 - Assurance and Risk

7.1

11:30, 10 Mins

7.1 - External Recommendations and Welsh Health Circulars Assurance Report

*Joanne Wilson
(Hywel Dda UHB -
Director of Corporate
Governance/Board
Secretary)*

| For assurance

Attachments

[7.1 Audit Tracker and WHC Report February 2026.pdf](#)



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Audit and Risk Assurance Committee

External Recommendations and Welsh Health Circulars Assurance Report

10 February 2026

Situation and Background



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This report aims to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of processes in place across the Health Board in the tracking of progress made to implement recommendations as raised by auditors, inspectorates and regulators, along with Welsh Health Circulars (WHCs) as issued by Welsh Government. This is in line with the requirements as noted in the Committee's Terms of Reference which state:

3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board is required to meet the following revised set criteria which relate to compliance with external recommendations from auditors, inspectorates and regulators:

- Financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews;
- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable performance.



Progress since the previous report to ARAC



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A summary is provided below of the progress made against the next steps which were identified in the previous tracker report provided to ARAC in October 2025:

| Next Steps | Progress Made |
|--|---|
| <p>To address any feedback from Board Committees since the introduction of the Assurance and Risk Report to further strengthen the assurances provided on the progress being made to the implementation of recommendations raised.</p> | <p>Completed – This report will continue to develop. Since its introduction last year, this report now includes a summary of discussions held at Board Committees on presentation of the Assurance and Risk Report, highlighting the progress being made in the implementation of recommendations raised within audit and inspectorate reports, Welsh Health Circulars, and any barriers to their completion.</p> |
| <p>To continue to work with the Performance team and explore and confirm timescales, when capacity allows, to develop the audit tracking performance dashboard via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework, so that this information is readily available to users across the Health Board.</p> | <p>The Head of Assurance and Risk and Head of Performance are in the process of developing a specification document to inform the development of an audit performance dashboard, based on relevant metrics and criteria which will be accessible to staff across the Health Board, and support the provision of data for future Committee reporting along with required analysis as part of the Governance domain for the internal escalation framework.</p> <p>However, this work has not progressed since the previous report to ARAC due to capacity, but will be reviewed during Q4 of 2025/26. Once the specification document has been finalised this will inform implementation timescales, pending resource availability.</p> |

Audits and Inspections



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All reports from audits, reviews and inspections carried out across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, and evidence requested to be uploaded to demonstrate their progress and full implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow.

Progress is monitored via the utilisation of a traffic light system based on performance against **original completion dates**. Since the last Committee report, three new status categories were introduced in October 2025 to provide a more accurate reflection of progress. Definitions for these new categories are included in the table below:

| Status Category | Definition |
|---|---|
| Overdue | The recommendation is behind schedule to the timescale provided by the lead officer. |
| Unable to Complete (NEW) | The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures. |
| Pending Decision (NEW) | The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending. |
| In Progress | The recommendation is currently in progress, and within the agreed original timeframe for implementation. |
| Reliant on External Factors | The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement. |
| Complete Pending Formal Approval (NEW) | The Service / Function have completed the recommendation and currently awaiting formal approval to close. |
| Complete | The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received. |

The Assurance and Risk team and Quality, Assurance and Safety team (QAST) liaise directly with services and review the status of the monitored reports to support the provision of progress updates and revised completion dates where applicable, and to provide technical support as required. Training is also offered to service leads on the AMaT 'Inspection Recommendations and Actions' module by both the Assurance and Risk team and QAST.

Overview of the Audit Tracker



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This report provides an overview of the open Audit and Inspections reports based on the most recent analysis point at the time of preparation (31 December 2025).

There are some data variations in this report compared to the previous report in October 2025 due to organisational structural changes within the Health Board effective from 1 December 2025. These include the transfer of Long-Term Care and Chronic Conditions from the Primary Care Clinical Care Group to Community & Integrated Medicine, Medicines Management from Primary Care to the Medical Director, and Health Records from Chief Operating Officer Management to Digital (Director of Finance).

Key movements since the previous report presented to ARAC in October 2025 (based on data extracted 31 August 2025) include:

- increase in number of open reports from 123 to 134;
- reduction in number of overdue reports from 56 to 49;
- closure of 3 Audit Wales reports, 3 Internal Audit reports, 2 Peer Reviews, 1 Public Health Wales report, 1 Health Inspectorate Wales report and 1 Welsh Language Commissioner report.

The graphs on the following slides show the number of open reports per auditor/inspectorate/regulator as reported to ARAC during financial year 2025/26, and per Clinical Care Group / Executive Function.



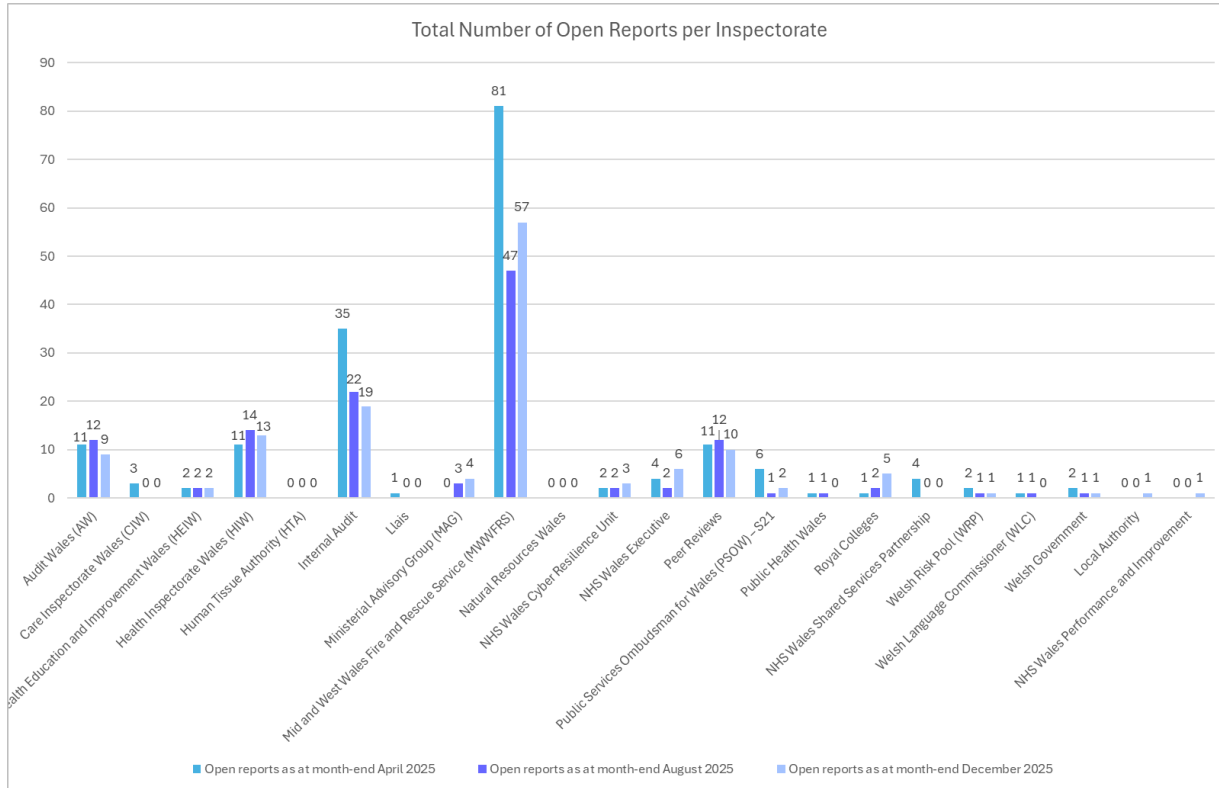
Overview of the Audit Tracker



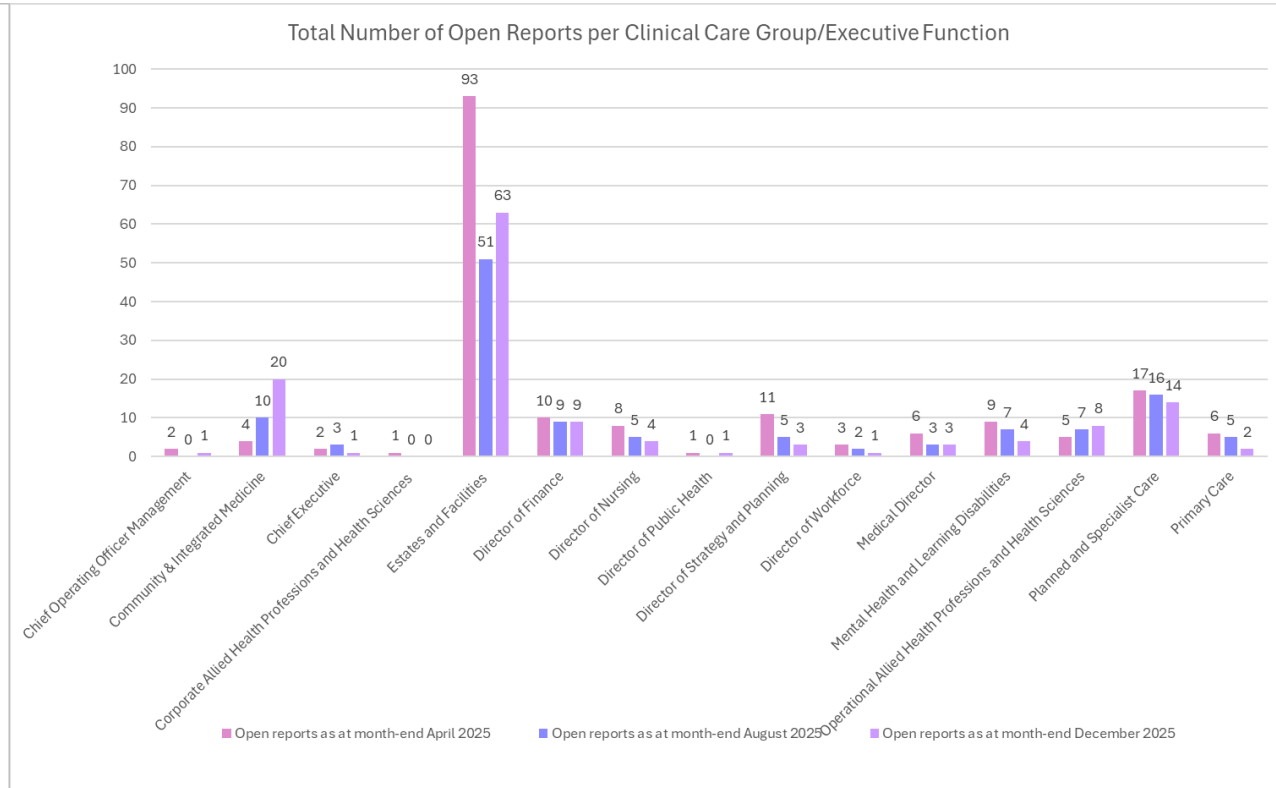
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Total Number of Open Reports per Inspectorate



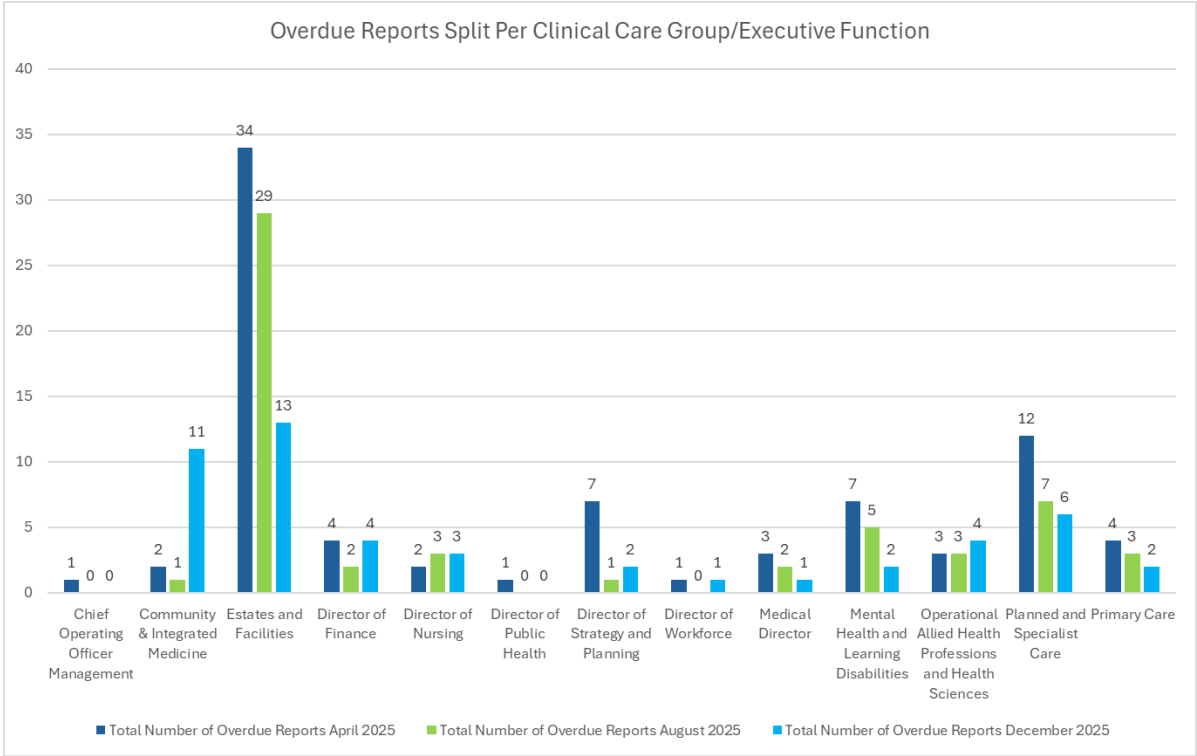
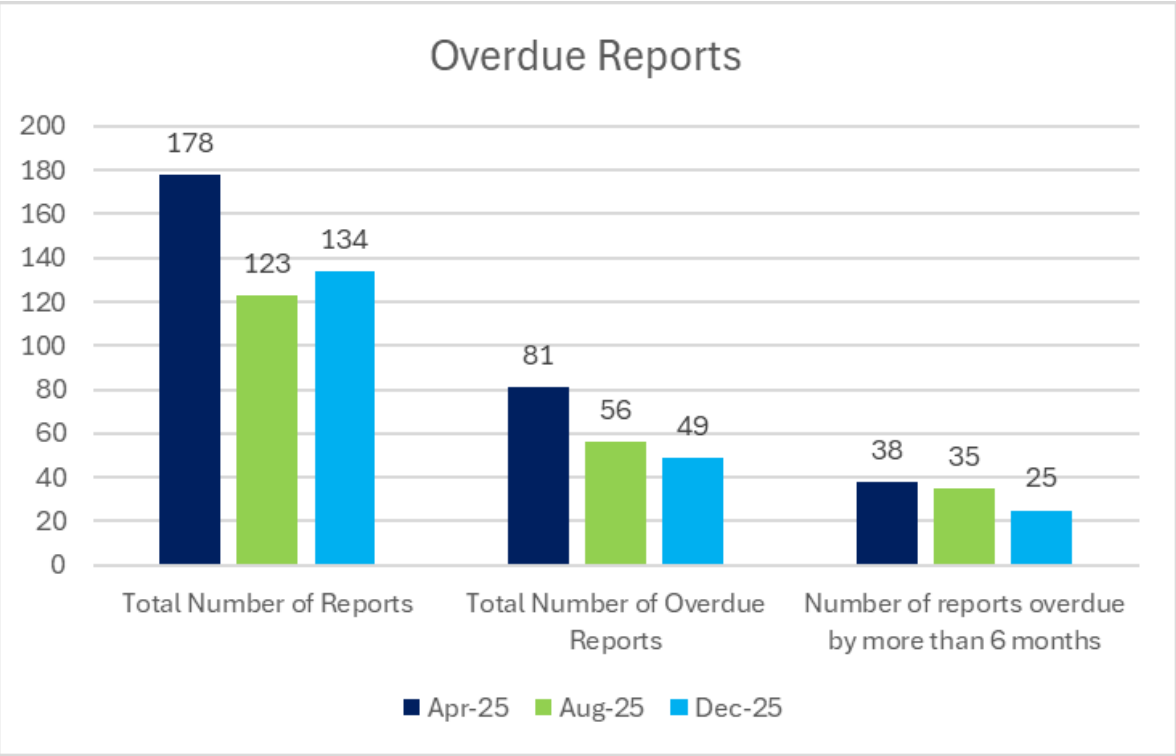
Total Number of Open Reports per Clinical Care Group/Executive Function



Audit Tracker Analysis – Overdue Reports

Of the current overdue reports, 25 are overdue by more than six months, an improvement compared to the 35 reports noted in October 2025. These reductions reflect continued progress made in clearing the backlog of historical reports, and the graphs illustrate a sustained downward trend in both the volume and ageing of the overdue reports.

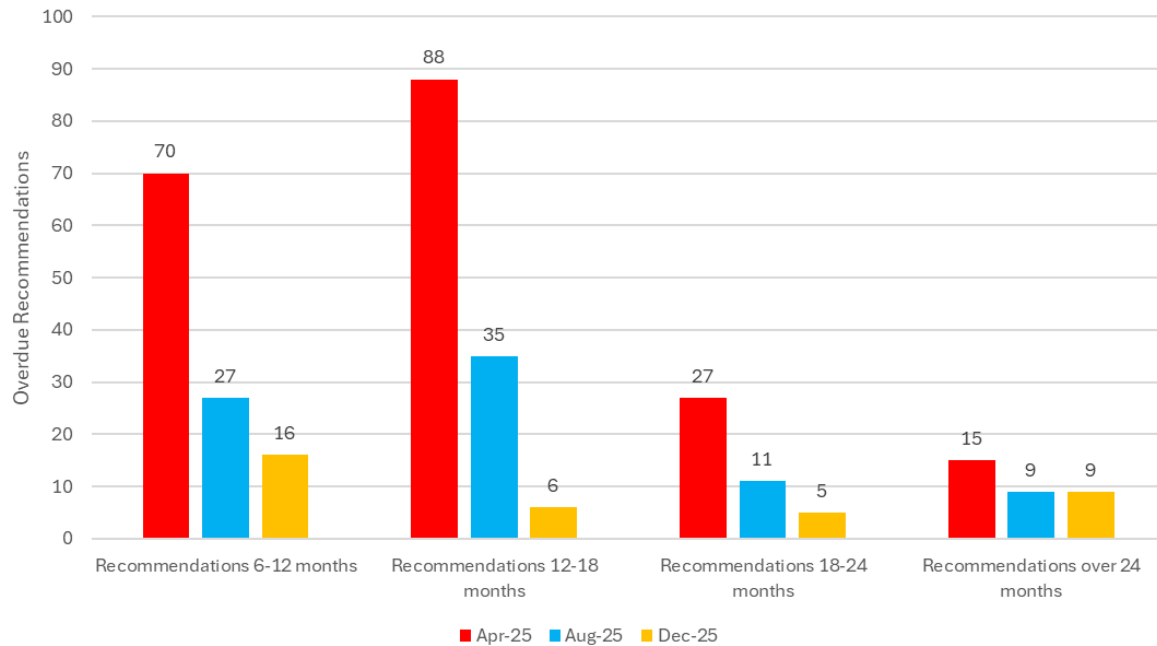
The data reflects an improving trend, with several functions fully closing reports. Estates & Facilities, while still holding the highest volume of overdue reports, achieved a reduction from 29 to 13 since the previous report. Community and Integrated Medicine saw the largest increase in overdue reports from 1 to 11. Several functions maintained zero overdue reports throughout the period, indicating sustained compliance.



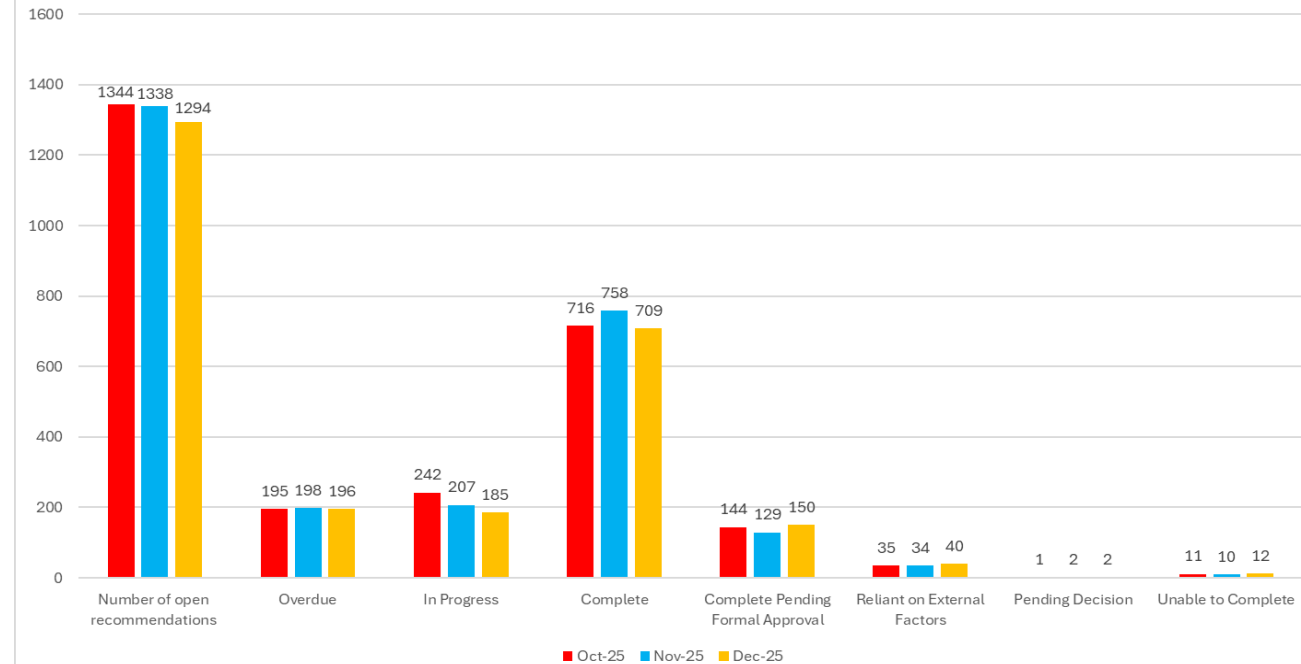
Audit Tracker Analysis – Overdue recommendations

Whilst the total number of recommendations has slightly increased from 1,272 in August 2025 to 1,294, the number of **open** recommendations has decreased from 557 to 435. The number of **overdue** recommendations (i.e those where the original completion date has not been met) has also decreased from 236 to 196, with **36 overdue by more than 6 months** (August 2025: 82), showing a significant improvement in this area. The number of recommendations without revised timescales has also improved from 162 to 133.

Recommendations Overdue by more than 6 months



Number of Recommendations at December month-end



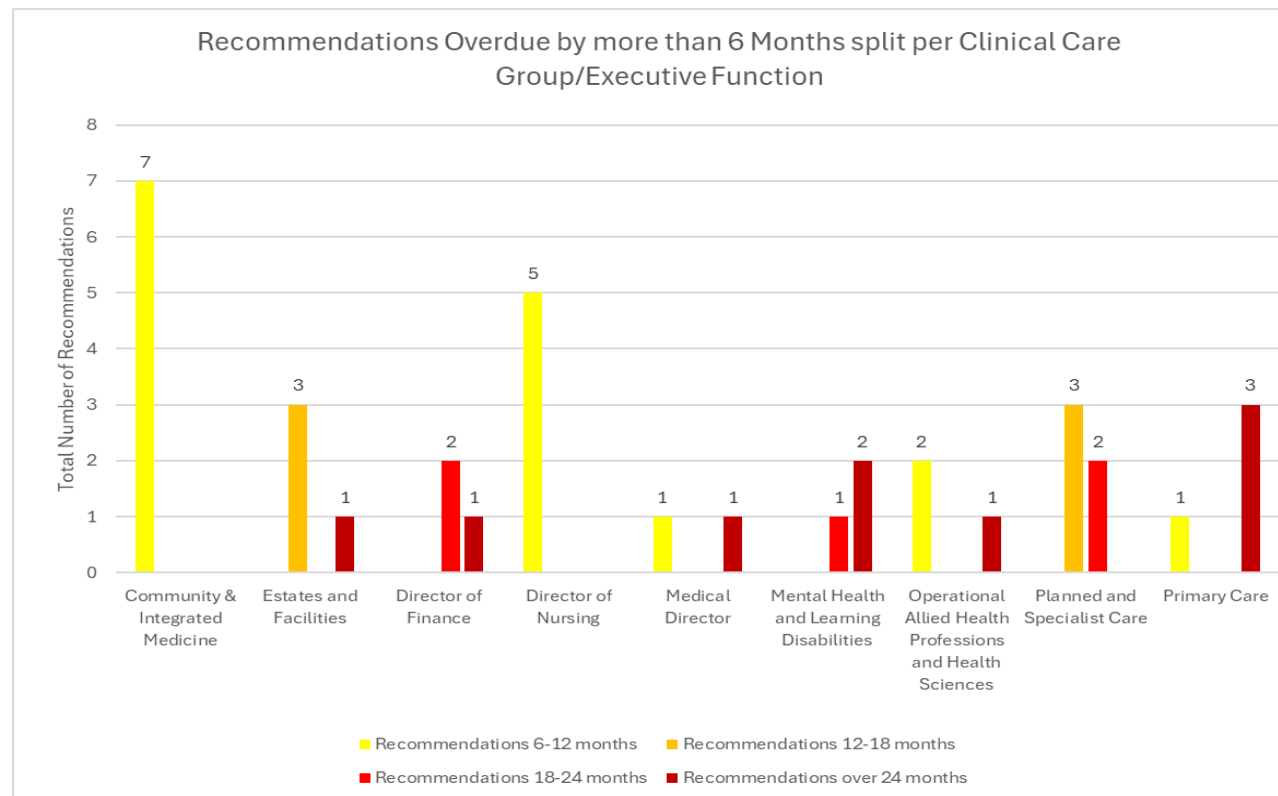
Audit Tracker Analysis – Overdue recommendations



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Meetings were scheduled during Q4 of 2025/26 with relevant Executive Leads and CCG / Function leads to review recommendations overdue by more than 6 months, to identify whether they have been fully implemented, or if additional support or escalation is required to further progress. Due to operational pressures and demands, these meetings have been stood down and will be rescheduled for Q1 2026/27.



Key improvement metrics for progress against audits, inspections and WHCs (as well as risk management and Ministerial Directions) are relayed via the CCG / Executive Function structures, with a level between 1 and 4 assigned for each metric based on the level of assurance around the targets in each area. Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those CCGs or Functions who may be assessed as being in Level 4. At present, CCGs and Functions are assigned as being either level 1, 2 or 3 pending formalisation of these processes.

Measures to assess against the Governance domain for audits and inspections are [more detail later in this report.](#)

Audit Tracker Analysis – Recommendations that are “Unable to Complete”



12 recommendations (<1%) on the Audit & Inspection tracker are marked as “Unable to Complete” as at December 2025.

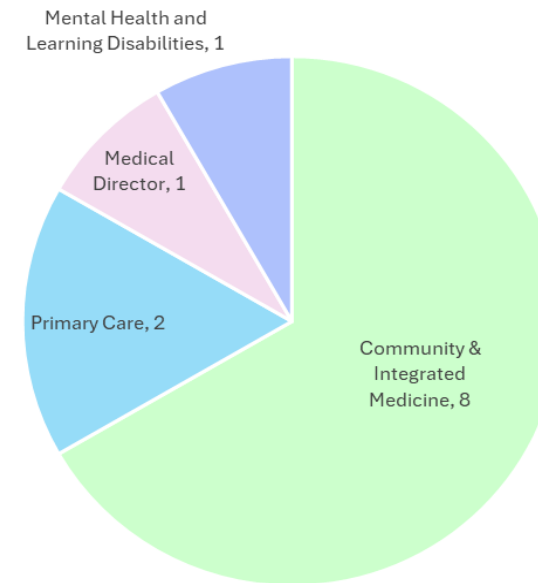
Common barriers noted for recommendations that are ‘Unable to Complete’ include:

- The original actions were dependent on plans that were subsequently not developed or implemented;
- Financial constraints / lack of funding;
- Long term absence / workforce challenges / recruitment constraints; and
- Awaiting outcomes of wider plans (Operational Change Process, Clinical Service Plan, Fragile Services Plan).

Where CCGs and Functions note recommendations as being “Unable to Complete”, leads are required to formally note barriers to the full implementation of recommendations on AMAT.

These recommendations are then required to be escalated local operational governance arrangements. The relevant Lead Executive is required to provide approval of acceptance of these barriers prior to recommendations being closed. “Unable to Complete” recommendations will be discussed as part of the review meetings of long-standing overdue recommendations.

Recommendations that are "Unable to Complete" Split per Clinical Care Group/Executive Function



Audit Tracker Analysis - Recommendations without revised timescales

Recommendations without revised timescales are mainly attributed to the following:

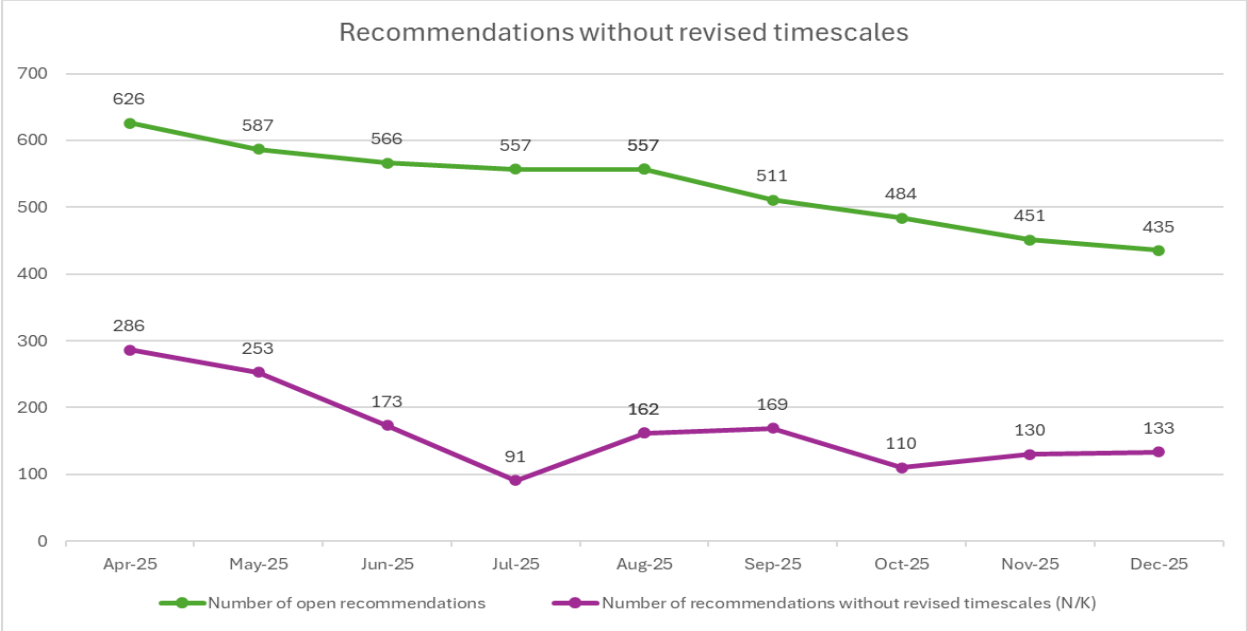
- Recommendations previously noted as ‘complete’ being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- A delay in the provision of revised completion dates due to operational pressures and capacity;
- CCGs / Executive Functions have provided progress updates on AMAT but not included a revised completion date.

The following slide details the number of recommendations without revised timescales per Clinical Care Group / Executive Function.

As at December 2025, 133 of the recommendations that have exceeded their original completion dates do not have revised timescales, an improvement from 162 in the previous report August 2025, with improvements noted in Community & Integrated Medicine (from 106 to 76) and Planned & Specialist Care (from 24 to 8).

In the absence of a specific ‘revised date’ field on AMaT, the Assurance and Risk team continue to remind services of the need to include revised completion dates within the governance reports presented to CCG / CSG and Executive Function governance meetings and continue to review recommendations where progress updates have not been obtained, with the relevant business partner for those services prioritising the support offered.

Scoping work continues to explore the development of performance dashboards to capture data from AMaT via ‘Power BI’ with colleagues in the Performance Team. Due to capacity, development has been on hold, however a meeting is being scheduled to finalise the requirements and identify timescales to enable the completion of this action. This would provide services with improved oversight of their performance, including the number of recommendations without a revised timescale, and further support the internal escalation framework.



**Recommendations that are reliant on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems to inform revised completion dates are not counted as ‘overdue’.*

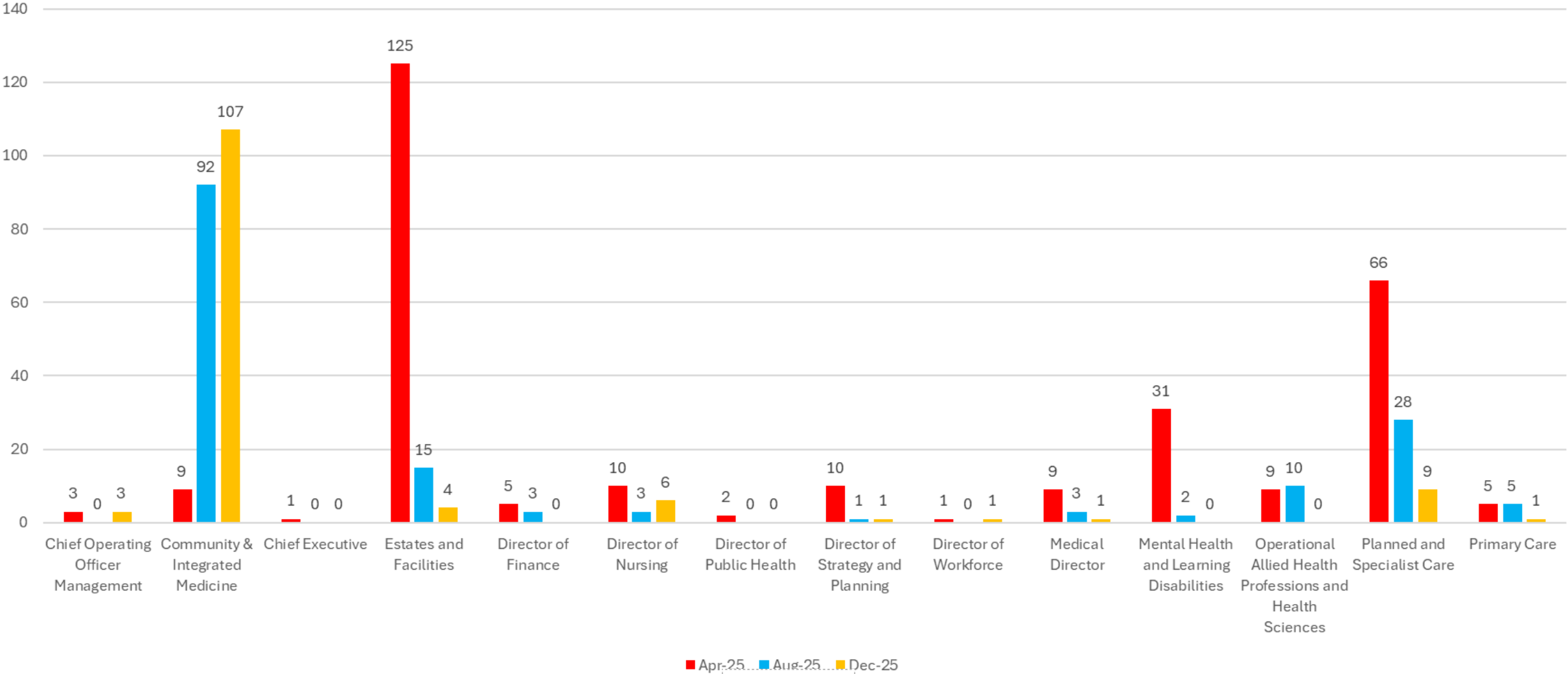
Audit Tracker Analysis - Recommendations without revised timescales



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Recommendations Without Revised Timescales per Clinical Care Group/Executive Function



■ Apr-25 ■ Aug-25 ■ Dec-25

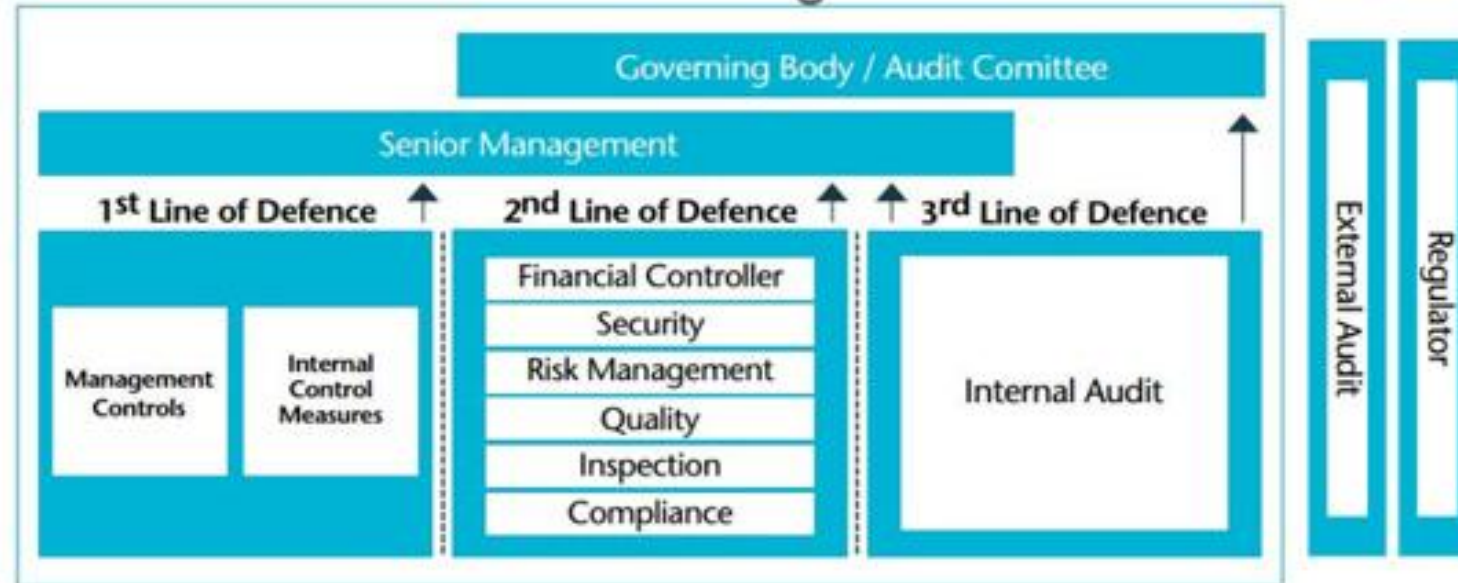
Three Lines of Defence



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The Health Board operates within the “Three Lines of Defence” model, which provides a simple and effective way to delegate and coordinate roles and responsibilities within an organisation to ensure the appropriate allocation for the management, reporting and escalation of the implementation of recommendations.



Operational Management (1st line)

First line are functions which own and manage risk, with operational staff responsible for maintaining internal controls such as processes, procedures and identifying risks, addressing as required.

Progress on the implementation of recommendations and WHCs are discussed at the Clinical Service Groups' (CSG) Integrated Governance Group meetings for operational areas in the first instance, and then escalated if required to their CCG Integrated Governance Group meetings. CSG meetings are scheduled to occur fortnightly to fall in-between alternating Business, Planning and Performance and Quality, Health and Safety CCG meetings. For Executive Functions (EF), recommendations are discussed within the Executive Function Services' local management meetings, and escalated as appropriate to Senior Leadership Team meetings/relevant Lead Executive as appropriate. CCG and EF governance arrangements are considered when assessing the escalation status for Governance.

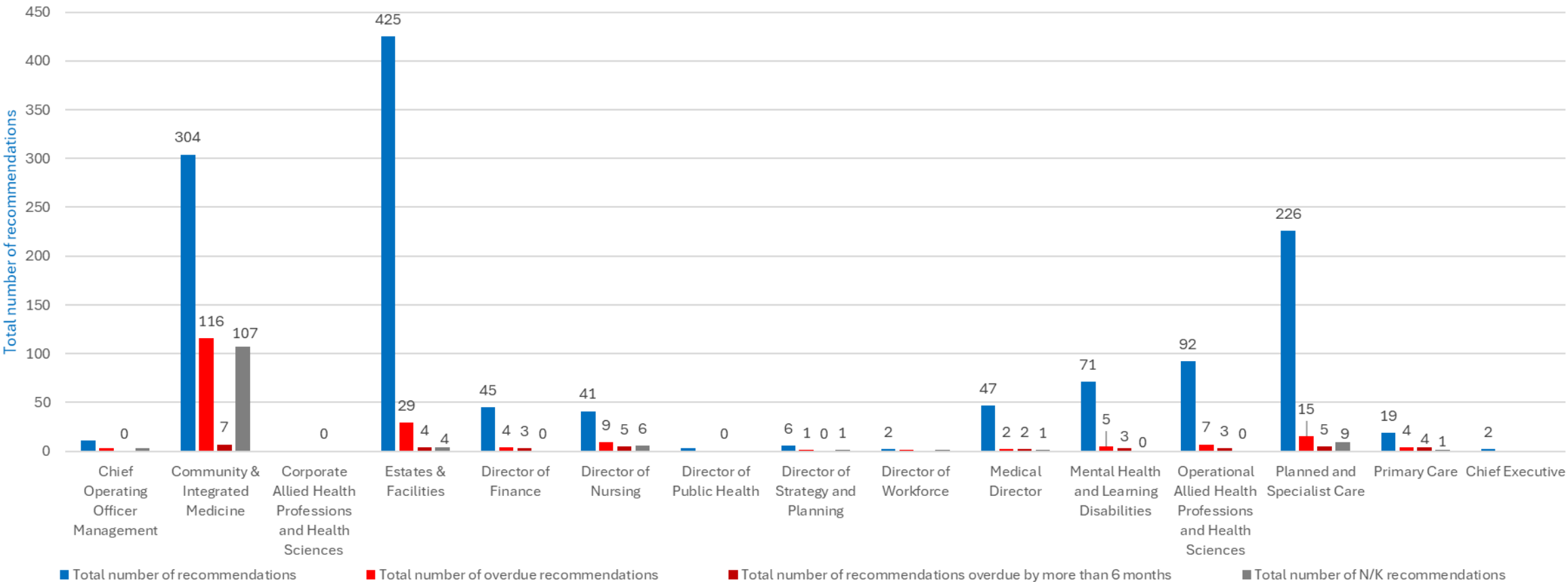
Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are provided to management and service leads via e-mail which identify proposed actions for the CCG / Function to take forward to address areas of improvement or concern in respect of outstanding recommendations and Welsh Health Circulars.

Three Lines of Defence: 1st Line – Audits and Inspections

The graph below provides a summary of open reports as at December 2025, and the status of the recommendations split per CCG/ Executive Function.

The graph below details how many recommendations are overdue per CCG/Function, and of those overdue recommendations, how many are overdue by more than 6 months as well as the recommendations without revised completion dates. Detail on the underpinning processes have been included earlier in this report.

Total Number of Recommendations split per Clinical Care Group/Executive Function



Three Lines of Defence



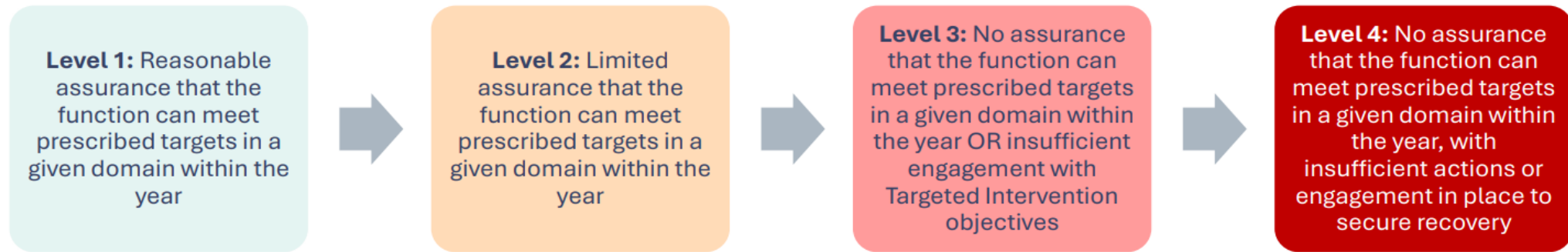
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Internal Escalation (2nd Line)

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG /Executive Functions are assessed monthly against seven domains, including 'Governance' (with specific focus on four key areas noted below), to drive improvement in performance, and awarded one of four levels based on their performance:

- Risk Management;
- Implementation of recommendations raised in audits / inspections and regulatory activity;
- Implementation of Welsh Health Circulars and Ministerial Directions; and
- Governance arrangements.



Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those CCGs or Functions who may be assessed as being in Level 4. At present, CCGs and Functions are assigned as being either level 1, 2 or 3 pending formalisation of these processes.

Independent Assurance (3rd line)

The third line of defence relates to those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies.

Three Lines of Defence: 2nd Line - Audits and Inspections



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Internal Escalation - Measures to assess against the Governance Domain – Audit and Inspections

Levels are awarded based on the assessments undertaken by each function meeting the prescribed targets within the year.

| Level | Criteria |
|---|---|
| Level 4 – no assurance and insufficient actions / engagement | <p>No plan in place and no engagement, (e.g., no responses to recommendations raised, no revised dates where original completion dates have lapsed).</p> <p>No evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources</p> |
| Level 3 – no assurance | <p>Responses to recommendations have been developed, but the function is not delivering against revised completion dates, with no realistic revised completion dates provided.</p> <p>Management responses have not been developed within a month of receipt of report.</p> <p>Less than 80% compliance with achieving original and revised completion dates stipulated against recommendations</p> <p>Limited evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources</p> |
| Level 2 – Limited assurance | <p>Responses to recommendations have been developed, but lack of evidence that original timescales are being achieved.</p> <p>Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates.</p> <p>Between 80-90% compliance with achieving original completion dates stipulated against recommendations</p> <p>Some evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources</p> |
| Level 1 – Reasonable assurance | <p>Responses to recommendations have been developed and the function is delivering against original completion dates</p> <p>Over 90% compliance with achieving original completion dates stipulated against recommendations</p> <p>Evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources</p> |

Three Lines of Defence: 2nd Line- Internal Escalation - Governance Domain Levels



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| Service | August 2025 | September 2025 | October 2025 | November 2025 | December 2025 |
|---|-------------|----------------|--------------|---------------|---------------|
| Chief Operating Officer Management | 1 | 1 | 2 | 2 | 2* |
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 |
| Estates & Facilities | 2 | 1 | 1 | 1 | 1 |
| Executive Director of Allied Health Professions and Health Sciences | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Finance | 1 | 1 | 1 | 1 | 2* |
| Executive Director of Nursing, Quality and Patient Experience | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Public Health | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy and Planning | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Workforce and Organisational Development | 1 | 1 | 1 | 1 | 1 |
| Executive Medical Director | 1 | 1 | 1 | 1 | 1 |
| Medicines Management | n/a | n/a | n/a | n/a | 1 |
| Governance and Communication | 1 | 1 | 1 | 1 | 1 |
| Mental Health and Learning Disabilities | 2 | 2 | 2 | 1 | 1 |
| Operational Allied Health Professions and Health Sciences | 2 | 1 | 1 | 1 | 1 |
| Planned and Specialist Care | 3 | 3 | 2 | 2 | 2* |
| Primary Care | 2 | 2 | 2 | 2 | 2 |

A summary of each CCG / Executive Function's performance for the Governance domain can be found in the table, and reflects the organisational structure effective from 1 December 2025 (changes detailed on [slide 5](#)).

Along with engagement, governance arrangements, risk management, and the monitoring of the implementation of WHCs and Ministerial Directions, the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews has been a dominant factor in assessing Function's escalation level.

The minimum requirement for a service to be de-escalated to Level 2 is that 80% of audit and inspection recommendations are implemented within agreed timescales, and 90% to achieve Level 1 status.

Detailed analysis of the Community and Integrated Medicine CCG who are the only CCG/Function assessed as Level 3 as at December 2025 is provided on the next slide, based on their performance in respect of the timely implementation of recommendations from audits and inspections.

* Indicates a CCG / function that has been escalated for factors other than audit and inspection recommendations.

Internal Escalation - Governance Domain : Level 3 - No Assurance (Audits and Inspections)



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Community & Integrated Medicine (C&IM) CCG

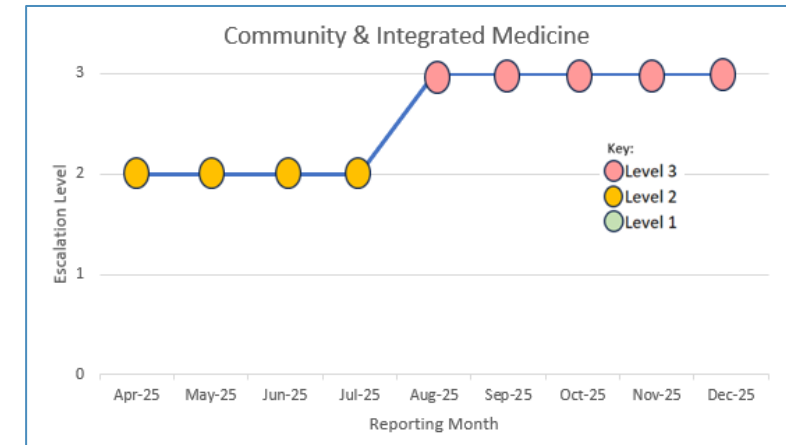
As of 31 December 2025, **116 of 304 (38%) recommendations assigned to the CCG are overdue**, with 7 of these overdue between 6-12 months. Of the 116, **107 do not have a revised implementation dates (N/K)**. The lack of revised implementation dates is a combination of:

- No update provided on AMaT; or
- If updates are provided on AMaT, no clear revised completion date is included.

The CCG has been asked to consider the status of any overdue recommendations as to whether any could be changed to an alternative category (e.g. pending decision / unable to complete), as per the [new status categories](#).

The breakdown by CSG of the 116 overdue recommendations are:

- **67 with Carmarthenshire Integrated System**, 4 of which are overdue 6-12 months. 66 of these 67 recommendations do not have revised implementation dates (N/K). Of the 67, 39 are from the NHS Wales Executive *Report on Urgent and Emergency Care Opportunities: GGH site report (October 2024)*.
- **28 with Ceredigion Integrated System**, 2 of which are overdue 6-12 months. 20 of these recommendations do not have revised implementation dates (N/K);
- **3 with Pembrokeshire Integrated System**, none of which are overdue by more than 6 months. All 3 recommendations do not have revised implementation dates (N/K); and
- **18 with the overarching Clinical Care Group**, 1 of which is overdue by 6-12 months. All 18 recommendations do not have implementation timescales (N/K).



Engagement varies across the CCG however the Assurance and Risk Officer has offered each CSG support for deep dive sessions to review overdue recommendations; these have not yet been scheduled due to current operational pressures. A meeting was scheduled for February 2026 with CCG leads and Executives to review recommendations overdue by 6 months or more, to determine the appropriate course of action to support their progression and implementation, however due to operational pressures and demands, this has been stood down and will be rescheduled for Q1 2026/27.

Management responses are also awaited to the NHS Executive Ambulance Patient Handover Process report, as well as the Getting it Right First Time (GIRFT) GGH revisit in September 2025. Management responses have been received following the revisit of the NHS Executive Opportunities Assessment of Urgent & Emergency Care at WGH.

Internal Escalation - Governance Domain : Level 2 – Limited Assurance



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The following services were awarded a Level 2 in terms of their audit and inspection reports as at December 2025, with both been awarded Level 2 status throughout the financial year to date:

| Service | Reason for award of L2 | De-escalation Criteria | Meetings scheduled to review recommendations overdue by more than 6 months |
|-------------------------------|------------------------------------|---|--|
| Executive Director of Nursing | 9 (22%) of recommendations overdue | To achieve de-escalation to L1, Executive Function required to implement over 90% of recommendations and provide revised completion dates for those where completion dates have lapsed. Whilst the percentage of overdue recommendations is within the L3 threshold, the <u>number</u> is low in comparison to other CCGs and Functions (9/41 recommendations). | The meeting that was scheduled for 22 January 2026 will be rescheduled |
| Primary Care | 4 (21%) recommendations overdue* | To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales. Whilst the percentage of overdue recommendations is within the L3 threshold, the <u>number</u> is low in comparison to other CCGs and Functions (4/19 recommendations). | 15 January 2026 |

Data for December 2025 does not include the performance of those CSGs previously aligned to Primary Care – Medicines Management, Long-Term Care

Three Lines of Defence: 2nd Line - Board and Committee Oversight – Audit and Inspections



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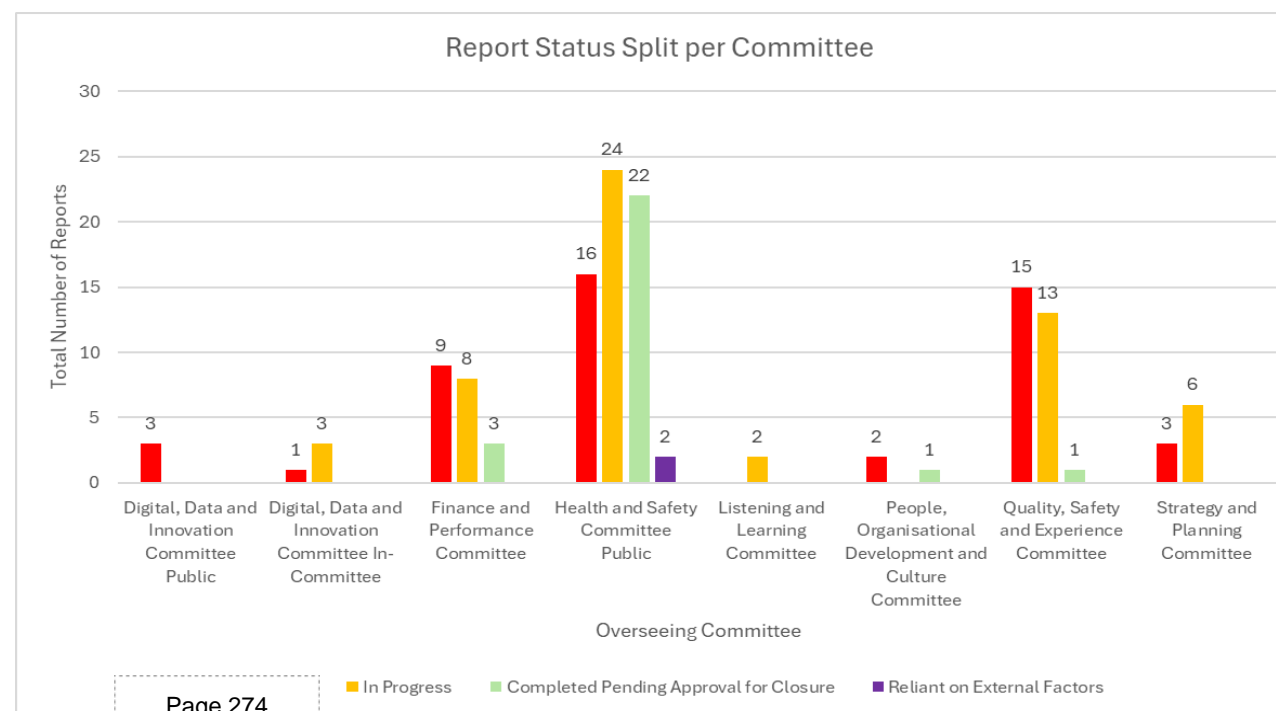
The graphs provide a breakdown of the number of reports and recommendations assigned to each Board level committee as at 31 December 2025.

Board level Committees receive assurance of the timely implementation of external recommendations via the *Assurance and Risk Report*. The reports detail progress on implementing recommendations aligned to each committee, highlighting any barriers to implementation and offering assurance on delivery.

The table below highlights actions from discussions at Board-level Committees in October and December 2025 relating to the progress being made in implementing recommendations raised at the relevant meeting. Progress against actions will be reported through the relevant Committee Table of Actions.

On initial receipt of reports from inspectorates and regulators, these should be presented to the relevant committee for awareness of their findings, highlighting recommendations which have been raised. This process is followed for reports issued by Internal Audit, External Audit, Peer Reviews, HIW and Care Inspectorate Wales (CIW). Assurance on the overall process of tracking recommendations is undertaken by ARAC.

| Committee | Minute Reference | Action |
|---|------------------|--|
| Audit and Risk Assurance Committee (ARAC) | AC(25)167 | To examine process undertaken in closing Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow) report in 2017, share examples of good practice elsewhere, ensure that consideration of the report forms part of the People Organisational Development and Culture Committee (PODCC) item on the new operational structure and share the report with the Chair of QSEC. |
| | AC(25)172 | To examine Human Tissue Authority report with the Audit and Risk Business Partner for Pathology, the action plan and translate it into actions on the Audit tracker. |
| Quality, Safety and Experience Committee (QSEC) | QSEC 25 (42) | Cleaning Standards Audit Report – Discussion will take place outside of the meeting to determine whether to request a verbal update via the table of actions in October 2025 followed by a more substantial item a few months after this ahead of the follow up audit in March 2026. |



Three Lines of Defence: 2nd Line - Thematic Analysis



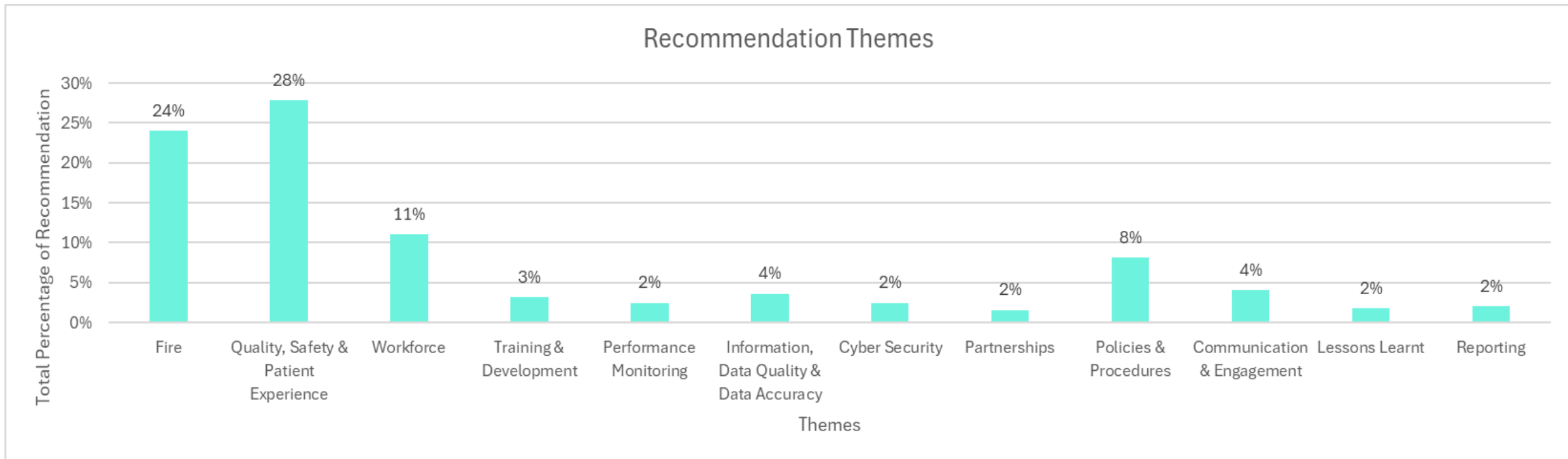
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As part of the second line of defence, each recommendation is assigned a theme, enabling the Health Board to analyse groups of similar recommendations. The Assurance and Risk team share these themed recommendations with relevant subject matter experts on a bi-monthly basis to mirror the process used for thematic risk registers, with ongoing reviews to ensure alignment between Datix and AMaT.

The graph below provides a thematic analysis for all open recommendations per theme as at December 2025. 28% of the open recommendations were assigned the Quality, Safety & Patient Experience theme, and 24% assigned the Fire theme.

The following themes had less than 1% of recommendations assigned to them and are therefore not shown: Health and Safety, Governance, Medical Devices, Infection Control, Information Governance, Medication, Business Disruption, Approvals, Financial Management & Control, Planning Delivery & Deadline Management, Resourcing, Strategy, Capital Equipment, ICT (Information and Communication Technology), Risk Management, Fragile Services.



Welsh Health Circulars (WHCs)



All WHCs are managed via AMaT, which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Committees have responsibility to seek assurance that the Health Board is compliant with WHCs and that these are implemented in line with stated/agreed timescales, and where this has not been possible, to receive assurance the impacts resulting from late/non-delivery are understood and managed appropriately. Where WHCs are not clear in terms of implementation timescales, leads are requested to provide the planned date for implementation by the Health Board.

To align with the new statuses introduced for Audit & Inspection recommendations and maintain a consistent approach, three additional status categories have now been implemented for WHCs as outlined below:

| Status Category | Definition |
|---|--|
| Overdue | The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place. |
| Unable to Complete (NEW) | The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures. |
| Pending Decision (NEW) | The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending. |
| In Progress | The WHC is currently in progress, and within the agreed original timeframe for implementation. |
| Reliant on External Factors | The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement. |
| Complete Pending Formal Approval (NEW) | The Service / Function have completed the WHC and are currently awaiting formal approval to close. |
| Complete | The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received. |

Oversight of the delivery of WHCs has been included in CCG Integrated Governance Group (IGG) Terms of Reference, with the requirement to escalate appropriately in instances of non-compliance.

The timely implementation of WHCs is included within the [Governance domain of the Health Board's internal escalation framework](#), with services escalated in instances of non-compliance.

Overview of Welsh Health Circulars



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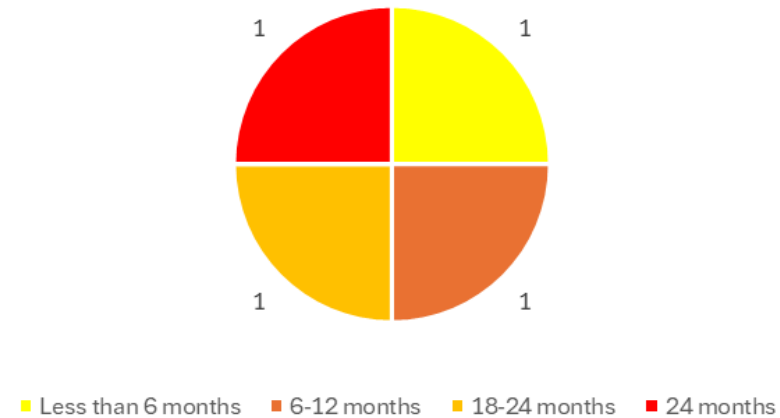
As at 31 December 2025, there were **32 open Welsh Health Circulars** assigned to the Health Board.

The graphs on this and the next slide show their status category and provide an analysis of WHCs which are noted as being “overdue”, split by Clinical Care Group / Executive Function.

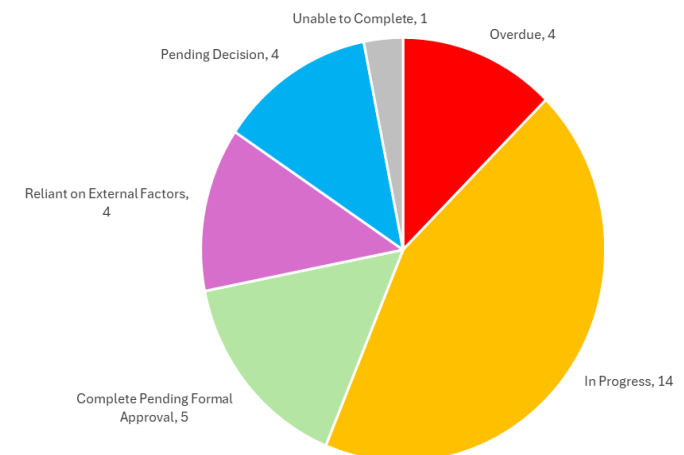
In instances where WHCs cannot be implemented, the relevant lead is required to update AMaT to reflect the barriers to implementing the WHC and add a corresponding risk to the Clinical Service Sub-Group’s risk register on Datix. A Quality Impact Assessment (where appropriate) is also required to be undertaken, as well as escalating the WHC for the attention of relevant CCG Leads via their CCG IGG meetings. Barriers cited which prevent the implementation of these WHCs include lack of funding and ongoing challenges in recruiting staff.

Progress on the implementation of WHCs are also reported to the relevant Committee via the Assurance and Risk Report.

Overdue WHC's



Number of WHCs split per Status Category



Overview of Welsh Health Circulars

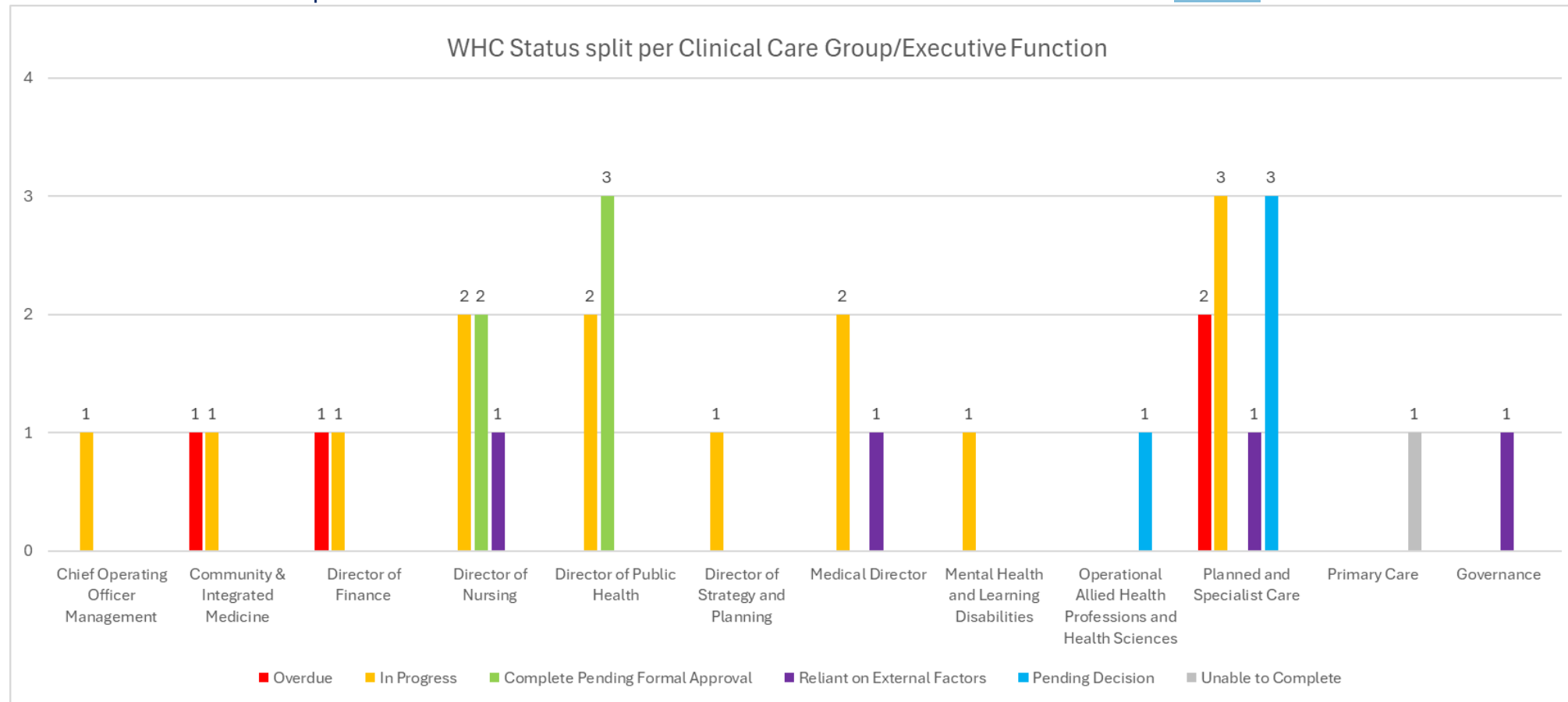


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Along with risk management and the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews, the implementation of WHCs is a key factor in assessing a Function's escalation level.

A summary of each CCG / Executive Function's performance for the Governance domain for December 2025 can be found on [slide 15](#).



The next slide outlines the minimum criteria required for a service to be assigned its escalation level based on the status of WHCs. This is followed by a detailed analysis of one Clinical Care Group (CCG) that was designated Level 3 as of December 2025.

Three Lines of Defence: 2nd Line - Welsh Health Circulars



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Internal Escalation - Measures to assess against the Governance Domain – Welsh Health Circulars

Levels are awarded based on the assessments undertaken by each function meeting the prescribed targets within the year.

| Level | Criteria |
|---|--|
| Level 4 – no assurance and insufficient actions / engagement | <p>No plan in place and no engagement, (e.g., no responses to WHC / MD requirements, no revised dates where original completion dates have lapsed).</p> <p>Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has not been raised, and a Quality Impact Assessment has not been completed (if applicable).</p> <p>No evidence that in instances of non-compliance, WHCs are escalated via CCG management structures where necessary.</p> |
| Level 3 – no assurance | <p>Responses to WHCs / MDs have been developed, but the function is not delivering against revised completion dates</p> <p>Limited evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable).</p> <p>Limited evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.</p> |
| Level 2 – Limited assurance | <p>Responses to WHCs / MDs have been developed, but lack of evidence that original timescales are being achieved.</p> <p>Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates.</p> <p>Some evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable).</p> <p>Some evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.</p> |
| Level 1 – Reasonable assurance | <p>Responses to WHCs / MDs have been developed, and the function is delivering against original completion dates.</p> <p>Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed.</p> <p>Evidence that in instances of non-compliance, WHCs and MDs are escalated via CCG management structures where necessary.</p> |

Internal Escalation - Governance Domain : Level 3 - No Assurance (WHC Continued)



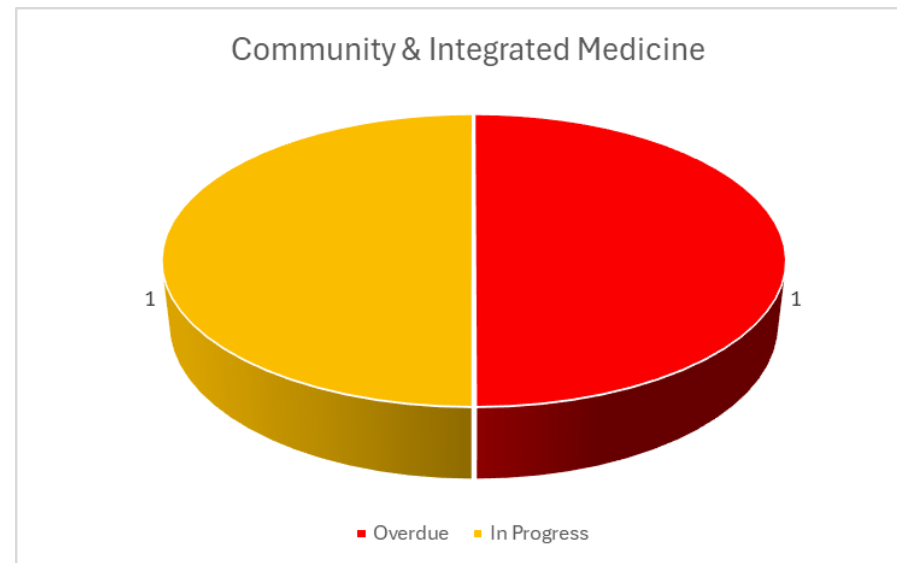
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Community & Integrated Medicine CCG

As at 31 December 2025, two Welsh Health Circulars (WHCs) are assigned to the Community & Integrated Medicine CCG. The Ambulance Patient Handover Guidance WHC (WHC/2024/041) is in progress, with the Transformation Programme Office gathering evidence to support closure of the WHC.

The National Clinical Guideline for Stroke (WHC/2024/006), received in March 2024, is overdue by 18-24 months with no confirmed implementation timescale (N/K). An associated risk is recorded on the risk register (Risk 233 *Risk of poor patient outcome due to insufficient stroke therapy staff & lack of 7 day Consultant affecting the Health Board*. Current Risk Score 12 (High)) and a revised Quality Impact Assessment (QIA) is to be submitted to the QIA panel for review. Implementation cannot proceed until the Clinical Services Plan is developed, as Stroke Services form part of this wider plan. Current barriers to the implementation of this WHC include insufficient resources such as staffing, equipment, and appropriate facilities



Three Lines of Defence: 2nd Line: Board and Committee Oversight - WHCs



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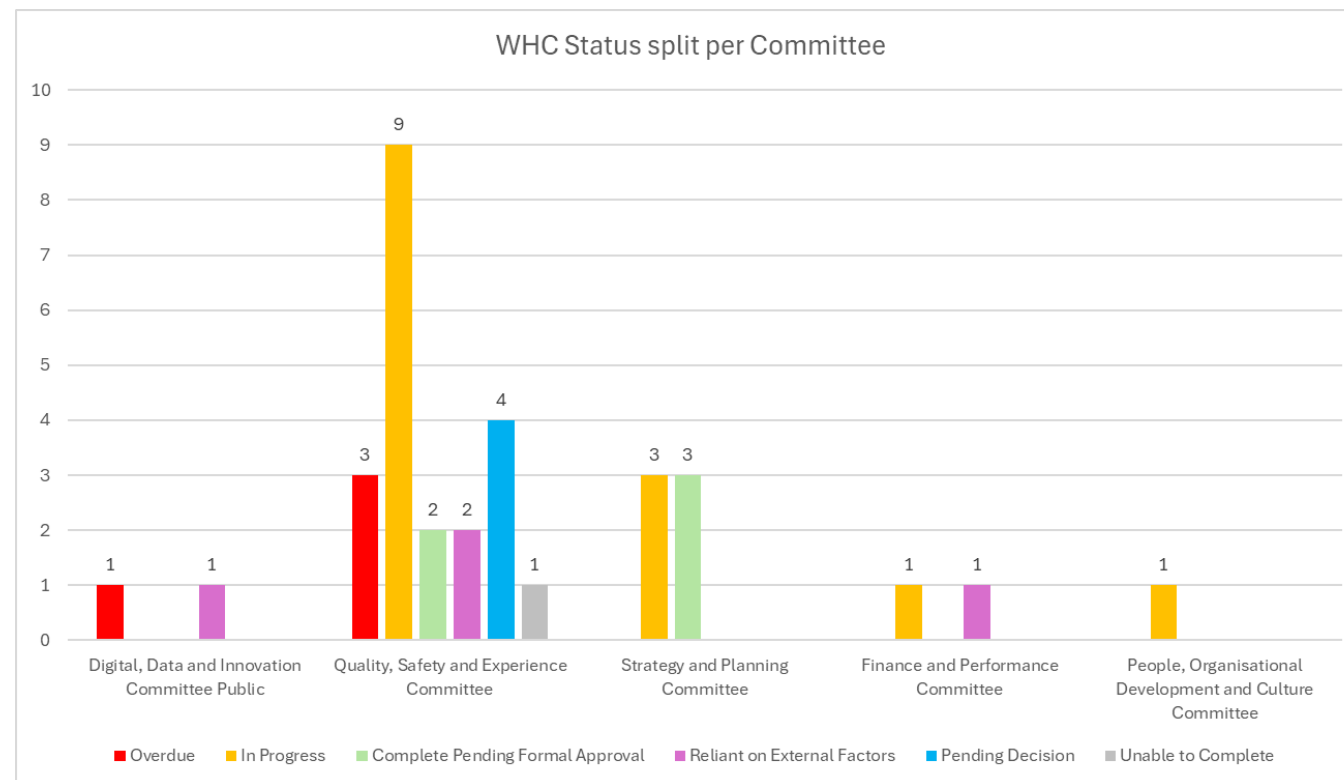
The graph provides a breakdown of the number of WHCs assigned to each Board level committee as at 31 December 2025

Board level Committees receive assurance of the timely implementation of the WHCs via the Assurance and Risk Report. The report details progress made in the implementation of WHCs, providing oversight and assurance while highlighting any barriers to implementation. The Committees are responsible for seeking assurance that the Health Board is compliant with the requirements of WHCs, and that these are implemented in line with stated and/or agreed timescales. In instances where this has not been possible, the Committees are asked to receive assurance that the impacts resulting from late/non-delivery are understood and managed appropriately.

The table below highlights actions from discussions at Board-level Committees in October and December 2025 relating to the progress being made in implementing recommendations raised at the relevant meeting. Progress against actions will be reported through the relevant Committee Table of Actions.

| Committee | Minute Reference | Action |
|---|------------------|--|
| Digital, Data & Innovation Committee (DDIC) | DDIC(25)44 | Assurance on governance arrangements – Implementation date requested for Welsh Health Circular 03-22: Further extending the use of Blueteq in secondary care |

The process of obtaining formal approval for the closure of the WHCs requires the relevant Lead Executive to confirm that all requirements have been appropriately implemented.



Next Steps and Recommendations



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Next Steps

This report has identified the following areas where further improvements can be made:

- To develop a revised plan and timescales with colleagues in the Performance team, taking into consideration capacity and existing development priorities to develop an audit tracking performance dashboard via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework. This will allow Health Board-wide access to information, and further support the escalation analysis undertaken by the Assurance and Risk Team.

Recommendations

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** that the Health Board is:

- continuing to address and implement findings from audits, inspections and regulators;
- addressing and implementing the requirements as raised within Welsh Health Circulars; and
- strengthening the internal escalation arrangements for the domain of governance.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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8 - Post Payment Verification

8.1

11:40, 0 Mins

8.1 - Post Payment Verification (PPV) Annual Report

DEFERRED to 14 April 2026 meeting

| For assurance

8.2

11:40, 0 Mins

8.2 - Primary Care PPV Report

DEFERRED to 14 April 2026 meeting

| For assurance

9 - For Information

9.1

11:40, 0 Mins

9.1 - ARAC Workplan 2025/26

| For information

Attachments

[9.1 Audit Work Programme 2025-26.pdf](#)

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2025/26

The proposed work programme is aligned to the requirements of the 2012 Revised NHS Wales Audit Committee Handbook, Draft Terms of Reference and example agenda and timetable.

| AGENDA ITEM/ISSUE | LEAD | 15 April 2025 | 8 May 2025 | 24 June 2025 | 12 Aug 2025 | 14 Oct 2025 | 9 Dec 2025 | 10 Feb 2026 | 14 April 2026 |
|---|-----------------|---------------------|------------------|--------------------|-------------------|-------------------|------------------|-------------------|---------------------|
| INTRODUCTIONS | | | | | | | | | |
| Apologies | Chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declaration of Interests | All | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| GOVERNANCE | | | | | | | | | |
| Minutes from previous meeting | Chair | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Matters Arising & Table of Actions | Chair | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Matters Arising not on agenda | Chair | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Self-Assessment of Committee's effectiveness | Chair | | | D | ✓ | | ✓ | | |
| Escalation Status Update | PK/LD/SA | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review and report upon the adequacy of arrangements for declaring, registering and handling interests | JW | | ✓ | | | | | | ✓ |
| Receive full report of all offers of gifts and hospitality | JW | | ✓ | | | | | | ✓ |
| Compliance with Ministerial Directions | JW | | ✓ | | | | | | |
| Compliance with Welsh Health Circulars (WHCs) | JW | | ✓ | | | | | | |
| Review ARAC Annual Report | Chair | | ✓ | | | | | | |
| Review Board Effectiveness Report | JW | | ✓ | | | | | | |
| Review Accountability Report, incl Annual Governance Statement | JW | | ✓ (Draft) | ✓ (Final) | | | | | |
| Review Annual Head of Internal Audit Report and Opinion (incl Capital/PFI) | JJ | | ✓ (Draft) | ✓ (Final) | | | | | |
| Internal Audit: Annual Governance Statement Review | JJ | | ✓ | ✓ | | | | | |
| Review, agree and recommend to the Board the audited accounts & financial statements | HT | | ✓ (Draft) | ✓ (Final) | | | | | |

| AGENDA ITEM/ISSUE | LEAD | 15 April 2025 | 8 May 2025 | 24 June 2025 | 12 Aug 2025 | 14 Oct 2025 | 9 Dec 2025 | 10 Feb 2026 | 14 April 2026 |
|---|--------------------|----------------------|-------------------|---------------------|--------------------|--------------------|-------------------|--------------------|----------------------|
| Audit Enquiries to those charged with Governance and Management | HT | | ✓ | | | | | | |
| Audit Wales ISA 260 incl Letter of Representation | Audit Wales | | | ✓ | | | | | |
| Review the Health Board's Annual Report (Overview & Perf Section) | HT | | ✓ (Draft) | ✓ (Final) | | | | | |
| Review changes to Standing Orders & Standing Financial Instructions* | JW | ✓ (SOs) | | ✓ (SFIs) | | | | | |
| Annual Review of Standing Orders and Standing Financial Instructions | JW | ✓ (SOs) | | ✓ (SFIs) | | | | | ✓ |
| Scheme of Delegation | JW | ✓ | | | | | | ✓ | |
| Annual Review of Terms of Reference | Chair/JW | | | ✓ | | | | | |
| All Wales NHS Audit Committee Chairs' Meeting Update | Chair | | | | D | ✓ | ✓ | ✓ | ✓ |
| NWSSP's Construction Frameworks for Swansea Bay & Hywel Dda UHBs | LD | | | | ✓ | | | | |
| Review of any other sources of external assurance to ensure approp planning & coordination and that the Board is informed accordingly of any issues relating to compliance, risks of non-compliance & recommendations | All | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Provide assurances where a significant activity is shared with another organisation (eg NWSSP/JCC) | HT/SM | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls | JJ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review of Capital & PFI Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon | EJ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

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| AUDIT WALES | | | | | | | | | |
| Review External Audit Plan via update reports | Audit Wales | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees | Audit Wales | ✓ | | | | | | | ✓ |
| Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back | Audit Wales | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Consider any Audit Wales National Value for Money Examinations & Performance Reports | Audit Wales | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Receive the Auditor's General report to those charged with governance (Year-end) | Audit Wales | | ✓ | | | | | | |
| Structured Assessment 2024 Management Response Update | Audit Wales/JW | | | | ✓ | | | | ✓ |
| Structured Assessment 2025 | Audit Wales | | | | | | ✓ | | ✓ |
| Review of Urgent and Emergency Care (Part 1 and Part 2) | Audit Wales/AC | D | | ✓ | D | ✓ | ✓ | | |
| Planned Care Review | Audit Wales/AC | D | | ✓ | | | | | |
| Review of Capital Investment Prioritisation | Audit Wales/LD | | | ✓ | | | | | |
| Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment | Audit Wales/AC | ✓ | | | | | | | |
| Review of the Management of Outpatients | Audit Wales/AC | | | | D | D | D | D | ✓ |
| Deep Dive - Review of Investment in Digital Systems | Audit Wales/HT | | | | D | | D | D | ✓ |

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| Review of Radiology Services | Audit Wales/AC | | | | | | | D | ✓ |
| Deep Dive - Review of the Arrangements to Manage Estates | Audit Wales/JS | | | | | | | | D |
| Review of Cancer Services | Audit Wales/AC | | | | | | | | D |
| National Fraud Initiative Briefing Note | Audit Wales | | | | | ✓ | | | |
| Audit Fees Consultation 2026/27 | Audit Wales | | | | | | ✓ | | |
| INTERNAL AUDIT | | | | | | | | | |
| Internal Audit: Audit Plan Progress Report | JJ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review and approve Annual Internal Audit Plan | JJ | ✓ | | | | | | | ✓ |
| Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon | JJ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit | JJ | ✓ | | | | | | | |
| Standards of Cleanliness IA Update and Action Plan | JS | | | | ✓ | | | | |
| Learning Lessons (Reasonable Assurance) | JJ/SD | ✓ | | | | | | | |
| Elective Waiting List Management (Substantial Assurance) | JJ/AC | ✓ | | | | | | | |
| Consultant Job Planning Follow-up (Reasonable Assurance) | JJ/MH | ✓ | | | | | | | |
| Financial Management (Reasonable Assurance) | JJ/HT | ✓ | | | | | | | |
| Performance Management (Substantial Assurance) | JJ/HT | ✓ | | | | | | | |

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| Executive Team Governance (Substantial Assurance) | JJ/PK/JW | D | ✓ | | | | | | |
| Annual Planning (Reasonable Assurance) | JJ/LD | D | ✓ | | | | | | |
| Digital Strategic Partner (Substantial Assurance) | JJ/HT | | ✓ | | | | | | |
| Discharge Management Follow-up (Advisory Report) | JJ/AC | | | ✓ | | | | | |
| Standards of Cleanliness Follow-up (Limited Assurance) | JJ/AC/JS | D | D | ✓ | | | | | |
| Withybush Hospital (WGH) RAAC (Reasonable Assurance) | JJ/AC/JS | D | D | ✓ | | | | | |
| Continuing Healthcare – Database Maintenance and Finance Processes (Substantial Assurance) | JJ/HT | D | D | ✓ | | | | | |
| Contract Management (Advisory Report) | JJ/HT | | | ✓ | | | | | |
| Follow Up Review (Reasonable Assurance) | JJ/JW | | | ✓ | | | | | |
| Corporate Risk: Ophthalmology (Reasonable Assurance) | JJ/AC | | | | ✓ | | | | |
| Sickness Management (Limited Assurance) | JJ/LG | | | | ✓ | | | | |
| Nursing Management (Limited Assurance) | JJ/SD | | | | ✓ | | | | |
| Validation of Emergency Department Waiting Time Data (Limited Assurance) | JJ/AC | | | | | ✓ | | | |
| Control of Contractors (Advisory Report) | JJ/JS | | | | | ✓ | | | |
| Human Tissue Authority (Limited Assurance) | JJ/JS | | | | | ✓ | | | |
| Commissioning – Long Term Agreements (Reasonable Assurance) | JJ/LD | | | | | ✓ | | | |
| Capital Governance Arrangements (Advisory Report) | HR/EJ/LD | | | | | ✓ | | | |

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| Medical Devices Regulations (Substantial Assurance) | JJ/AC | | | | | | ✓ | | |
| Escalation Governance (Substantial Assurance) | JJ/PK/JW | | | | | | | ✓ | |
| Managed Practices (Reasonable Assurance) | JJ/AC | | | | | | D | ✓ | |
| Vaccination and Immunisation (Limited Assurance) | JJ/AG | | | | | D | D | ✓ | |
| Patient Experience (Reasonable Assurance) | JJ/SD | | | | | | | ✓ | |
| Cyber Security (IC) (Substantial Assurance) | JJ/HT | | | | | | D | ✓ | |
| Level 3 / 4 Directorates | JJ/HT | | | | | | D | D | ✓ |
| Operational Governance Arrangements | JJ/AC | | | | | | D | D | ✓ |
| Theatre Stock System Implementation | JJ/AC | | | | | | | D | ✓ |
| Decision Making for High Cost Drugs | JJ/HT | | | | | | | D | ✓ |
| Departmental / Local IT systems management | JJ/HT | | | | | | | D | ✓ |
| Estates Assurance – Space Utilisation | JJ/LD | | | | | | | D | ✓ |
| Wellsky System | JJ/HT | | | | | | | | |
| Joint Committee with SBUHB | JJ/JW | | | | | | | | ✓ |
| Medical Workforce Stabilisation | JJ/MH | | | | | | | | ✓ |
| GP Out of Hours | JJ/AC | | | | | | | | ✓ |
| Major Infrastructure Investment Plan | JJ/LD | | | | | | | | ✓ |
| Infection Prevention & Control | JJ/SD | | | | | | | | ✓ |
| IRMER | JJ/JS | | | | | | | | D |
| Sickness Management Follow-up | JJ/LG | | | | | | | | |
| Human Tissue Authority Follow-up | JJ/JS | | | | | | | | |
| Validation of Emergency Department Waiting Time Data Follow-up | JJ/AC | | | | | | | | |
| Estates/Facilities Directorate – Cleaning Standards | JJ/JS | | | | | | | | |
| Commissioning – Third Sector | JJ/AC | | | | | | | | |

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| Follow up and agreed Action Implementation Tracking - | JJ/JW | | | | | | | | |
| Integrated Audit & Assurance Plans (SSU) – Withybush General Hospital Fire – Phase 2 | EJ/LD | | | | | | | | |
| Glangwili General Hospital Fire – Phase 2 | EJ/LD | | | | | | | | |
| CLINICAL AUDIT | | | | | | | | | |
| Review annual forward clinical audit plan and terms of reference | SD | ✓ | | | | ✓ | | | ✓ |
| Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit | SD | ✓ | | | | ✓ | | | ✓ |
| FINANCIAL FOCUS | | | | | | | | | |
| Review risks and controls around financial management (via Financial Assurance Report) | HT | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review Annual Summary of Single Tender Actions (STAs) | HT | | | ✓ | | | | | |
| Annual statement of financial procedures | HT | | | | | | | ✓ | |
| Immaterial over and underpayment of salaries (IC) | HT | | | | | | | ✓ | |
| Receive Post Payment Verification (PPV) report | HT | | | D | ✓ | | | D | ✓ |
| Receive PPV annual report | HT | | | D | ✓ | | | | |
| Receive Primary Care PPV report | JP | | | D | ✓ | | | D | ✓ |
| Review of Schedule of Losses & Compensation* | HT | | | | | | | | |
| Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract * | HT | | | | | | | | |

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| COUNTER FRAUD | | | | | | | | | |
| Review work plan & results from Counter Fraud activities, including anti fraud policies, etc. | CFO | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee) | CFO | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review and approve Counter Fraud Annual Report | CFO | ✓ | | | | | | | ✓ |
| Review and approve annual forward work plan for Counter Fraud activities | CFO | ✓ | | | | | | | ✓ |
| NHS CF Authority SRT Return | CFO | ✓ | | | | | | | ✓ |
| Right To Work Governance and Checks (In-Committee) | AC/RE | ✓ | | ✓ | | | | | |
| Annual Review of Requisitions (as part of main Counter Fraud update) | CFO | | | | | | | ✓ | |
| Counter Fraud, Bribery and Corruption Policy Review (3 yearly) | CFO | | | | ✓ | | | | |
| Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews* | CFO | | | | | | | | |
| ASSURANCE AND RISK | | | | | | | | | |
| External Recommendations and WHC Assurance Report | JW/CW | | | ✓ | | ✓ | | ✓ | |
| Risk Assurance Report | JW/CW | ✓ | | | ✓ | | ✓ | | ✓ |
| Risk Management Framework and Strategy | JW/CW | | | | ✓ | | | | |
| Scrutiny of Outstanding Impr Plans * | JW/CW | | | | | | | | |
| DEEP DIVE | | | | | | | | | |
| TBC * | | | | | | | | | |
| FOR INFORMATION | | | | | | | | | |
| ARAC Work Programme 2025/26 | Chair | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Audit Wales Letter regarding Future Report Writing Style | | | | | ✓ | | | | |
| National Internal Audit Reports * | | | | | | | | | |

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| REVIEW OF THE MEETING | | | | | | | | | |
| Matters & Risks for Escalation to the Board | Chair/JW | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

* To be included on agenda as applicable

Initials

| | | |
|---|--|---|
| AC – Andrew Carruthers AG – Ardiana Gjini CH – Carly Hill CW – Charlotte Wilmshurst CFO – Counter Fraud Officer CSO – Committee Services Officer EDs – Executive Directors EJ – Eifion Jones HIW – Healthcare Inspectorate Wales HT – Huw Thomas | IMs – Independent Board Members JJ – James Johns JP – Jill Paterson JS – James Severs JW – Joanne Wilson KJ – Keith Jones LC – Liz Carroll LD – Lee Davies LO’C – Louise O’Connor | LG – Lisa Gostling MH – Mark Henwood NLI – Nicola Llewellyn PK – Philip Kloer RE – Rob Elliott SA – Shaun Ayres SD – Sharon Daniel SMJ – Sian-Marie James TP – Tracy Price |
|---|--|---|

| Audit Committee Tasks | | 15 April 2025 | 8 May 2025 | 24 June 2025 | 12 Aug 2025 | 14 Oct 2025 | 9 Dec 2025 | 10 Feb 2026 | 14 April 2026 |
|--|----------------------|----------------------|-------------------|---------------------|--------------------|--------------------|-------------------|--------------------|----------------------|
| Prepare Schedule of meeting dates | JW/CSO | | | | | | ✓ | | |
| Agenda Setting Meeting with Chair & Exec Lead (at least 1m prior to mtg) | Chair/JW | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Disseminate agenda & papers 7 days prior to meeting | CSO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes and action log to be circulated within 7 days of the meeting | CSO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Produce ARAC Update Report for Board | Chair/JW/CSO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Monitor agreed actions from previous meetings | CSO | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Develop & monitor annual work plan linked to corporate objectives, assurance framework and Local and national priorities for Audit | Chair/JW | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ongoing Development of IMs (Briefings/Training/Development sessions) | Chair/JW | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Annual Report on Committee's activity for onward submission to the Board – timed to support AGS | Chair/JW | | ✓ | | | | | | |
| Process for regular and rigorous self assessment of Committee's effectiveness | Chair/JW +IMs | | | D | ✓ | | ✓ | | |
| Annual bi-lateral meeting between Chair & LCFS * | CFO | | | | | | | ✓ | |
| Independent Members private discussions with Internal & External Audit, HIW and LCFS * | All IMs | | | | | | | ✓ | |
| Assess performance of Internal Audit * | Chair/IMs | | | | | | | ✓ | |
| Assess performance of External Audit * | Chair/IMs | | | | | | | ✓ | |

* Separate meeting

10

11:40, 0 Mins

10 - Any Other Business

11 - Review of Meeting

11.1

11:40, 0 Mins

11.1 - Matters and Risks for Escalation to the Board

| For discussion

12 - Date and Time of Next Meeting

9.30am, 14 April 2026