Date	**11/02/2025**
Time	**09:30 - 13:00**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 11 February 2025

1 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 NWSSP – Audit and Assurance Services - Internal Audit (Part 1)

09:30, 0 min

2.1 Management of Bed Capacity (Limited Assurance)

09:30, 20 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)

2.2 Mortuary Services (Limited Assurance)

09:50, 20 min
James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Dylan Jones (Hywel Dda UHB - Head of Pathology Service), Simon Chiffi (Hywel Dda UHB - Head of Operations), Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

3 Audit Wales

10:10, 0 min

3.1 Revised Operational Governance Arrangements

10:10, 20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.2 **Structured Assessment - 2023 Management Response Update and 2024 Management Response**

10:30, 20 min
Anne Beegan, Urvisha Perez, Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), Huw Thomas (Hywel Dda UHB - Director of Finance), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Bruce Bolam (Hywel Dda UHB - Deputy Director Public Health/Consultant in Public Health)

3.3 **Audit Wales Update Report**

10:50, 5 min
Urvisha Perez

3.4 **Audit Wales Outline Annual Plan 2025**

10:55, 10 min
Anne Beegan, Urvisha Perez

3.5 **Review of Urgent and Emergency Care**

11:05, 0 min
Anne Beegan, Urvisha Perez

3.6 **Planned Care Review**

11:05, 0 min
Anne Beegan, Urvisha Perez

3.7 **Review of Arrangements for Capital Programme Prioritisation**

11:05, 0 min
Anne Beegan, Urvisha Perez

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4 **NWSSP – Audit and Assurance Services - Internal Audit (Part 2)**

11:05, 0 min

4.1 **Internal Audit Plan Progress Report**

11:05, 5 min
James Johns (NWSSP - Internal Audit)

4.2 **Health and Safety (Limited Assurance)**

11:10, 20 min
James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Tim Harrison (Hywel Dda UHB -

Head of Health, Safety and Security), Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

4.3 Data Quality (Limited Assurance)

11:30, 20 min
James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance), Anthony Tracey (Hywel Dda UHB - Digital Director)

4.4 Financial Management

11:50, 0 min
James Johns (NWSSP - Internal Audit)

4.5 Performance Management Arrangements

11:50, 0 min
James Johns (NWSSP - Internal Audit)

4.6 Executive Team Working

11:50, 0 min
James Johns (NWSSP - Internal Audit)

4.7 Elective Waiting List Management

11:50, 0 min
James Johns (NWSSP - Internal Audit)

4.8 Learning Lessons

11:50, 0 min
James Johns (NWSSP - Internal Audit)

4.9 Medical Workforce (Medical Locums Planned Care)

11:50, 0 min
James Johns (NWSSP - Internal Audit)

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5 Financial Focus

11:50, 0 min

5.1 Financial Assurance Report

11:50, 10 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

5.2 **Annual Statement of Financial Procedures**

12:00, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

5.3 **Counter Fraud Update**

12:05, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

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6 **Assurance and Risk**

12:10, 0 min

6.1 **Audit Tracker**

12:10, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

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7 **Governance**

12:20, 0 min

7.1 **Minutes of the Meeting held on 10 December 2024**

12:20, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

7.2 **Table of Actions**

12:20, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

7.3 **Matters Arising not on Agenda**

12:25, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

7.4 **Escalation Status Update Report**

12:25, 20 min
Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Deputy Director of Operational Planning and Commissioning)

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8 **NWSSP – Audit and Assurance Services - Internal Audit (Part 3)**

12:45, 0 min

8.1	**Targeted Intervention Governance (Reasonable Assurance)** 12:45, 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), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Deputy Director of Operational Planning and Commissioning)*
9	**For Information** 12:55, 0 min
9.1	**ARAC Workplan 2024/25** 12:55, 0 min
10	**Any Other Business** 12:55, 0 min
11	**Review of Meeting** 12:55, 0 min
11.1	**Matters and Risks for Escalation to the Board** 12:55, 0 min
12	**Date and Time of Next Meeting** 12:55, 0 min

Table of contents

11/02/2025 09:30 - 13:00

1

09:30, 0 Mins

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1 - 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

09:30, 0 Mins

2 - NWSSP – Audit and Assurance Services - Internal Audit (Part 1)

2.1

09:30, 20 Mins

2.1 - Management of Bed Capacity (Limited Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine)

For assurance

Attachments

2.1 Mgmt of Bed Capacity Final IA Report.pdf

Management of Bed Capacity

Final Internal Audit Report

2024/25

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2425-14
Fieldwork	November 2024 – January 2025
Executive Sign Off	26 January 2025
Audit Committee	February 2025
Executive Lead	Andrew Carruthers, Chief Operating Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This review has sought to provide assurance on the arrangements of established bed capacity baselines, and the allocation and utilisation of beds including the use and de-escalation of surge beds.

Overview

Positive actions have been undertaken to remodel ward established core bed numbers and reducing surge beds at Withybush General Hospital as part of the Target Intervention programme, scrutiny of surge usage and de-escalation at daily hospital and Health Board patient flow meetings and the coordinated approach to reviewing established core bed number against nurse staffing levels as part of the statutory requirement for Section 25B wards.

However, we have concluded **limited** assurance on this area with the following findings requiring management attention:

- Little to no evidence to support established core bed numbers for Section 25A wards [High Priority]
- Variances in the established core bed numbers [High Priority]
- Multiple sources of established core bed numbers with varying figures [High Priority]
- Lack of a formal service change process, including the adjustment established core bed numbers [High Priority]
- Interpretation of surge and 'flex' beds potentially led to variances in established core bed numbers [Medium Priority]

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

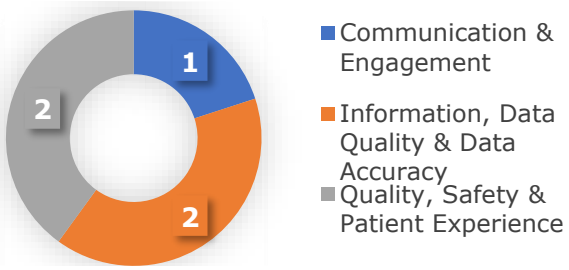
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Established ward bed base numbers have been agreed across the Health Board	1, 2, 3	**Limited**
2	Service changes accurately reflect the establishment resource required and is supported by key data, including acuity levels and key quality drives	4	**Limited**
3	A process for the utilisation and de-escalation of surge beds, including the authorisation of resources, has been agreed and implemented	5	**Reasonable**

Management Actions

4	1
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Established ward bed base numbers have been agreed across the Health Board	**Limited**

Overview / Summary of Observations

Established core bed numbers are regularly reported to the hospital and Health Board patient flow meetings through the daily 'sitrep' reports. The reports also details other key related information including the number of occupied beds, utilised surge beds and patient 'boarding' numbers.

Established core bed numbers are also recorded in the WPAS[1] and reported on the Health Board's IRIS Dashboard, whilst a review and calculation of Section 25B wards are undertaken as per the requirement of the Nurse Staffing Levels (Wales) Act.

The approach taken to calculating nurse staffing levels for Section 25B wards considers numerous key factors including bed numbers. The recent Internal Audit Nurse Staffing Act report (Ref. HDU-2425-18) confirmed that all Section 25B wards demonstrated compliance with the prescribed methodology and triangulated approach set out within the Act.

However, this approach is currently not a requirement under the Act for Section 25A wards. Whilst we noted the same approach is considered when reviewing Section 25A wards, there was a lack of evidence from key factors to justify established core bed numbers.

A reconciliation of the established core bed numbers recorded in the patient flow daily 'sitrep' reports identified variances against the core bed numbers held by Finance and Informatics, including the reporting of closed wards.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Evidence to Support Core Bed Numbers** A review of Section 25A wards across the Health Board's four acute sites noted very little evidence to support the established core bed numbers.	Patient safety is impacted due to inappropriately resourced wards resulting from no review of supporting data.	**Agreed Action:** An exercise on the reconciliation of actual numbers of core beds within the WPAS system will be undertaken to ensure the accuracy of reported number.
			Expected Evidence of Implementation: 1) Agreed implementation plan for core bed reconciliation on WPAS.
		High Priority	**Officer:** Deputy General Manager Carmarthenshire **Date:** 31st March 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	

[1] Welsh Patient Administration System

2	**Established Core Bed Numbers** Of the 69 acute hospital wards listed on WPAS (and published on the IRIS Dashboard), testing identified: • Five wards that are closed continue to be listed in WPAS with assigned established core bed numbers. • 21 wards where bed numbers on the patient flow daily 'sitrep' reports do not match to the figures listed in the WPAS. • 18 wards where bed numbers held by Finance do not match the figures listed in the WPAS. • 12 wards where bed numbers held by Finance do not match the figures listed in the patient flow daily 'sitrep' reports. • 11 wards that were not listed on either the patient flow daily 'sitrep' reports or Finance held information.	There is a financial risk to the Health Board due to the incorrect reporting of established core bed numbers. **High Priority**	**Agreed Action:** Following an exercise on the reconciliation of actual numbers of core beds with the WPAS system, this will be shared with other departments and services to ensure ward core bed numbers correctly aligned. **Expected Evidence of Implementation:** 1) Agreed implementation plan for core bed reconciliation on PAS and the sharing of agreed number with other departments and services 2) Process in place for monthly bed returns from Senior nurse managers and subsequent PAS updates 3) Power BI dashboard available to view returns **Officer:** Deputy General Manager Carmarthenshire & Head of Information Services **Date:** 31st March 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
3	**Consolidation of Core and Surge Bed Numbers** There is a lack of a triangulated approach and a central repository to ensure the accuracy of current established core and surge bed numbers across the organisation that employees, departments and services can access.	Multiple sources holding core bed number resulting in the use and reporting of incorrect data. **High Priority**	**Agreed Action:** The triangulation of data in a central repository will be addressed as part of the implementation of the new *Pt-Flow* and *E-Obs* system – a hospital wide 'at a glance' summary is included in the deliverable system – for all staff that need access to this. In the meantime, appropriate staff will be trained on how to record opening of beds identifying them as surge on the WPAS. **Expected Evidence of Implementation:** 1) A central repository for ward bed numbers will be establish following the configuration and implementation of the new *Pt-Flow* and *E-Obs* system 2) Agreed training plan for recording beds as surge and record of training undertaken **Officer:** Deputy General Manager Carmarthenshire **Date:** 31st March 2025 (interim solution) then involvement in *E-Obs* system configuration when available
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 2: Service changes accurately reflect the established resource required and is supported by key data including acuity levels and key quality drivers	**Limited**

Overview / Summary of Observations

The Designated Person responsible for calculating NSL for Section 25B wards on behalf of the Health Board is the Director of Nursing, Quality & Patient Experience aided operationally by the Head of Nursing for Professional Standards and Regulation and Finance Business Partner (Planning & Major Projects). A review the NSL of each ward to ensure they have been accurate calculated in line with bed numbers and the other key supporting data

Where adjustments to established core bed number are required to be made, this would be communicated to the Finance Business Partner who would calculate the cost of the adjustment before submitting it to the Designated Person for scrutiny and approval. The Designated Person presents these changes on a six-monthly basis to the Health Board with the recent NSL paper submitted in November 2024.

A review of the proposed service changes to Padarn Ward in the recent NSL paper confirmed that supporting data, including established core bed numbers was reviewed, in addition to acuity levels, key quality indicators.

However, there is a lack of a formal service change process, including adjustments of established bed core numbers for all other Section 25 wards.

Key Findings		Risk & Impact	Agreed Management Action
4	**Service Changes Process** There is a lack of a formal service change process, including the adjustment of established bed core numbers for all Section 25 wards.	Patient safety is impacted due to inappropriately resourced wards resulting from no review of core bed numbers.	**Agreed Action:** To ensure a consistent approach for service changes, the establishment of a change procedure to modify core bed numbers will be developed. This solution will be superseded following the implementation of the new *Pt-Flow* and *E-Obs* system.
			Expected Evidence of Implementation: 1) Agreed sign-off procedure for changes to core bed numbers and completion of implementation confirmation
		High Priority	**Officer:** Deputy General Manager Carmarthenshire **Date:** 31st March 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 3: A process for the utilisation and de-escalation of surge beds, including authorisation of resources, has been agreed and implemented	**Reasonable**

Overview / Summary of Observations

There is a clear Health Board-wide process in place for the utilisation and de-escalation of surge beds. The impact of key defined factors, including delayed patient discharge, ambulance handover/ emergency department numbers, closure of beds, infection control issues and the repatriation of patients contribute to increased service demands that result in the temporary use of surge beds.

Actions to de-escalate the use of surge beds was evident at the daily hospital and Health Board patient flow meetings with scrutiny evident from the identified organisational lead including ad hoc meetings throughout the daily to obtain updates and review progress of implemented actions.

The use of surge beds requires additional resource to be committed by the ward in order for the beds to be utilised, whilst 'flex beds' is the use of additional beds within the established resource (i.e. no commitment of additional expenditure required).

We noted that the interpretation of surge and 'flex' surge beds varies across staff and sites that has potentially led to variances in established core bed numbers (as identified in Objective 1).

A review of hospital bed provision and alternative care models has been undertaken as part of the Health Board's Targeted Intervention (TI) programme Financial Roadmap (Domain 1 - Finance, Strategy & Planning). These plans include the net reduction of 35 closed beds at WGH, 25 of which are surge beds, whilst additional plans to close the forecast deficit include operational teams being tasked with setting out actions and steps to close all remaining surge capacity. We can confirm that the submission of bed remodelling proposals for WGH wards to the Financial Control Steering Group (FCSG) in October 2024. The proposal was subsequently approved by the FCSG.

	Key Findings	Risk & Impact	Agreed Management Action
5	**Surge and Flex Beds** The interpretation of surge beds and 'flex' beds varies across staff and sites that has potentially led to variances in established core bed numbers (as identified in Objective 1).	Patient safety and financial risk is impacted due to the varied interpretation of surge and 'flex' beds resulting in incorrect bed numbers being reported.	**Agreed Action:** To confirm the consistent interpretation of surge beds and 'flex' beds, actions will be taken to as part of the new *Pt Flow* and *E-Obs* system development, to ensure a clear delineation of all the bed types on the hospital 'at a glance' view to be included.
			Expected Evidence of Implementation: 1) The configuration of the hospital 'at a glance' view on the new *Pt-Flow* and *E-Obs* system to clearly identify surge and 'flex' beds 2) Agreed training plan for recording beds as surge and record of training undertaken
		Medium Priority	**Officer:** Deputy General Manager Carmarthenshire & Head of Information Services
	Theme: Communication & Engagement	Control Operation	**Date:** 31st March 2025

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.

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

2.2 **09:50, 20 Mins**

2.2 - Mortuary Services (Limited Assurance)

James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Dylan Jones (Hywel Dda UHB - Head of Pathology Service), Simon Chiffi (Hywel Dda UHB - Head of Operations), Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

For assurance

Attachments

2.2 Mortuary Services (Jt SBUHB HDdUHB) Final IA Report.pdf

Mortuary Services

Final Internal Audit Report

2024/25

Swansea Bay University Health Board
Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	SBU-2425-16 / HDU-2425-21
Fieldwork	October - November 2024
Executive Sign Off	14 January 2025
Audit Committee	23 January 2025 (SBUHB)/ 11 February 2025 (HDUHB)
Executive Lead	Christine Morrell (SBUHB) & James Severs (HDUHB) - Executive Directors of Allied Health Professions & Health Science
Audit Team	Osian Lloyd & James Johns, Heads of Internal Audit
	Felicity Quance & Sophie Corbett, Deputy Heads of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Joint review of the arrangements in place between Swansea Bay and Hywel Dda University Health Boards to support the effective provision of mortuary services, ensuring compliance with Human Tissue Authority regulations. The audit focussed on the arrangements in place for mortuary services only and did not review the wider pathology service as a whole.

Our joint audit review of mortuary services was originally planned for 2023/24 but was deferred at the request of both health boards as they were due to have Human Tissue Act (HTA) audits.

Overview

The South-West Wales regional pathology programme brings together three organisations - Swansea Bay (SBUHB) and Hywel Dda (HDUHB) University Health Boards and Public Health Wales. A Strategic Outline Case to support the development of a regional pathology service was approved by Welsh Government in November 2020 and an Outline Business Case (OBC) was being developed at the conclusion of our review. However, the programme is effectively 'on hold' pending confirmation from Welsh Government over capital funding.

Independently of any decisions relating to the capital financing of the wider programme, both health boards (SBUHB and HDUHB) have agreed to work together in order to ensure the full and consistent provision of a mortuary service across the health boards' regions, including a mutual staff sharing arrangement to support service continuity.

Our review has concluded that despite the commitment of the Regional Pathology Programme Director and efforts of other staff, progress with taking the programme forward has been slow due to funding and staff capacity issues. These challenges with both funding and that there is minimal programme management resource available have been recognised by both health boards and have been clearly documented.

We have concluded limited assurance on this area. The significant matters requiring management attention by each health board include:

- There is a need to strengthen the documentation of roles and responsibilities, including in relation to the role of the Designated Individual (DI) and to clarify the financial arrangements between the health boards.
- The programme management structure for the mortuary element of the Regional Pathology Programme requires a review. It does not have a clear scope, delivery plan or a mechanism for recording key risks.
- Funding issues have clearly impacted capacity to deliver the Programme. Key leadership roles have not been recruited resulting in the lack of robust business continuity arrangements when the Regional Pathology Programme Director's two-year secondment ends in February 2025.
- There is a need to review governance structures, to ensure they are effective and provide sufficient oversight over the mortuary element of the Programme.

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

Scope & Assurance Summary

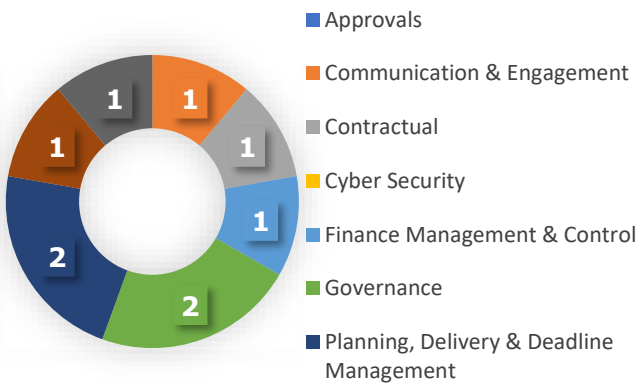
	Objectives	Related Findings	Assurance
1	Roles and responsibilities are clear to support co-ordination and oversight over arrangements for programme delivery.	1,2,3,4	**Limited**
2	There is an approved plan in place to establish the joint mortuary service, setting out the key deliverables and milestones with arrangements in place for monitoring and reporting progress.	5, 6, 7, 8	**Limited**
3	The health boards receive sufficient information on the programme's delivery, ensuring key risks and issues are reported and escalated where appropriate.	9	**Limited**

Management Actions

4 High Priority

5 Medium Priority

Themes



Risk Types

Financial Loss

Quality or Safety Issues

Public Perception & Reputational Risk

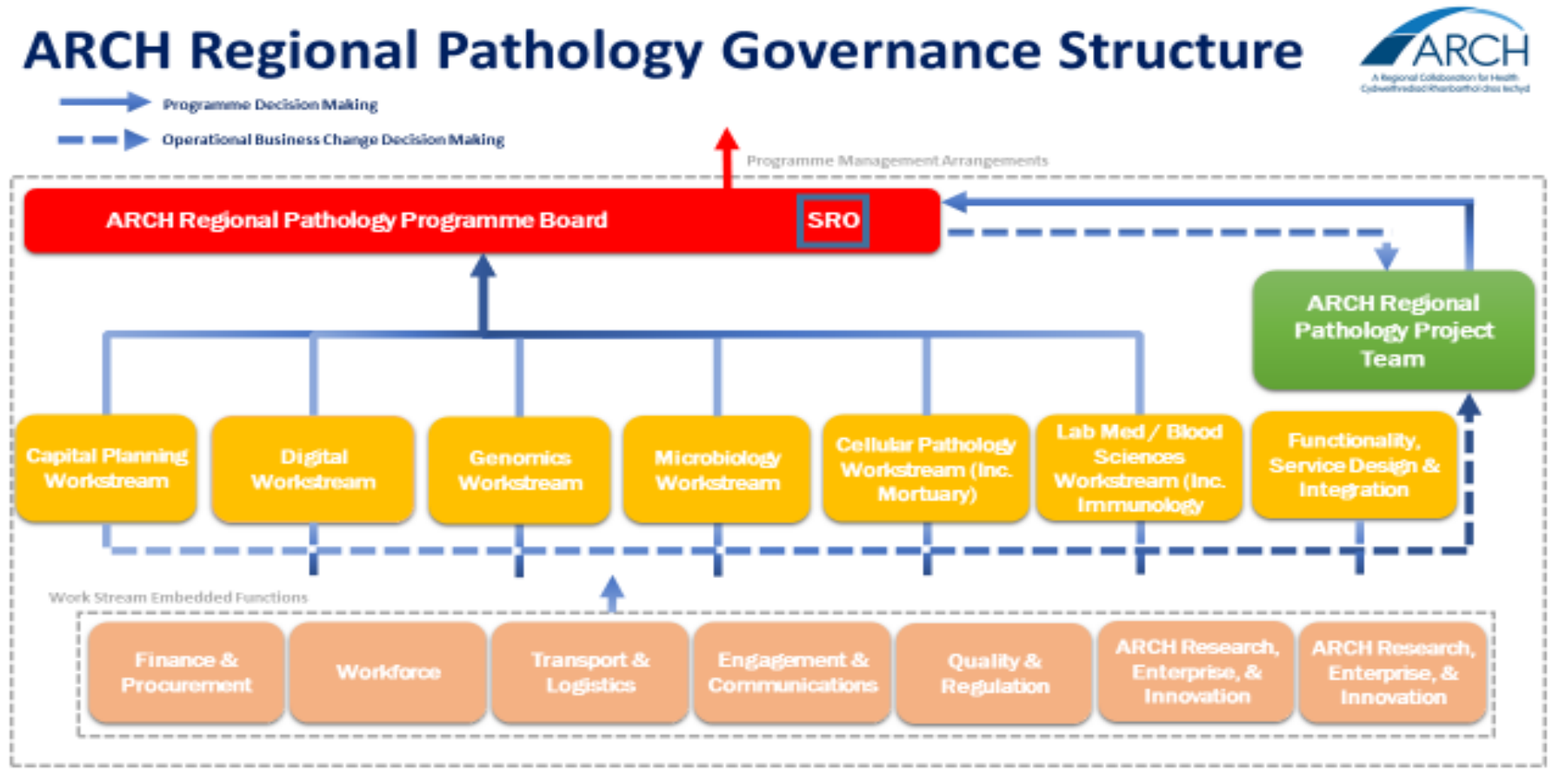
At a Glance:

Pathology services across South-West Wales have been severely challenged due to a number of factors, including critical workforce shortages, poor estates and health and safety concerns. Morriston Hospital has been identified as the location for the new regional build within the South-West Wales regional pathology programme. The laboratory will incorporate regional services for Cellular Pathology, Immunology, Microbiology and also Blood Sciences (where feasible). Due to the availability of capital funding, mortuary services will remain in its existing building which will be refurbished accordingly.

A Transitional Memorandum of Understanding (MoU) between SBUHB and HDUHB relating to the 'Operational Delivery Network South-West Regional Pathology' was approved in May 2024, which shall continue until 31 March 2025 or until such time as the pathology operational delivery network (ODN) programme is fully operational.

Regional Pathology Governance Structure (ARCH)

The Regional Pathology governance structure (below) details the cellular pathology workstream, which includes the mortuary element, as part of the ARCH Regional Pathology Programme Board:



Findings & Agreed Action Plan

Objective 1: Roles and responsibilities are clear to support co-ordination and oversight over arrangements for programme delivery.	**Limited**

Overview / Summary of Observations

There is a Transitional Memorandum of Understanding (MoU) between the health boards that supports the Operational Delivery Network (ODN) for the South-West Wales Regional Pathology Programme (the Programme). This includes the terms of reference for both the Pathology ODN Delivery Board and the Pathology ODN Operational Group. A signed version of the MoU could not be provided during our review, (see **Key Finding 1**) but has been approved by both health boards in May 2024.

Roles and responsibilities are also detailed within a Mortuary Service MoU, which assists with providing a consistent service provision across the two health boards (bereavement services are not included as part of the agreement as both organisations have different approaches to this service). The document has been signed, but we have been unable to confirm how the MoU has been shared within both health boards (see **Key Finding 1**).

Job descriptions have been prepared for the key regional posts currently in place, but not for the Designated Individual (DI) that undertakes this responsibility for both health boards (see **Key Finding 2**).

Funding arrangements between the health boards need to be strengthened to clearly evidence the recharge between them for costs relating to the regional mortuary service and the ODN (see **Key Finding 3**).

Both health boards work on a regional basis through ARCH (A Regional Collaboration for Health), but there is a lack of clarity within the programme structure to ensure that there is sufficient co-ordination over the regionalisation of the mortuary services and that roles and responsibilities are clearly defined (see **Key Finding 4**).

	Key Findings	Risk & Impact	Agreed Management Action
1	**Memorandum of Understanding** Roles and responsibilities have been clearly documented within the Transitional MoU and Mortuary Service MoU. While the Transitional MoU has been approved by both health boards in May 2024, no signed version of the document could be located during our review. The Mortuary Service MoU was originally instigated in 2022 to address staffing issues in HDUHB. The document has been reviewed and approved by the Chief Executives of both health boards in March 2024. However, the contact point for SBUHB is not recorded within the document; and we have been unable to confirm the reporting of the MoU within the health boards and its communication to mortuary staff.	Unclear roles and responsibilities could lead to the regional pathology programme not being delivered, ineffective use of resources and a lack of value for money.	**Agreed Action:** We will ensure the Transitional MoU is signed and the document is easily accessible. The Mortuary MoU will be reviewed and updated to ensure key contact information is included, and we will ensure the final version is circulated appropriately within both health boards and communicated to mortuary staff. **Expected Evidence of Implementation:** Signed Transitional MoU document Revised Mortuary MoU

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Transitional MOU signature, Neil Miles, Regional Pathology Programme Manager Mortuary MOU contact and communication to staff – Yasmin Brown, Regional Mortuary Manager **Date:** 31/03/2025
	Theme: Governance	Control Design	
2	**Job Planning – Designated Individual** The current regional posts in place are the Regional Mortuary Manager, two Regional Senior Technical Leads and the DI. We were provided with the job descriptions for these posts apart from the DI role, which is detailed within Section 18 of the Human Tissue Act (HTA) 2004 legislation. The postholder undertakes a consultant pathologist role and has a DI responsibility within SBUHB, but we have not been provided with a copy of his current job description to confirm that this role is sufficiently detailed. The DI role has been extended to HDUHB. While a job planning meeting has been undertaken, no formal job plan has been agreed to encompass his regional responsibilities.	Roles and responsibilities are not clearly defined, which could impact the delivery of the mortuary service and may result in non-compliance with legislation.	**Agreed Action:** Outcome of job planning discussion, including DI role and job plan on a regional basis, with Dr MB to be finalised and agreed. The job plan will be subject to an annual review which will be undertaken by SBUHB with an HBUHB operational member of staff (DJ or CB). **Expected Evidence of Implementation:** Agreed job plan uploaded onto Allocate; annual review scheduled.
		Medium Priority	**Officer:** Liz Humphries, Interim Directorate Manager, Pathology, SBU **Date:** 31/03/2025
	Theme: Contractual	Control Design	
3	**Financial Responsibilities** The Transitional MoU details in respect of the ODN that the "*Health Boards agree to share the costs and expenses arising in respect of the Project between them in accordance with the Contributions Schedule set out in Annex D*," and that the	Financial arrangements are unclear leading to disputes in relation to recharges.	**Agreed Action:** We will formally document the agreement between the health boards of shared costs for the provision of the regional mortuary service and ODN.

	Key Findings	Risk & Impact	Agreed Management Action
	Schedule will be approved within three months of the date of the Transitional MoU (May 2024). We note that the development of the ODN has been impacted by capital funding and the delivery plan is behind schedule, however, the ODN Service Specification and commissioning arrangements have not been finalised. This would assist in determining how the ODN, including leadership roles, will be financed. In relation to the regional mortuary service provision, there is a spreadsheet that details the basis for the sharing of staffing costs between the health boards. However, current arrangements need to be more explicit to confirm the basis of the recharge.		**Expected Evidence of Implementation:** SLA document developed detailing financial arrangement between the Health Boards to establish the Mortuary service.
		Medium Priority	**Officer:** Edward King, Finance Manager, Morriston SBU **Date:** 31/03/2025
	Theme: Finance Management & Control	Control Design	
4	**Programme Structure** Originally, regionalisation of the mortuary services was conceived as a separate workstream within the programme focusing on the capital build. The scope was extended to encompass staffing issues at HDUHB and the ODN, but mortuary now forms part of the Regional Pathology Cellular Pathology Working Group. This has resulted in gaps within the project management process as there is no clearly defined project scope outlining roles and responsibilities. Additionally, the terms of reference provided for the cellular pathology working group are dated 2022 and would benefit from a review as the document details that, "*arrangements shall be reviewed on at least a 6 monthly basis*."	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver the regionalisation of the mortuary service.	**Agreed Action:** We will ensure that the scope of the regionalisation of the mortuary services is clearly detailed along with roles and responsibilities. Terms of reference for the cellular pathology working group will be reviewed and approved. Review existing HTA regional and regional meetings and focus on HTA issues and utilise new operational groups to discuss regional mortuary operational matters.
			Expected Evidence of Implementation: Regional Management Meeting and Regional Mortuary Operations meeting structure to be adopted. Revised ToR and meeting agenda and papers to provide the evidence
		High Priority	**Officer:** Craig Baker, Cellular Pathology Service Manager, HDU **Date:** 31/03/2025
	Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 2: There is an approved plan in place to establish the joint mortuary service, setting out the key deliverables and milestones with arrangements in place for monitoring and reporting progress.	**Limited**

Overview / Summary of Observations

There was a dedicated ARCH Regional Pathology programme team (the programme team) in place from 2023 to support delivery of both the OBC and the ODN. While the OBC has been drafted, it has yet to be submitted. The delivery of the programme has been impacted while waiting for clarification from Welsh Government over funding.

Welsh Government funding had been provided towards fee support for the supply chain partner and the programme team's staffing costs for the business case and ODN development. However, at the conclusion of our review, only the Regional Pathology Programme Director remains within the team and other fixed-term contracts have now ended. As part of the 2024/25 IMTP process, SBUHB has submitted a capital prioritisation form to Welsh Government on behalf of the region that includes the pathology capital scheme, but it is unclear when the health boards will be notified of the outcome.

If external funding is granted, there is limited capacity currently to progress delivery of the programme. Further, business continuity arrangements are currently not robust when the Regional Pathology Programme Director's secondment ends in February 2025 (see **Finding 5**).

Similarly, as a regional workforce structure has yet to be finalised, the lack of capacity to develop the joint mortuary service has impacted the standardisation of policies and procedures; and there are also digital limitations, e.g. different systems are used. There is currently no dedicated delivery plan to establish the joint service (see **Finding 6**) nor a project Risk Action Issue Decision (RAID) log to ensure that any key mortuary service risks are captured, regularly monitored and escalated appropriately (see **Finding 7**).

There is a documented communications and engagement plan for Regional Pathology. Several engagement workshops have been held with staff across both health boards, and once there is clarity over the direction of the programme, the plan would benefit from an update to ensure that actions have clearly defined timescales and progress with implementing them is reported (see **Finding 8**).

Despite these challenges, operationally, the existing mortuary service provisions within both health boards remain unaffected; but existing facilities are not suitable, e.g. undersized to meet forensic and religious requirements. Regional working has addressed the mortuary staffing issues previously experienced within HDUHB including dedicated managerial support and the provision of joint training sessions across both health boards.

Key Findings		Risk & Impact	Agreed Management Action
5	**Availability of Programme Resource** The Transitional MoU details key leadership roles for ODN delivery, including the Regional Pathology Network Director; Network Clinical Director and the Pathology Transformation Programme Director. While job descriptions have been prepared, there has been no recruitment into these posts which will result in a lack of continuity when the Regional Pathology Programme Director's two-year secondment ends in February	Loss of knowledge and lack of resources to deliver the programme and ODN.	**Agreed Action:** We will ensure that all key issues and lessons learnt relating to the programme are documented. These will be shared at the Regional Management Meeting and Regional Mortuary Operations meeting (see key finding 4) to ensure they are considered and amendments made / changes embedded as the programme progresses.

	Key Findings	Risk & Impact	Agreed Management Action
	2025. It may also result in the health boards being unable to go live with the ODN from April 2025 as planned (a review is currently being undertaken to assess the readiness of the Network). During our audit, there was a reliance on the Regional Pathology Programme Director to provide operational documentation rather than the wider programme evidence he was responsible for. Key issues and lessons learnt relating to the programme have not been documented.		**Expected Evidence of Implementation:** Lessons learned reflection report to be completed.
		High Priority	**Officer:** Neil Miles, Programme Director, Regional Pathology, ARCH **Date:** 31/03/2025
	Theme: Resourcing	Control Design	
6	**Mortuary Service Delivery Plan** Finding 4 highlighted gaps in how the mortuary element was incorporated in the wider programme. This also includes not having a clear plan for the joint mortuary service that includes timescales to deliver the following: • standardising processes between the two health boards as currently there are no regional documented policies and procedures in place; • mechanisms to share information currently held separately by each health board, e.g. quality management, SharePoint sites, etc; • use of technology, e.g. the Regional Mortuary Manager uses two laptops to access the information of each respective health board; • the regional workforce plan for future mortuary service provision, which has been discussed but had not been finalised by the conclusion of our review;	Performance is not effectively monitored leading to a failure to deliver the joint mortuary service.	**Agreed Action:** A dedicated delivery plan will be developed for the regionalisation of the mortuary service that will incorporate SMART criteria to define success and provide realistic timescales for delivery.
			Expected Evidence of Implementation: A SMART plan to be developed documenting year 1 achievements of the regional mortuary service and a delivery plan for year 2 as part of the annual planning exercise currently ongoing in both Health Boards.

Key Findings		Risk & Impact	Agreed Management Action
	• identifying training needs of the mortuary staff as currently no regional training plan has been developed. We note that there has yet to be an opportunity to reflect on common themes or joint learning arising from the HTA audits at both health boards; and • communication and engagement noting there are currently no joint team meetings across the two health boards (although there are regional DI and HTA meetings).	**High Priority**	**Officer:** Liz Humphries (Lead) with Yasmin Brown **Date:** 31/03/2025
	Theme: Planning, Delivery & Deadline Management	Control Design	
7	**Risk Management** Operational mortuary service risks are documented separately by each health board. SBUHB's register includes a risk relating to the insufficient mortuary staffing numbers with the adequacy of the control noted as 'inadequate'. All of the other five SBUHB mortuary service risks record inadequate controls are in place. The HDUHB's mortuary service risk register details six risks with five rated as an extreme current risk level (the other was high). The extract provided did not detail the controls. There is no overall project register that documents the risks to delivery of the regionalisation of the mortuary service. There is a Programme RAID log detailing both strategic and operational risks, including funding risks, but mortuary service risks are not detailed. We also note that the Cellular Pathology workstream's RAID log does not detail any risks at all.	Inconsistent management with inadequate escalation of key risks.	**Agreed Action:** A dedicated risk register will be developed to incorporate risks relating to the regionalisation of the mortuary service. A Regional Mortuary Operational Management Group will be formed whose terms of reference will include oversight of this risk register, which will be a standing agenda item. Risks will be escalated to the ODN Operational Group, where appropriate. **Expected Evidence of Implementation:** SBU Risk Register review undertaken. Monthly SBU Mortuary (and Cell Path) risk register review. Feeds into monthly CGRM Pathology meeting HDU Risk register updated regularly. Shared with HDU Pathology wide monthly risk register meeting. Regional Risk management update as part of the existing Regional HTA meeting (monthly). Terms of reference for the Regional Mortuary Operational Management Group meeting. Agendas for the Regional Mortuary Management Group.

Key Findings		Risk & Impact	Agreed Management Action
		Medium Priority	**Officer:** Craig Baker, Cellular Pathology Service Manager, HDU **Date:** 31/03/2025
	Theme: Risk Management	Control Design	
8	**Communications & Engagement Plan** A Communications & Engagement Plan was developed in July 2022 to ensure there is regular engagement of the Regional Pathology Programme. Thirteen actions are detailed within the Plan, but there are no clear timescales for delivery. Noting the passage of time from the release of the Plan, there is scope for such to be reviewed and updated as well as to confirm the reasonableness of the actions included.	Opportunities to raise internal and external awareness may be missed.	**Agreed Action:** To review Communications and Engagement plan as part of the review of the ODN implementation progress during March 2025.
			Expected Evidence of Implementation: Revised communications plan and actioning of that plan in 2025/26.
		Medium Priority	**Officer:** Neil Miles, Programme Director, Regional Pathology, ARCH **Date:** 31/03/2025
	Theme: Communication & Engagement	Control Design	

Objective 3: The health boards receive sufficient information on the programme's delivery, ensuring key risks and issues are reported and escalated where appropriate.	**Limited**

Overview / Summary of Observations

Arrangements need to be strengthened to ensure adequate oversight of the regional pathology programme. The current reporting structure is too complex, particularly when you consider the need to factor in staff's capacity to prepare papers and to attend the various meetings within the governance structures for ARCH (see **page 3**); HTA Assurance; and the ODN Delivery.

When the ODN was being developed, a dedicated Board was in place along with various sub-groups that met regularly, including Commissioning & Finance and Workforce and Digital. However, meetings for the ODN Delivery Board have either been cancelled (none have been held since June 2024) or not been quorate (March 2024) (see **Finding 9**). The ODN Operational Group, whose terms of reference are detailed in the Transitional MoU, has never met and while most of the existing sub-groups continue to meet, there is no robust mechanism in place to ensure there is adequate reporting and escalation of key issues.

The health boards have differing operational reporting arrangements. While both have an operational group reporting into the regional HTA Assurance Group, HDUHB has recently established their own HTA assurance group (at the conclusion of our review, SBUHB were reviewing their own HTA assurance arrangements). HDUHB also have their own operational management meeting reporting into the monthly regional Designated Individual meeting. However, there is no equivalent for SBUHB.

In terms of wider reporting within the health boards (focusing on the period January-October 2024), there has been reporting of operational arrangements within the mortuary service, e.g. capacity as part of winter planning. However, there have been limited updates on the mortuary element of the Regional Pathology Programme and the frequency of committee reporting is not in line with the Transitional MoU (see **Finding 9**):

- Within SBUHB, there was a report in July 2024 to the Quality, Safety & Patient Experience Group (Morriston); and updates on regional working and progress with addressing actions from a recent HTA audit reported to the Patient Safety & Compliance Group (June and September 2024). The Population Health & Partnerships Committee received a verbal update on ARCH (June 2024), but meeting minutes do not reference a discussion on the Regional Pathology Programme. We did not find evidence of any recent reporting to Quality and Safety Group.
- Within HBUHB, a detailed ARCH update that included progress with the Regional Pathology Programme was reported to Strategic Development and Operational Delivery Committee (February and June 2024). The terms of reference for the HTA Assurance Group were approved by Quality, Safety & Experience Committee (November 2024).

Both health boards have been directed under Section 12(3) of the National Health Services (Wales) Act 2006 to establish a joint committee, whose role includes exploring regional solutions that will progress sustainable service provision and improved quality and outcomes, whilst addressing workforce, infrastructure and financial constraints. Both health boards attended a joint Board to Board meeting on 17 October 2024, to develop a joint ambition and consider how to strengthen the existing regional working arrangements that were already in place, including that of the Regional Pathology Programme. The inaugural meeting of the Joint Committee is scheduled to take place in January 2025, to include drafting of the Terms of Reference, for consideration and subsequent approval by both Boards at the end of January 2025.

Key Findings		Risk & Impact	Agreed Management Action
9	**Governance Oversight** The governance structure that incorporates the ODN, ARCH and HTA Assurance does not provide sufficient oversight of arrangements in relation to the mortuary element of the Programme. We identified the following issues during our testing: • The Transitional MoU details that the "*quality and safety and finance and performance committees of each Health Board will review, at least annually, a report for the joint service on its quality and safety performance and its operational and financial performance. Escalation of this reporting will be more frequent should it be necessary.*" There has been no recent reporting to the committees at either health board. • Recent ODN Delivery Board meetings have been cancelled, resulting in there being no robust reporting structure to escalate key issues from the sub-groups. • The cellular pathology workstream reports into the ARCH Regional Pathology Programme Board, but there is insufficient oversight over arrangements in relation to the mortuary element of the workstream. • Differences in the level of ARCH reporting to each health board. • Terms of reference for each of the HTA meetings (SBUHB, HDUHB and regional) have recently been reviewed, but we note that several verbal updates are provided for agenda items at the regional HTA Assurance meetings instead of written reports.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	**Agreed Action:** Re-establishment of ODN Board. Establishment of agreed ODN Operational Group and separation of mortuary and cellular pathology under this structure to provide focus to mortuary issues. Written reports to be standard practice in Health Board HTA assurance meetings. **Expected Evidence of Implementation:** Revised ODN Board meeting papers as evidence and ODN Operational Group. March 2025 Health Board papers. Development of HTA assurance process over recent months to include move from verbal to written papers has been implemented with templated approach across both HBs. Copies of HTA papers (HDU and SBU).
		High Priority	**Officer:** Neil Miles, Programme Director, Regional Pathology, ARCH **Date:** 31/03/2025
	Theme: Governance	Control Operation	

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

3

10:10, 0 Mins

3 - Audit Wales

3.1

10:10, 20 Mins

3.1 - Revised Operational Governance Arrangements

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For assurance

Attachments

3.1 Operational Governance Arrangements ARAC February 2025.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Revised Operational Governance Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to inform the Audit and Risk Assurance Committee of the revised Operational Governance arrangements that are to be put in place in response to recommendation R2* from the 2022 Structured Assessment process, following the establishment of the new Operational Structure within Hywel Dda University Health Board (HDdUHB).

This report has been developed in conjunction with the Corporate Governance Team, who will support the Operational Structure through its implementation.

R2
While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgency.

Cefndir / Background

The new Operational Structure within HDdUHB is to be implemented following an Organisational Change Policy (OCP) process which commenced late 2023/early 2024. This was consulted upon widely to inform its development, and subsequently refined to achieve a model that would enable a more balanced sharing of accountability and responsibility as far as possible across the operational function.

It has been agreed that there will be two posts supporting the Chief Operating Officer - 1 x Deputy Chief Operating Officer and 1 x Director of Operational Planning and Performance.

It has further been agreed that 5 Clinical Care Groups will be established within the Operational Structure as follows:

- Planned and Specialist Care Clinical Care Group (to include Scheduled Care, Cancer and Oncology, and Children, Women and Family Health)

- Mental Health and Learning Disabilities Clinical Care Group
- Community and Integrated Medicine Clinical Care Group (this Clinical Care Group will be responsible for the Carmarthenshire Integrated System, Pembrokeshire Integrated System and Ceredigion Integrated System)
- Allied Health Professionals and Health Sciences Clinical Care Group
- Primary Care Clinical Care Group (to include Medicines Management and Long-Term Care)

An Estates and Facilities Clinical Care Group is also proposed, although this is likely to move to a different Executive Portfolio, and not remain with the Chief Operating Officer, subject to agreement by the Remuneration and Terms of Service Committee.

Asesiad / Assessment

Each Clinical Care Group will have a triumvirate leadership model, made up of, in the main:

- A Service Director, who will report to the Deputy Chief Operating Officer, and be accountable (including professional accountability) to the Chief Operating Officer);
- An Associate Medical Director, who will report to and be accountable to the Service Director (and professionally accountable to HDdUHB's Medical Director);
- An Assistant Director responsible for Patient Safety, Quality and Experience, who will report to and be accountable to the Service Director (and professionally accountable to HDdUHB's Director of Nursing, Quality and Patient Experience, or Director of Allied Health Professions and Health Science, as appropriate to their professional registration).

The Clinical Care Groups will be accountable for their underpinning Clinical Service Groups, taking ownership of and seeking assurance from each.

In terms of the Clinical Care Groups' reporting arrangements, each Group will hold a fortnightly Integrated Governance Group meeting covering, on rotation, planning and performance (including financial performance, workforce management, risk management), and quality, health and safety; this reporting arrangement/approach will also be replicated within their underpinning Clinical Service Groups.

Each Clinical Care Group's Integrated Governance Group will report into the fortnightly Integrated Quality, Finance and Performance Delivery Group (IQFPDG) meetings, to coincide with their current split of agendas between planning and performance, and quality and safety (to include health and safety). A schedule has been developed for these Clinical Care Groups Integrated Governance Group meetings, to ensure an appropriate feed into IQFPDG and to ensure the agendas of the Clinical Care Groups Integrated Governance Group meetings align with IQFPDG's rhythm of meetings.

It is proposed that the Estates and Facilities Group will also hold a fortnightly Integrated Governance Group meeting, covering the same agendas as the Clinical Care Groups.

Draft Terms of Reference for each Clinical Care Group's Integrated Governance Groups have been crafted, through which to conduct their business, together with standard agendas for each of their Integrated Governance Group meetings. This will ensure the appropriate coverage of their business, depending on their alternate focus between business planning and (financial) performance and quality (health) and safety. The proceedings of these meetings will be captured within an Action Notes template, and a report based on these will be scheduled onto relevant agendas of IQFPDG meetings.

It is also anticipated that some of the work of the Clinical Care Groups will feed into a number of the Health Board's assurance Committees and Sub-Committees.

Currently, a number of Directorate Quality, Safety and Experience Groups feed into the Quality, Safety and Experience Sub-Committee (QSESC) on a rotational basis. It is proposed that the work of the Clinical Care Group's Integrated Governance Group, when focused on its quality, health and safety agenda, could provide a Quality Assurance Report (currently under development) to the Quality, Safety and Experience Committee, which would focus less on reporting from discussions at meetings and more on the quality dashboard, the quality and safety improvement to address any areas of concern, and report on areas of success to improve shared learning. However, this feed into the assurance arm of the Health Board would only take place once reports have been scrutinised at IQFPDG to consider them for any required management or operational response.

A similar feed will be put in place from the Clinical Care Group's Integrated Governance Group, again when focused on its quality, health and safety agenda, up to the newly established Health and Safety Sub-Committee (H&SSC), or alternatively, the Health and Safety team could provide a summary of emerging issues, hot topics, themes, etc to the H&SSC, either as part of their team's report or as a separate report. Again, this feed into the assurance arm of the Health Board would only take place once reports have been through IQFPDG to consider them for any management or operational response required.

Provision will also be made for standalone reports from the Clinical Care Groups to feature on Committee or Sub-Committee agendas, where directed and once scrutinised by IQFPDG, to provide any early warnings or assurance that may be required. Quality and safety matters for example, would be reported up to the Quality, Safety and Experience Committee, (QSEC) or Sub-Committee; health and safety matters to the Health and Safety Committee (HSC) or Sub-Committee; and planning matters or proposed service changes, etc to the Strategy and Planning Committee (SPC).

In order to better equip Clinical Care Groups in their establishment, each will be provided with a Standard Operating Procedure or Framework, setting out the purpose of the Clinical Care Group, its underpinning principles, leadership expectations, desired behaviours and duties.

This Standard Operating Procedure or Framework will also include a number of Annexes covering, for example, the Clinical Care Group's Membership, Roles and Responsibilities; Scheme of Delegation (including a financial Scheme of Delegation) identifying the level of autonomy/authority to be given to Clinical Care Groups/Clinical Service Groups; Integrated Governance Group Terms of Reference; Integrated Governance Group Standard Agenda Template; Action Notes Template; 3 As Reporting Template; Decision Trees (i.e. covering Business Case Development, Recruitment to Additional Posts), etc.

In respect of the IQFPDG, the current arrangements in place have been reviewed in terms of its membership to ensure an appropriate Executive Director and Officer Member composition, to include representation from each of the Clinical Care Groups Triumvirate, together with representation drawn from corporate functions.

IQFPDG's Terms of Reference have also been reviewed, to ensure the appropriate oversight of each Clinical Care Group's business.

IQFPDG will receive reports from all Clinical Care Groups prior to their being discussed at other meetings, including Committees and Sub-Committees of the Board, and endorsement from the

IQFPDG will be necessary for the progression of a range of operational matters through the Health Board's governance framework and pathways.

Where appropriate, IQFPDG will start the process for completion of papers for relevant Committees of the Board, Targeted Intervention, and other appropriate meetings.

Given that corporate functions are expected to be represented at IQFPDG, the current arrangements in place around the existing Operational Planning, Governance and Performance Group (OPGPG) are to be stood down, to be replaced by a regular touchpoint meeting between the Chief Operating Officer and Senior Team. However, these touchpoint meetings will not form part of any formal governance arrangements, as Clinical Care Groups will report directly into IQFPDG, which will in turn report into Executive Team.

Endorsement of these new Operational Governance arrangements will be required from Executive Team by mid February 2025, to ensure implementation of the revised Operational Governance arrangements can take effect by 1 April 2025.

An Operational Governance Implementation Plan has been developed, to determine the governance tasks required to take forward the new arrangements, and to identify by whom and by when. Progress against this Operational Governance Implementation Plan is currently being tracked in terms of actions required by the Corporate Governance Team and those required of the Operations Directorate and individual Executive Directors (see attached).

It is anticipated that a broader Operational Implementation Plan will be developed to address the non-governance related tasks required to establish the new Operational Structure, to be undertaken by the Operations Directorate in conjunction with Executive Director colleagues.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **RECEIVE AN ASSURANCE** on the Operational Governance arrangements to be put in place to establish the new Operational Structure within HDdUHB, in response to recommendation R2 from the 2022 Structured Assessment process.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 The purpose of the Audit and Risk Assurance Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the UHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales. 2.2 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes. 2.3 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how,

	its system of assurance may be strengthened and developed further. 2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.
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)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Chief Operating Officer and Clinical Executive Directors TI Co-ordination Group

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

OPERATIONAL STRUCTURE
GOVERNANCE IMPLEMENTATION PLAN

Task	Who	By When	Progress
Finalise the Operational Scheme of Delegation • Align to HB SOD • Review by individual EDs • ET to review SOD • Finalise delegation levels within SOD	Governance Team EDs ET Operations Directorate	04/01/25 15/01/25 29/01/25 14/02.25	Complete Complete Complete
Finalise the Standard Operating Procedure/Governance Framework for CCGs Seek approval from ET	Governance Team/Operations Directorate ET	14/02/25 19/02/25	
Develop Process Map for CCG administrators and identify any training needs	Operational Directorate with support from Corporate Governance Team	14/02.25	
Establish a Sharepoint page with links to SOP, SOD, and templates (TORs, agendas, reports, etc)	Operational Directorate with support from Corporate Governance Team	February 2025	
CCGs to schedule meetings for 2025/26 and beyond according to schedule in the SOP, including sending invites.	CCG Service Directors/ Administrators	28/02/25	
IQFPDG to approve revised TORs (for 1st April 2025)	Operational Directorate	12/03/25	
Adopt CCG IGG TORs at first meeting of CCG IGG	CCG Service Directors through IGG meetings	01/04/25	
Review effectiveness of revised operational governance arrangements, and review Quality & Safety and Health & Safety assurance governance arrangements	CCG leads/Committee Chairs and lead EDs/Corporate Governance Team	Summer 2025	

3.2

10:30, 20 Mins

3.2 - Structured Assessment - 2023 Management Response Update and 2024 Management Response

Anne Beegan, Urvisha Perez, Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), Huw Thomas (Hywel Dda UHB - Director of Finance), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Bruce Bolam (Hywel Dda UHB - Deputy Director Public Health/Consultant in Public Health)

For assurance

Attachments

3.2 Structured Assessment Management Response ARAC February 2025.pdf

3.2 HDUHB Structured Assessment 2024 Report (Final).pdf

3.2 Appendix 1 - Management Response Form - HDUHB SA 2024.300124.pdf

3.2 Appendix 2 - Structured Assessment 2022 Management Response.Outstanding~.pdf

3.2 Appendix 3 - Structured Assessment 2023 Mgmt Response Outstanding Recs.~.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Wales Structured Assessment 2024 Management Response
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Philip Kloer, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee (ARAC) is asked to take assurance from the management response (Appendix 1) to the recommendations identified by Audit Wales (AW) in their Structured Assessment 2024 (SA24) report.

Cefndir / Background

The structured assessment work undertaken by Wales Audit Office enables the Auditor General to discharge his statutory requirement under section 61 of the Public Audit (Wales) Act 2014 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency and effectiveness in their use of resources.

The key focus of the Structured Assessment 2024, attached, was on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness, corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. An update on progress against recommendations identified in previous structured assessment reports has also been included in the document.

The 2024 Structured Assessment has been considered and discussed in depth at the Audit and Risk Assurance Committee held on 10 December 2024.

Asesiad / Assessment

AW provided three recommendations in the SA24 report, in relation to:

- R1 Improving Together Framework – Director of Finance
- R2 Quality Improvement Strategic Framework – Director of Nursing, Quality and Patient Experience
- R3 Well-being Objectives and strategy refresh – Director of Public Health

The Health Board's management response, at Appendix 1, has been developed in response to these new recommendations.

AW also provided an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports. These are provided in Appendix 2 (SA22) and Appendix 3 (SA23).

Progress on implementation of the new recommendations, and the recommendations that remain open from previous Structured Assessments (outlined on page 30-32 of Structured Assessment 2024, will be monitored by ARAC throughout 2025/26.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to consider whether the management response provides assurance that the recommendations within the Structured Assessment 2024 report, and the outstanding recommendations from Structured Assessments 2022 and 2023, will be addressed appropriately.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
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:	Structured Assessment 2024 report
Rhestr Termau: Glossary of Terms:	Included in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	All relevant Executive Directors have been asked to contribute to the management response.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report.
Gweithlu: Workforce:	No direct impacts from this report.
Risg: Risk:	No direct impacts from this report.
Cyfreithiol: Legal:	No direct impacts from this report.
Enw Da: Reputational:	No direct impacts from this report.
Gyfrinachedd: Privacy:	No direct impacts from this report.
Cydraddoldeb: Equality:	No direct impacts from this report.

Archwilio Cymru
Audit Wales

Structured Assessment 2024 – Hywel Dda University Health Board

Audit year: 2024

Date issued: November 2024

Document reference: 4432A2024

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@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.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2024 structured assessment work at Hywel Dda University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Health Board's corporate approach to setting or reviewing well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.

2 Our 2024 structured assessment work took place at a time when NHS bodies were continuing to respond to a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. In addition, NHS bodies are still dealing with the legacy of the COVID-19 pandemic. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of our work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:

- board transparency, cohesion, and effectiveness;
- corporate systems of assurance;
- corporate approach to planning; and
- corporate approach to financial management.

4 We have not reviewed the Health Board's operational arrangements as part of this work. We reported a separate review of the Health Board's operational governance arrangements in July 2024. In that review, we found that the Health Board's current operations structure is complex resulting in blurred lines of accountability, and governance arrangements within directorates are inconsistent. Whilst the Health Board is progressing its new operations structure, presenting opportunities to improve governance arrangements, delays in rolling out the new structure is causing instability within directorate leadership teams.

5 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:

- model Standing Orders, Reservation and Delegation of Powers;
- model Standing Financial Instructions;
- relevant Welsh Government health circulars and guidance;

- the Good Governance Guide for NHS Wales Boards (Second Edition); and
- other relevant good practice guides.

6 In January 2024, Welsh Government escalated the whole Health Board to targeted intervention[1]. This covers all six domains of the NHS Wales escalation and oversight framework, these are: 'quality of care', 'governance', 'leadership, capability and culture', 'performance and outcomes', 'fragile services' and 'finance, strategy and planning'. The escalation status reflects the scale of the Health Board's challenges and lack of sustained progress in addressing them. In response to its escalation status, the Health Board has established a set of initiatives and governance arrangements to oversee and manage the escalation process and address the challenges at pace. This includes new Executive Team governance arrangements[2], developing a targeted intervention monitoring framework to monitor progress on the 56 de-escalation criteria, introducing an internal escalation framework, delivering key initiatives through focused 100-day cycles of work, progressing the programme of clinical services plans to address fragile services and a set of financial improvement initiatives

7 We undertook our work between April 2024 and November 2024. The methods we used to deliver our work are summarised in **Appendix 1**. Our work was conducted in accordance with the auditing standards set by the International Organisation of Supreme Audit Institutions.

8 We also provide an update in this report on the Health Board's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

9 Overall, we found that **the Health Board's corporate arrangements continue to operate effectively, despite a period of significant change, with a small number of areas that could be further improved. Whilst the financial position for 2024-25 remains extremely challenging, the Health Board is taking positive steps to get onto a more sustainable footing.**

[1] Under the Joint Escalation and Intervention Arrangements, Welsh Government officials meet Audit Wales and Healthcare Inspectorate Wales at least twice a year to discuss the performance of each health body. There are five escalation levels: routine arrangements, area of concern, enhanced monitoring, targeted intervention, and special measures. In November 2024, the Welsh Government confirmed that the Health Board would remain in targeted intervention.

[2] There are three executive level groups which report into the Formal Executive Team. These are: 'Integrated Quality, Finance and Performance Delivery', 'A Healthier Mid and West Wales' and 'Value and Sustainability' groups. A 'Targeted Intervention Co-ordination Group' co-ordinates and manages the Health Board's response to Targeted Intervention.

- We considered whether the Health Board's Board conducts its business, appropriately, effectively, and transparently. We found that whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.
- We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. We found that the Health Board continues to have appropriate arrangements for corporate oversight of risk, performance, tracking recommendations, and the quality and safety of services. The performance management framework however needs to be updated to reflect current performance arrangements, and more frequent updates on the implementation of the Quality Improvement Strategic Framework should be provided.
- We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery. We found that development and delivery of the Health Board's plans continue to be supported by appropriate oversight, underpinned by a pragmatic approach to addressing planning team capacity issues. There is scope to review well-being objectives as part of a planned long-term strategy refresh.
- We considered whether the Health Board has a sound corporate approach to managing its financial resources. We found that whilst the financial position for 2024-25 remains extremely challenging, the Health Board is taking positive steps to improve its financial position and to develop a roadmap to ensure financial sustainability. There remains a clear approach for financial planning and managing and monitoring the financial position, but there is a need to strengthen the approach to delivering cost savings opportunities.

Recommendations

10 **Exhibit 1** details the recommendations arising from our work. The Health Board's response to our recommendations is summarised in **Appendix 3**. [Appendix 3 will be completed once the report and management response have been considered by the relevant committee]

Exhibit 1: 2024 recommendations

Recommendations
Improving Together Framework R1 The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements: • deescalating and supporting directorates at the highest level of escalation for extended periods; and • coordinating support for directorates escalated over several domains (**see paragraph 53**).
Quality Improvement Strategic Framework R2 The Quality, Safety and Experience Committee should receive, at least annual, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (**see paragraph 60**).
Well-being objectives and strategy refresh R3 To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (**see paragraph 69**).

Detailed report

Board transparency, effectiveness, and cohesion

11 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

12 We found that **whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.**

Public transparency of Board business

13 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings; and
- business and decision-making being conducted transparently.

14 We found that **the Health Board continues to maintain a strong commitment to public transparency**.

15 As in previous years, the Board maintains its strong commitment to public transparency, with well publicised Board meetings, which members of the public can observe in-person, virtually or via a recording published on the Health Board's website. The Health Board continues to reserve private Board and committee sessions, for the most sensitive matters, with private Board agendas and a high-level summary of discussions published online. As recommended last year (see **Appendix 2 R1 2023**), committee update reports to the Board include a high-level update on matters discussed at private committee sessions.

16 Board and committee papers continue to be published on the Health Board's website a week before meetings, with late papers kept to a minimum. Last year, we noted that as recommended in 2022, the Health Board published its unconfirmed Board and committee minutes on its website soon after the meeting. However, this year the practice has not been consistently applied due to capacity constraints. It is important the Health Board publishes unconfirmed minutes shortly after meetings to maintain public transparency of business, especially as it has decided not to livestream or record its committee meetings. We continue to observe open and honest discussions at Board and committee meetings, with an improved focus on high-risk matters aided by the introduction of the Triple-A (Alert, Advise and Assure) process (**see paragraph 25**).

Arrangements to support the conduct of Board business

17 We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of a formal, up-to-date, and publicly available:

- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- policies and procedures in place to promote and ensure probity and propriety.

18 We found that **the Health Board has maintained robust arrangements to support the effective conduct of Board and committee business.**

19 The Health Board continues to review its Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions at least annually to ensure they reflect current arrangements. The Board, following scrutiny by the Audit and Risk Assurance Committee (ARAC), last approved amendments to its Standing Orders in May 2024 to reflect the establishment of the Joint Commissioning Committee[3]. The Standing Financial Instructions were also reviewed and remained unchanged. Up-to-date versions of these documents are available on the Health Board's website.

20 In March 2024, the Board approved some initial changes to responsibilities delegated to the Interim Executive Medical Director and Executive Director of Allied Health Professions and Health Science roles, but the updated Scheme of Delegation was not updated on the Health Board's website. As part of this year's main review of the Scheme of Delegation, the Health Board took the opportunity to compare the responsibilities set out within the Scheme of Delegation with the duties outlined in Executive Director's job descriptions. This exercise exposed several gaps in responsibilities within both the job descriptions and Scheme of Delegation. In October 2024, ARAC received the updated Scheme of Delegation for approval, which addresses these gaps. The Board is due to approve the final version in November 2024. As recommended in our Review of Operational Governance the Health Board will need to review its updated Scheme of Delegation as the new operations structure is rolled out.

21 Since last year, the Health Board has introduced an electronic system to manage declarations of gifts, hospitality and sponsorship. In compliance with its Standing Orders, ARAC continues to receive the annual report on the Adequacy of Arrangements for Declaring, Registering and Handling of Interests, Gifts, and Hospitality. We continue to observe compliance with Declarations of interest, which

[3] In April 2024, the NHS Wales Joint Commissioning Committee replaced the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU).

remains a standing item on all Board and committee agendas. Up to date versions of Board Member and staff registers of interests are available on the Health Board's website. There are clear processes for ensuring policies are reviewed and kept updated. Directorates are held to account on policy management through Directorate Improving Together sessions, and policy management is part of the governance domain of the internal escalation framework. Individual committees routinely receive updates on policies within their remit, which include an overview of out-of-date policies and requests for policy approval and extensions.

Effectiveness of Board and committee meetings

22 We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;
- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and
- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

23 We found that **Board and committee meetings continue to be conducted appropriately and effectively, with strengthened arrangements to escalate high-risk matters to the Board. Preparations to establish a joint committee with Swansea Bay University Health Board are progressing well.**

24 The Board and its committees continue to work effectively, with up-to-date Terms of Reference (TOR) and work programmes. During the summer of 2024, relevant committee TORs were updated to reflect oversight responsibilities in line with the Health Board's targeted intervention monitoring framework and to reflect oversight responsibilities for corporate and directorate risks, instead of strategic risks for which the Board maintains oversight.

25 The Health Board is currently reviewing its committee structure and arrangements, which have remained largely unchanged for several years. Any changes are likely to be implemented in April 2025, although a wholescale restructure is not anticipated. From our observations, Board and committee meetings continue to be well chaired and administered, with good support from the Corporate Governance Team. There is good Executive Member representation at committee meetings, and it is positive that operational officers routinely attend to present papers. Independent members continue to provide good challenge and remain open when they are not assured by the information presented. As highlighted in **paragraph 16**,

in April 2024 the Health Board introduced its Triple-A (Alert, Advise, Assure) process to strengthen its Board assurance and escalation process. Whilst still embedding, the new process seems to bring clarity to discussions, enables independent members to take assurance based on the information provided and focuses discussions on high-risk matters. It has also strengthened escalation arrangements to the Board, as committee assurance papers report on matters to 'Alert', 'Advise' or 'Assure' the Board. Those we interviewed spoke positively about the new process. The internal escalation framework, which supports targeted intervention, also uses similar assurance ratings[4].

26 Following a pause, the new Chair recommenced the committee chair's meetings in October 2024. In the interim independent members had other opportunities to meet and cross refer matters, for example through monthly meetings with the Interim Chief Executive and at Board Seminars.

27 To strengthen regional working, in March 2024, the Cabinet Secretary for Health and Social Care indicated her intention to issue a ministerial directive to the Health Board to establish a formal joint committee with Swansea Bay University Health Board[5]. Preparations for the joint committee are progressing well and in October 2024 a joint Board to Board meeting took place to discuss working arrangements. The inaugural joint committee meeting is due to take place in January 2025 and the terms of reference will be agreed by the Board in January 2025. Over the course of the year, the Board has received regular updates on the joint committee's development.

Quality and timeliness of Board and committee papers

28 We considered whether the Board and committees receive timely, high-quality information that supports effective scrutiny, assurance, and decision making. We were specifically looking for evidence of:

- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

29 We found that **the Board and its committees receive good quality, timely papers, which the Health Board is continuing to strengthen as part of ongoing improvement.**

30 The Health Board continues to use the SBAR[6] cover reports, which are clear, well written and when appropriate incorporate the Triple-A format, which strengthens the clarity of papers and assurance. The Health Board also maintains its use of

[4] The internal escalation framework uses three escalation levels: level 1 (reasonable assurance, level 2 (limited assurance) and level 3 (no assurance).

[5] https://www.gov.wales/written-statement-establishing-joint-committee-swansea-bay-and-hywel-dda

[6] Situation, Background, Assessment, Recommendation.

interactive data tools and dashboards to support information highlighted in cover reports. However, at times ARAC has received too much information on the targeted intervention monitoring framework, which can draw independent members into discussions outside of their remit. ARAC's role is to receive assurance on the systems and processes to oversee delivery of the framework, and on progress towards de-escalation by taking assurance from other committees. However, ARAC receives a very detailed progress report at each meeting which draws independent members into discussion about performance. Also, in each cycle of committee meetings, ARAC is the first, so it is difficult for it to take assurance from other committees as they are yet to take place. The Health Board has recognised that this is an issue, and work is currently underway with the nominated targeted intervention officer to address this.

31 To support ongoing improvement, independent members provided feedback on the quality of papers through the 2023-24 Board effectiveness review process (**see paragraph 42**). As a result of the feedback, the Health Board is reviewing report writing and presenting guidance, exploring alternative formats to the SBAR template and exploring systems to help assure and inform committees of areas which need a more in-depth review. There were no issues raised about the timeliness of papers.

Board commitment to hearing from patients/service users and staff

32 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- the Board using a range of suitable approaches to hear from a diversity of patients/service users, the public and staff.

33 We found that **the Board continues to hear from a range of patients and staff and has enhanced arrangements for patient safety walkabouts.**

34 At each meeting, the Board continues to receive the Improving Patient Experience Report which includes a series of links to patient experience recordings/soundbites and written comments. Together, these illustrate positive and negative aspects of patient and service user experience. To set the tone of the meeting, from November 2024 the Board will start each meeting with a patient or staff story. Relevant committees continue to receive staff and patient stories such as the Quality, Safety and Experience Committee (QSEC) and People and Organisational Development Committee (PODCC). Following feedback from the committee effectiveness review, there is also provision in the Health and Safety Committee's 2024-25 work plan to receive relevant patient stories. However, as of September 2024 the committee is yet to hear a story, the Health Board reported that it is unlikely to take this forward. In recent months the Health Board has had to make some difficult decisions, for example undertaking a managed dispersal at St

David's GP Practice in Pembrokeshire, and in-patient beds in Tregaron Community Hospital in Ceredigion. Reports received by the Board show the Health Board's commitment to hearing from the public and stakeholders to inform its decisions. In both cases, the Health Board invited feedback from the public and stakeholders using a variety of methods such as in-person drop-in events, postal and online surveys and via email and phone.

35 Board members continue to take part in regular patient safety walkabouts. Since last year, the Health Board has taken steps to clarify the process for Board members (**Appendix 2 R2 2023**). This includes refreshing a briefing document outlining the process and purpose of patient safety walkabouts, offering a briefing session to Board members as part of inductions and on-going development, and including a six-monthly update in the Quality Assurance Report received by QSEC.

36 The Health Board has an evolving 'Speaking Up' Process which allows staff to raise concerns confidentially. PODCC receives periodic updates and assurance on its continued development. The Health Board also continues to have active staff networks and advisory groups such as for BAME, LGBTQ+ and armed forces groups, which also routinely provide updates to PODCC.

Board cohesiveness and commitment to continuous improvement

37 We considered whether the Board is stable and cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and
- a relevant programme of Board development, support, and training in place.

38 We found that **the Board is managing a significant period of change well and is taking positive steps to ensure it remains cohesive and effective through Board development opportunities and arrangements for continuous improvement.**

39 The Health Board is going through a significant period of change. The new Vice-Chair and Chair joined the organisation in February and June 2024 respectively. In February 2024, the Chief Executive left, and the Executive Medical Director/Deputy Chief Executive was appointed as Interim Chief Executive, and the Executive Director of Workforce and OD took on the role of Interim Deputy Chief Executive. The Deputy Medical Director was appointed as Interim Executive Medical Director. The Interim Chief Executive was subsequently appointed substantively in October 2024 with immediate effect, which will now mean that the process for appointing a substantive Executive Medical Director can commence. Since December 2023, the Executive Director of Nursing, Quality and Patient Experience post has also been

covered on an interim basis. Additionally, in the latter part of 2023, the Health Board welcomed new Executive Directors for Public Health, and Allied Health Professions and Health Science.

40 The level of changes, coupled with the challenges facing the Health Board has the potential to de-stabilise the Board, but it has taken a pro-active approach to building cohesion and resilience. Since March 2024, the Board has been taking part in a programme of organisational development (OD) sessions as part of its wider programme of development, which have been received positively by those we interviewed. Additionally, the Health Board is also now implementing its new operational structure following a period of consultation and engagement with staff (**Appendix 2 R2 2022**).

41 The Board has maintained its robust approach to learning, development, and continuous improvement, including a programme of Board Development activities, which include the OD sessions. This year, part of the new Chair and Vice-Chair's induction programmes have been extended to all Board members through a series of optional 'lunch and learns' These refresher sessions cover topics such as patient safety walkarounds, finance, patient service and complaints, risk and estates/capital projects.

42 Arrangements for reviewing the Board's effectiveness remain strong. The process continues to draw on internal and external sources of assurance, which include committee self-assessment surveys and facilitated workshops, and the Board's annual self-review against a maturity matrix. For 2023-24, given its escalation status, the Board reduced its maturity rating from Level 4[7] last year to Level 2[8]. This shows the Board has a mature and open approach to reviewing its effectiveness. After each Board and committee meeting, there continues to be dedicated time for independent members to reflect on the meeting. This process was formalised last year to allow ongoing review of committee effectiveness, which the Health Board is reporting works well.

Corporate systems of assurance

43 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

44 We found that **the Health Board continues to have appropriate arrangements for corporate oversight of risk, performance, tracking recommendations, and the quality and safety of services. The performance management framework however needs to be updated to reflect current performance arrangements,**

[7] Level 4 is defined as 'we have well developed plans and processes and can demonstrate sustainable improvement throughout the service'.

[8] Level 2 is defined as 'we are aware of the improvements that need to be made and have prioritised them but are not yet able to demonstrate meaningful action'.

and more frequent updates on the implementation of the Quality Improvement Strategic Framework should be provided.

Corporate approach to overseeing strategic and corporate risks

45 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic and corporate risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.
- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities; and
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system and corporate risks.

46 We found that **the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.**

47 The Board continues to review its Board Assurance Framework (BAF) at every other meeting. The strategic risks set out in the BAF remain integrated with the Health Board's strategic and planning objectives and are aligned to an appropriate committee for scrutiny and oversight. This ensures that Board and committee business is informed by the Health Board's strategic risks.

48 The Health Board has an up-to-date risk appetite statement, which was approved by the Board in January 2024. The Health Board does not have a single risk appetite, instead agreeing an appropriate appetite across a range of its business areas. This is a pragmatic approach given the range of activities within the Health Board's remit.

49 The Health Board's revised Risk Management Strategy was approved by the Board in March 2024, which is supported by an up-to-date risk management framework and procedure. The strategy sets three key risk management objectives for delivery over 18 months which are being progressed. These are:

- implement and embed the refreshed risk appetite statements;
- support the strengthening of operational risk management arrangements; and
- understand how established risk management processes currently contribute to the overall health of the Health Board.

50 The Board and its committees maintain robust oversight of the Corporate Risk Register, which the Board continues to receive at every other meeting. Committees

routinely scrutinise corporate risks assigned to them, providing assurance to the Board through committee assurance reports. ARAC continues to receive the Risk Assurance Report, which provides assurance on the effectiveness of the Risk Management Framework, and progress on implementing the Risk Management Strategy. The report maintains good analysis of risk management across the organisation, including risk themes and issues. Since August 2024, the frequency of the Risk Assurance Report has increased from six-monthly to every other meeting, to reflect the Health Board's escalation status. The report now also includes a high-level summary of each directorate's escalation status in relation to their risk management process. In July 2024, there were four directorates at the highest level of escalation (level 3), these being the operational, facilities, planned care, and women and children's directorates. In May 2024, the Chair of ARAC issued a letter to the Executive Team to highlight concerns about overdue risks and audits.

Corporate approach to overseeing organisational performance

51 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

52 We found that **Board and corporate oversight of organisational performance has been strengthened, however there is a need to update the performance management framework to ensure it reflects current arrangements**.

53 The Health Board has updated its performance management arrangements since the Board approved its Improving Together Framework in March 2023. For example, as highlighted in **paragraph 6**, it has introduced an internal escalation framework to help progress its targeted intervention monitoring framework. This assesses directorates each month, using a score between 1 and 3, against the six domains of the NHS Wales escalation and oversight framework. Directorate Improving Together sessions (**Appendix 2 R3 2022**) are now held twice yearly, with more frequent meetings held to support directorates at the highest level of escalation (level 3) for any of the domains. The updated, escalation arrangements are positive, however the Health Board should update its Improving Together Framework documentation to ensure it adequately reflects current arrangements. As part of work to update the framework, the Health Board should also ensure it reflects de-escalation conditions and support for directorates at the highest level of escalation for extended periods, and co-ordinated support for directorates escalated over several domains (**Recommendation 1**).

54 Last year we recommended the Health Board develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended (**Appendix 2 R3 2023**). In the latter part of 2024-25, Internal Audit plan on reviewing performance management arrangements, including recent changes such as the internal escalation arrangements.

55 The Board and its committees continue to have good oversight of organisational performance, through the Integrated Performance Assurance Report (IPAR), received by the Board at each meeting. Since July 2024, the IPAR provides an overview of each directorate's escalation status against the internal escalation framework. The cover report accompanying the IPAR is well written and has recently adopted the 'Triple A' format, making it easier to identify and focus on high-risk areas. The detailed IPAR report continues to be clear about the key challenges and actions taken for each metric.

Corporate approach to overseeing the quality and safety of services

56 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- the Board providing effective oversight and scrutiny of the effectiveness of the quality governance framework;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

57 We found that **whilst there is appropriate corporate oversight and scrutiny of the quality and safety of services, there is a need for more regular updates on the implementation of the Quality Improvement Strategic Framework.**

58 The Health Board continues to embed the duties set out in the Health and Social Care (Quality and Engagement) Act (2020). In compliance with the duties, it published its annual report setting out how it met the duties of quality and candour during 2023-24. The report was presented at the Annual General Meeting held in September 2024 and published on the Health Board's website.

59 The Quality, Safety, and Experience Committee (QSEC) maintains oversight of the quality and safety of services. It routinely receives deep-dives and service specific reports, for example related to oncology services and stroke service access times. The committee is also supported by a sub-committee structure receiving assurance reports from the Operational Quality, Safety and Experience and the Listening and Learning sub-committees. It also continues to receive the Quality and Safety Assurance Report at each meeting, which gives an overview of key quality and

safety information and metrics[9]. Key quality metrics have now been aligned to the targeted intervention monitoring framework and internal escalation framework, with oversight for both incorporated into the committee's workplan.

60 Last year we reported that in March 2023 the Board approved the revised Quality Improvement Strategic Framework (2023-2026). The Quality and Safety Assurance Report provides updates on quality improvement initiatives, with the level of detail varying each meeting. There is an opportunity to provide an annual, standalone update on Quality Improvement activities, including progress on implementing the Quality Improvement Strategic Framework, a roundup of improvement initiatives and the impact they are having to date. (**Recommendation 2**).

Corporate approach to tracking recommendations

61 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations in a timely manner.

62 We found that **the Health Board has maintained robust arrangements for tracking audit and review recommendations, with internal escalation arrangements used to strengthen operational audit tracking arrangements.**

63 ARAC continues to receive robust assurance on the Health Board's audit tracking arrangements. The committee now receives the Audit Tracker at every other meeting, providing a comprehensive summary of the status of recommendations and thematic analysis. Since October 2024, the Audit Tracker also provides a high-level summary of each directorate's escalation status on the governance domain, which includes managing audit and inspection recommendations.

64 Since the start of 2024, the Health Board has used the Audit Management and Tracking (AMaT) system to manage its recommendations. The system allows directorates to highlight barriers to fully implementing recommendations. Where directorates are at the highest level of the internal escalation (level 3) for governance[10], the Audit Tracker provides further analysis including barriers to progress and actions for improvement. The updated report ensures ARAC maintains assurance on tracking mechanisms, but also provides assurance that the internal escalation arrangements are supporting improvements to operational

[9] The Quality and Safety Assurance Report includes information and metrics related to related to patient safety incidents including nationally reported patient safety incidents, Duty of Candour, Infection, prevention and control, Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW), Welsh Health Circulars, Walkarounds and NHS Wales Nurse Staff (Wales) Act.

[10] In October 2024, the directorates at level 3 for governance were the operations, planned care, women and children, and mental health and learning disabilities directorates.

audit tracking arrangements. In October 2024 there were eight overdue Audit Wales recommendations reported to ARAC.

Corporate approach to planning

65 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

66 We found that **development and delivery of the Health Board's plans continue to be supported by appropriate oversight, underpinned by a pragmatic approach to addressing planning team capacity issues. There is scope to review well-being objectives as part of a planned long-term strategy refresh.**

Corporate approach to producing strategies and plans

67 We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision, appropriate objectives and a long-term strategy in place which are future-focused, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- a sound corporate approach to setting and reviewing well-being objectives in accordance with the sustainable development principle[11];
- the long-term strategy underpinned by an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

68 We found that **there continues to be appropriate corporate arrangements in place to support the development of plans, underpinned by a pragmatic approach to overcome planning team capacity issues. While the Health Board remains focused on its long-term strategy, plans to refresh it provide an opportunity to align its well-being objectives.**

69 The Health Board continues to have a focus on its long-term strategy 'A Healthier Mid and West Wales', which was launched in 2018, however it has indicated its

[11] Under The Well-being of Future Generations (Wales) Act 2015, the Health Board is required to set and publish well-being objectives that are designed to maximise its contribution to achieving each of the well-being goals. Further information is available here.

intention to refresh it next year. It has also indicated plans to review its well-being objectives, which were last refreshed in 2019. To ensure the strategic and well-being objectives are aligned, the Health Board should review its well-being objectives as part of its long-term strategy refresh (**Recommendation 3**). There have been significant changes at Board level since 'A Healthier Mid and West Wales' was developed, in refreshing the strategy, there is an opportunity for the new Board to develop a set of design principles to help set the context of the long-term strategy.

70 Last year we reported that the Health Board had started to develop a Clinical Services Plan specifically to look at nine fragile services, which is now one of the planning objectives in the 2024-25 Annual Plan. There has been good progress since last year's structured assessment. In January 2024, the Board received the issues paper (phase 1) for the Clinical Services Plan Programme and the Board agreed for all nine services, excluding primary and community services to move to phase 2 (options appraisal) of the programme. Primary Care has become a separate piece of work focusing on developing a Primary Care and Community Services Strategy. The options appraisal and an update on the strategic direction will be presented to Board in November 2024. The Board receives routine updates on the Clinical Services Plan Programme.

71 The Health Board was unable to produce a Welsh Government approved Integrated Medium-Term Plan (IMTP) for 2024-27 due to its planned financial deficit. Therefore, it developed an Annual Plan for 2024-25. In January 2024, the Board received a paper detailing the Health Board's approach to developing the 2024-25 Annual Plan. Whilst the approach remained largely unchanged, directorates were asked to work to a set of design principles related to resource management, plan integration, workforce realities, demand and capacity and ministerial priorities. In addition, the Health Board established a Planning Steering Group which coordinated the plan's development on behalf of the Executive Team, with SDODC maintaining oversight of the plan's development. Whilst independent members are engaged at key points of the Annual Plan's development, we received feedback questioning whether independent members could be more involved from the outset.

72 In March 2024, the Annual Plan was approved by the Board for onward submission to Welsh Government. Welsh Government have received the Annual Plan and set accountability conditions related to:

- delivering and improving on the deficit plan, further de-risking the financial plan to ensure the savings plan is delivered in-year, maximising opportunities for efficiency and productivity, and reviewing and addressing areas where the organisation is an outlier on cost growth; and
- progressing regional solutions and developing a clinical services plan.

73 Whilst there is still limited planning capacity within the corporate planning team, the Health Board reported that it is using resources from various directorates to mitigate these constraints (**Appendix 2 R1 2021**). In addition, where practical, the

Health Board has integrated the Annual Plan and targeted intervention monitoring framework, which ensures limited capacity is used wisely. Whilst it would be feasible to have Business Partners aligned to the Clinical Care Groups[12] in the new operational structure, the Health Board would prefer to keep business partnering arrangements flexible, which will also ensure greater resilience within the planning team (**Appendix 2 R2 2021**). The new operational structure includes a Director of Operational Performance and Delivery, which will ensure good links between the Clinical Care Groups and the corporate planning team.

Corporate approach to overseeing the delivery of strategies and plans

74 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[13] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

75 We found that **planning oversight arrangements remain robust, supported by focused and further streamlined planning objectives designed to progress strategic change programmes.**

76 Since last year, the Health Board has further streamlined its planning objectives. Its 2024-25 Annual Plan articulates 10 focused change programmes or planning objectives, which seek to address one or more of the following criteria: ministerial priority, statutory duty, service/estate fragility and/or is a critical enabler. Each planning objective also comes under one of three themes, which align to the Executive Team governance structure sub-groups. These are value and sustainability, quality and performance and A Healthier Mid and West Wales. These themes highlight the Health Board's focus on both current challenges, whilst planning for sustainable services in the medium- and longer-term. Each planning objective has a clearly articulated aim/expected outcome (**Appendix 2 R4 2022**), and the Annual Plan has a clear delivery plan with quarterly milestones and actions.

77 As reported in previous years, the process for monitoring strategic and planning objectives is robust. The Board continues to receive updates on the Annual Plan's

[12] The new operations structure is designed around four clinical care groups, these are: Mental Health and Learning Disabilities Clinical Care Group, Community and Integrated Medicines Clinical Care Group, Planned and Specialist Care Clinical Care Group and Allied Health and Health Sciences Clinical Care Group.

[13] Specific, measurable, achievable, relevant, and time-bound

delivery at each meeting, through update reports, committee assurance reports, the BAF and IPAR. However, whilst all planning objectives are aligned to one of the strategic objectives (**Appendix 2 R4 2023**), there are two strategic objectives[14] which none of the planning objectives align with. The Health Board acknowledges this and provides updates to the Board on all six strategic objectives via its BAF reports. Each year, the Board also receives an annual report outlining progress in meeting its eight well-being objectives. The 2023-24 report will be presented to the Board in November 2024.

78 Committees maintain good oversight of the delivery of planning objectives, through regular progress reports and deep dives, which are clearly mapped out in committee workplans. Due to each committee's remit, some have more planning objectives to oversee than others[15], although this is reflected in respective work programmes and is proportionate to the scale and scope of each of the planning objectives.

79 In previous years, we highlighted that delivery of wider corporate strategies and plans are monitored through the planning objectives, but a lack of standalone delivery plans made it difficult for the Board and its committees to gauge overall progress. Whilst this is still the case, the planning objectives are now individual change programmes, for example digital plan, estates plan, workforce stabilisation, financial recovery and route map, and clinical services plan, which ensure committees have routine progress updates on individual change programmes/planning objectives (**Appendix 2 R5 2022**).

Corporate approach to managing financial resources

80 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

81 We found that **whilst the financial position for 2024-25 remains extremely challenging, the Health Board is taking positive steps to improve its financial position and to develop a roadmap to ensure financial sustainability. There remains a clear approach for financial planning and managing and monitoring the financial position, but there is a need to strengthen the approach to delivering cost savings opportunities.**

[14] No planning objectives align to Strategic Objective 2 'working together to be the best we can be' and Strategic Objective 3 'striving to deliver and develop excellent services'.

[15] The following committees are responsible for overseeing planning objectives: Strategic Development and Operational Delivery Committee oversees seven planning objectives, Sustainable Resources Committee oversees two planning objectives, and the People, Organisational Development and Culture oversees one planning objective.

Financial objectives

82 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of the organisation:

- meeting its financial objectives and duties for 2023-24, and the rolling three-year period of 2021-22 to 2023-24; and
- being on course to meet its objectives and duties in 2024-25.

83 We found that **the Health Board did not achieve its revenue financial duties for 2023-24 and with an ongoing challenging financial position, will not achieve them in 2024-25 but the Health Board is taking positive steps to improve its financial position**.

84 The Health Board did not achieve its revenue financial objectives and duties for 2023-24. It reported a year-end deficit of £68.8 million against its revenue resource limit, and did not meet the target control deficit of £44.8 million set by Welsh Government. It also reported a cumulative deficit of £149.9 million for the three-year rolling period 2021-24, breaching its duty to break even. As in previous years, the Health Board reported a small surplus of £33,000 against its 2023-24 capital resource limit, meeting both in-year and rolling three-year financial duties against its capital resource limit[16]. It is likely to meet its capital financial duties for 2024-25.

85 The 2024-25 Financial Plan sets out a forecast deficit of £64.0 million against its revenue resource limit, which does not meet the Welsh Government's control target of £44.8 million and the Health Board's revenue financial duties for 2024-25. To meet its Financial Plan, the Health Board has set an ambitious £32.4 million savings target and profiled a deficit of no more than £5.3 million for each month. At Month 7 (2024-25), the Health Board is reporting an underspend against the £5.3 million monthly profiled deficit (£4.3 million). It is also reporting to be on track to achieving its year-end deficit plan. This is an improvement from Month 4 when the gap was £10.7 million, and the average monthly deficit was £5.7 million.

86 In September 2024, the Board held an Extraordinary Board Seminar to discuss mitigating actions to close the £4 million gap to achieving the deficit plan. The Health Board has taken positive steps to improve its position, which include:

- focusing on recurrent savings and delivery in-year;
- converting planned saving schemes into deliverable plans;
- greater 'grip and control' through the internal escalation framework;
- monitoring and oversight through the Executive Team Governance structure;
- reviewing clinical and non-clinical variable pay; and
- exploring service change opportunities.

[16] We are currently conducting a separate review of the Health Board's arrangements for prioritising its capital investments.

Corporate approach to financial planning

87 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

88 We found that **the Health Board has maintained a clear financial planning process and is taking steps to become financially stable, although progress is behind schedule and there is an urgent need to strengthen its approach to delivering sustainable cost savings opportunities**.

89 The Health Board continues to have a clear process for developing its annual financial plan, which is integrated with its Annual Plan development process (**see paragraph 66**). The Health Board maintains its top-down and bottom-up approach, with the corporate team identifying strategic opportunities and directorates supported by finance business partners, identifying operational savings opportunities. Governance and performance management processes, such as the Directorate Improving Together sessions and the Executive Integrated Quality, Performance and Finance Delivery Group, support the process. There continues to be appropriate Board engagement on the plan's development, with oversight provided by SRC and discussion at Board seminars. In October 2024, SRC received a paper outlining the financial plan principles and approach for developing the annual financial plan for 2025-26.

90 Whilst the Health Board has not yet developed a long-term financial plan (**Appendix 2 R6 2022**), it has developed a two-year financial route map to achieve Welsh Government's £44.8 million deficit control target by the end of 2025-26. This is one of the Health Board's planning objectives/change programmes. Given financial performance in recent years, achieving this would represent a significant step towards financial control and sustainability. SRC has oversight of the planning objective related to financial recovery and route map. An update provided at the October 2024 committee meeting stated that this planning objective was behind target.

91 In 2023-24, the Health Board did not achieve its £19.5 million savings target, delivering £14 million at year end. The Health Board also did not achieve the additional £11.3 million savings requirement set by Welsh Government to deliver the revised £44.8 million control target. The Health Board had not updated its total savings target to reflect this additional requirement. Our 2024 Review of Cost Savings Arrangements, found that the Health Board did not meet its financial

targets for 2023-24 and its track record on delivering recurrent savings is poor. Given the Health Board's challenging financial position for 2024-25, it urgently needs to address its cost drivers and strengthen its overall arrangements for delivering and monitoring sustainable cost savings opportunities to prevent its financial position from deteriorating further. As at Month 7 2024-25, the Health Board had identified £30.5 million of its £32.4 million savings target, leaving a gap of £1.9 million. However, of the £30.5 million savings identified less than half are recurrent (£14.2 million). Performance against savings targets continue to be scrutinised by SRC and reported to the Board.

Corporate approach to financial management

92 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2023-24 were submitted on time, contained no material misstatements, and received a clean audit opinion.

93 We found that **the Health Board continues to have appropriate arrangements in place to oversee and scrutinise financial management and controls, which have been further strengthened through arrangements to support targeted intervention**.

94 ARAC continues to receive a comprehensive Financial Assurance Report at each meeting. This allows the committee to scrutinise financial controls related to single tender actions, losses and special payments, under and overpayment of salaries and procurement compliance. Like other assurance reports, the Financial Assurance Report has also adopted the Triple-A format, clearly highlighting areas needing most attention. For example, the report received by ARAC in October 2024, 'alerts' members to losses exceeding £5,000, which need to be approved by the Committee. ARAC also maintains good oversight of counter-fraud activity. SRC continues to maintain ongoing oversight of financial control procedures, with an annual statement of financial procedures reported to ARAC for assurance.

95 Our 2024 Review of Cost Savings Arrangements, found that the Health Board broadly understands its cost drivers, and has taken positive steps to strengthen budget management at an operational level. Our report recognises that the Health Board has undertaken some proactive analysis to develop a better understanding

of the areas that are driving cost across directorates. The Financial Report, received by the Board and SRC, includes a clear analysis of both in-month and year to date operational cost drivers. All corporate and operational directorates have received and accepted accountability letters, which set out their annual budgetary requirements. For 2025-26, the Health Board aims to bring forward the timelines for issuing accountability letters.

96 There is a clear focus on delivering the deficit plan and the Health Board has strengthened financial monitoring and control. Several groups continue to monitor the financial position including Directorate Improving Together sessions and the internal escalation framework. The Financial Control sub-group oversees control measures focused on recruitment, training and procurement. The sub-group reports to the Executive Team via its Value and Sustainability Group, which is chaired by the Executive Director of Workforce and OD/Interim Deputy CEO.

97 The Health Board submitted its draft 2023-24 Financial Statements within the required timescales, and they were received by ARAC and the Board in July 2024. We issued an unqualified true and fair audit opinion, except for a qualified regularity opinion because the Health Board did not meet its revenue resource allocation over the three-year period.

Board oversight of financial performance

98 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of the Board:

- receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- appropriately scrutinising the ongoing assessments of the organisation's financial position.

99 We found that **the Health Board maintains good arrangements for monitoring and scrutinising its financial position, with greater scrutiny on issues contributing to the financial challenges**.

100 The Board and SRC continue to receive a detailed Finance Report at each meeting. As with other assurance reports, since July 2024, the cover report has adopted the Triple-A format making it easier to understand the key risks and challenges. The report continues to make good use of charts and dashboards, providing an overview of revenue and forecast position, savings performance and key cost drivers contributing to overspends. However, our 2024 Review of Cost Savings Arrangements, found that some recipients of the Finance Report found it complicated and difficult to understand. We recommended that the Health Board address this by supporting Board members to deepen their financial literacy skills to help them better understand the content of the reports. The Health Board is addressing this recommendation through its Board Development Programme and by holding separate training sessions for independent members. Enhanced understanding will strengthen oversight and scrutiny. Financial performance is also

presented in BAF, IPAR and targeted intervention reports, which are presented to the Board and appropriate committees.

101 As highlighted in **paragraph 94** ARAC also continues to receive assurance on financial controls, through the comprehensive Financial Assurance Report. SRC maintains oversight of the capital programme, receiving a report covering the All-Wales Capital Programme, performance against the capital resource limit and capital financial management[17]. SRC continues to provide a good level of scrutiny of financial reports, with scrutiny appropriately focusing on the issues causing the financial challenges and appropriate operational and executive officers attending to contribute to discussions (**Appendix 2 R5 2023**).

[17] We are currently conducting a separate review of the Health Board's arrangements for prioritising its capital investments.

Appendix 1

Audit methods

Exhibit 2 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Exhibit 2: audit methods

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Audit and Risk Assurance Committee; • Strategic Development & Operational Delivery Committee; • Health & Safety Committee; • Quality, Safety & Experience Committee; • People, OD and Culture Committee; and • Sustainable Resources Committee.
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the Annual Plan; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register;

Element of audit approach	Description
	• key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by Internal Audit, Healthcare Inspectorate Wales, the Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Board Chair; • Interim Chief Executive; • Executive Director of Finance; • Executive Director of Strategy and Planning; • Executive Director of Public Health; • Board Secretary / Director of Corporate Governance; We also held a group interview with the chairs of the following committees • Audit and Risk Assurance Committee; • Sustainable Resources Committee; • Strategic Development & Operational Delivery Committee; and • Quality, Safety & Experience Committee.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Health Board in implementing recommendations from previous structured assessment reports

Recommendation	Description of progress
Enhancing public transparency R1 We found that Public Board papers include a high-level summary of private Board meetings. To further enhance transparency, this arrangement should be extended to private committee meetings through individual committee assurance reports received by the Board (2023).	**Complete** – see paragraph 15.
Board member patient safety walkabout R2 Board members conduct regular Patient Safety walkabouts, supported by a member of the patient safety team who takes notes, with a clear process to provide feedback to visited services and monitor actions points. However, those we interviewed were unclear about what happened after the visit. The Health Board should clarify the Patient Safety Walkabout process with new Independent Members (2023).	**Complete** – see paragraph 35.

Recommendation	Description of progress
Performance management arrangement assurance R3 Given the Health Board is under the Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended (2023).	**In progress** – see paragraph 54.
Aligning planning and strategic objectives R4 The Health Board has taken steps to better articulate its planning objectives in its 2023-24 Annual Plan, by streamlining the planning objectives and setting them against eight strategic planning goals and four domains. However, the domains and strategic planning goals do not explicitly align to the Health Board's six overarching strategic objectives, as detailed in its Board Assurance Framework (BAF) and Integrated Performance Assurance Report (IPAR) dashboards. As part of the next planning cycle, the Health Board should more explicitly set out how each of its planning objectives link to its strategic objectives (2023).	**Complete** – see paragraph 77.
Financial scrutiny R5 Whilst there is a good level of scrutiny on the financial position within the Sustainable Resources Committee, the scrutiny has predominantly been focused on the Director of Finance. Whilst this has improved in recent meetings with members of the Core Delivery Group and the Financial Control Group now in attendance, the Health Board needs to do more to ensure scrutiny by Independent Members is appropriately focused across all members of the executive team (2023).	**Complete** – see paragraph 101.
Operational structure R2 While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks	**In progress** – see paragraph 40.

Recommendation	Description of progress
facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgency (2022).	
Operational performance management arrangements R3 While performance arrangements exist at an operational level, there is scope to bring these together into a holistic review of performance. Alongside the rollout of its Improving Together Framework, the Health Board should revisit its performance management arrangements to ensure that there is a joined-up approach at an operational level (2022).	**Complete** – see paragraph 53
Expected outcomes R4 The Health Board has not set out expected outcomes for all its planning objectives set out in its Annual Plan. In revising its planning objectives for 2023-2026, the Health Board needs to clearly articulate the expected outcomes for its streamlined set of planning objectives (2022).	**Complete** – see paragraph 76.
Implementation plans to support strategies R5 Implementation plans to support corporate enabling strategies did not always exist or include clear milestones, targets, and outcomes. The Health Board needs to ensure: • existing implementation plans include clear milestones, targets, and outcomes; and • implementation plans are developed for enabling strategies that currently do not have one. Alongside the monitoring of relevant individual planning objectives, this will enable periodic review of overall progress of delivery of the enabling strategies (2022).	**Complete** – see paragraph 79.
Financial sustainability plan R6 The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term	**In progress** – see paragraph 90.

Recommendation	Description of progress
financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected (2022).	
Alignment of plans R1 Planners are not involved in all planning processes and must rely on others to make sure that plans align. The Health Board should determine individual responsibilities for ensuring that key planning processes are effectively linked (2021).	**Complete** – see paragraph 73.
Planning capacity R2 The planning team has adopted a 'business partnering' approach to support the development of the quarterly operational plans, which has worked well but there has been over-reliance on one individual within the planning team due to capacity constraints. The Health Board should review its planning capacity to ensure that resilience is built into the team, and the expertise and knowledge needed to support the planning process are developed across all team members (2021).	**Complete** – see paragraph 73.

Appendix 3

Management response to audit recommendations

[**Appendix 3** will be completed once the report and management response have been considered by the relevant committee.]

Exhibit 4: Hywel Dda University Health Board's response to our audit recommendations

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
Improving Together Framework R1 The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements: • deescalating and supporting directorates at the highest level of escalation for extended periods; and			

Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
• coordinating support for directorates escalated over several domains (**see paragraph 53**).			
Quality Improvement Strategic Framework R2 The Quality, Safety and Experience Committee should receive, at least annual, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (**see paragraph 60**).			
Well-being objectives and strategy refresh R3 To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (**see paragraph 69**).			

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Management response form

Report title: Structured Assessment 2024 – Hywel Dda University Health Board

Completion date: November 2024

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements: • deescalating and supporting directorates at the highest level of escalation for extended periods; and • coordinating support for directorates escalated over several domains (see **paragraph 53**).	The Improving Together Framework will be updated to address the points raised in this recommendation. Timeline for completion: • February 2025 - full draft submitted to Strategic Development and Operational Delivery Committee for consideration • March 2025 – final draft submitted to Board for approval	31 March 2025	Executive Director of Finance

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R2	The Quality, Safety and Experience Committee should receive, at least annual, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (**see paragraph 60**).	A standalone annual report on Quality Improvement Activities will be added to the work plan for the Quality Safety and Experience Committee for 2025/26	30 April 2025	Executive Director of Nursing, Quality and Patient Experience
R3	To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (**see paragraph 69**).	The well-being objectives will be reviewed as part of the long-term strategy refresh	31 March 2026	Executive Director of Public Health

Management response

Report title: Structured Assessment 2022
Completion date: January 2023
Document reference: 3273A2022

Ref	Recommendation	Management response	Completion date	Responsible officer	Progress as at 31 January 2025
R2	**Operational structure** While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgency.	Work begun to review the operational structure in September 2022. A series of workshops have been held with the senior operational leadership team, and discussions with the executive Team. Sessions with the senior clinical leaders are planned for Q1 2023. The intention is to develop a proposal by Q2 2023 that can be agreed and implemented across the Health Board, that addresses the inconsistency identified. Ahead of this, the operational governance meeting structure will be revised in Q1 2023, which will support the actions being taken around R3.	~~December 2023~~ ~~September 2024~~ June 2025	Director of Operations	In progress – Appointments have been made to all but two of the Clinical Care Group (CCG) triumvirate posts, with the 2 x Associate Medical Director posts outstanding. During February further progress will be made in filling the remaining service group general manager roles and heads of nursing roles at Service Group Level (the level below the CCG's). Given the rigorous nature of the recruitment process, it could be June 2025 before everyone is in place.

Ref	Recommendation	Management response	Completion date	Responsible officer	**Progress as at 31 January 2025**
					The CCG Service Directors will all be in place in February 2025, which will enable the alignment of services to start as part of the transition to the CCG care group model and associated arrangements ahead of starting in that new format from the 1 April 2025 with people arriving as they serve their notice periods. Standardised governance arrangements will be in place for April 2025, alongside a leadership and organisational development plan to support implementation of the new structure.
R6	**Financial sustainability plan** The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to	The 2023/24 planning cycle is underway which will, with Board approval, reflect the challenges that have been experienced during 2022/23. Opportunities have been clearly articulated, and the planning	~~31 March 2023 for the short term financial recovery plan.~~	Director of Finance	*In progress – A report outlining the Health Board's strategic approach, and progress in developing a financial recovery plan set within the wider planning*

Ref	Recommendation	Management response	Completion date	Responsible officer	Progress as at 31 January 2025
	update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	cycle will be the vehicle for teams across the Health Board to deliver sustainable plans in the areas highlighted as opportunities, as well as undertaking their delegated financial responsibilities to review and deliver all efficiency and benchmarking opportunities. With the unprecedented demand challenges that have been experienced, the financial overspends have resulted in a significant deterioration to our deficit. The recovery plan will need to be cognisant of the impact which these demand challenges are having across our system.	~~31 March 2024 for the long-term strategy.~~ 31 March 2025		*cycle, was provided to the Board in January 2025. Further reports will be presented to the Sustainable Resources Committee in February, with the final plan presented to the Board for approval in March 2025.*

Organisational response

Report title: Structured Assessment 2023

Completion date: December 2023

Document reference: 3950A2023

Ref	Recommendation	Organisational response	Completion date	Responsible officer (title)	Progress **as at 31 January 2025**
R3	**Performance management arrangement assurance** Given the Health Board is under Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended.	We will commission an annual review of the effectiveness of the Improving Together Framework from Internal Audit. We will ask for the first review to be undertaken during Q1 2024/25.	30 June 2024	Executive Director of Finance	Completed - Internal Audit workplan confirmed for Q3 2024/25. The final report will be presented to ARAC in April 2025

3.3 **10:50, 5 Mins**

3.3 - Audit Wales Update Report

Urvisha Perez

For assurance

Attachments

3.3 Audit Wales ARAC Update (11.02.25).pdf

Archwilio Cymru
Audit Wales

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

Date issued: February 2025

This document has been prepared for the internal use of Hywel Dda University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit and Risk Assurance Committee Update

About this document

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

2 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.

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Audit of the 2023-24 Charitable Funds Accounts	Director of Finance	To provide an audit opinion on the Health Board's 2023-24 Charitable Funds Accounts.	The audit fieldwork is complete. The audit opinion is due to be signed on 31 January.	January 2025
Audit of the 2024-25 Annual Report and Accounts	Director of Finance	To provide an audit opinion on the 2024-25 Annual Report and Accounts.	Planning	June 2025

Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Structured Assessment 2024 – core	Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Complete	Final report presented in December 2024. The management response is in today's papers.

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of urgent and emergency care	Director of Operations	This work will examine different aspects of the urgent and emergency care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. The work will include an examination of the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We also plan to review progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Blog and data tool published in April 2022 Part 1 – Regional report being drafted Part 2 – Fieldwork underway	 April 2025 April 2025
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Director of Finance	This review will examine 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.	Planning	August 2025

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Planned Care review	Director of Operations	This work will follow on from the national report on tackling the planned care backlog. Whilst the exact focus of this work is still to be determined, it is likely to consider: • The extent that health boards have achieved Welsh Government targets for recovering planned care services; • The efficacy of local plans and activity to recover waiting lists; and • Use of the additional Welsh Government financial allocations to improve waiting lists.	Fieldwork underway	April 2025
Review of arrangements for Capital Programme Prioritisation (Local work 2023)	Director of Strategy and Planning	This work will review the Health Board's arrangements for prioritising its capital programme, including estates and equipment maintenance within the context of operating within significant financial pressures.	Fieldwork underway	June 2025

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of the management of outpatients (Local work 2024)	Director of Operations	The focus of this work will be 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. We will keep the Audit and Risk Assurance Committee updated as we develop this work.	Project brief to be issued	August 2025

Other relevant publications

6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – relevant examinations and studies published by the Auditor General

Title	Publication Date
Cancer Services in Wales	**January 2025**
The National Fraud Initiative in Wales 2022-23	October 2024
Active Travel (and Data Tool)	September 2024
Affordable Housing	September 2024
NHS Wales Finances Data Tool	August 2024

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. The links to the reports on our website are provided.

Title	Publication Date
Fee Scheme 2025-26	January 2025
Audit Quality Report 2024: Strengthening trust in audit	January 2025

8 There are no relevant Audit Wales consultations currently underway.

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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.

3.4

10:55, 10 Mins

3.4 - Audit Wales Outline Annual Plan 2025

Anne Beegan, Urvisha Perez

For discussion

Attachments

3.4 HDUHB 2025 Outline Audit Plan (Final).pdf

Archwilio Cymru
Audit Wales

Hywel Dda University Health Board

Outline Audit Plan 2025

Audit year: 2024-25

Date issued: January 2025

This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our Statement of Responsibilities.

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

About Audit Wales

Our aims:

Assure

the people of Wales that public money is well managed

Explain

how public money is being used to meet people's needs

Inspire

and empower the Welsh public sector to improve

Our ambitions:

Fully exploit our unique perspective, expertise and depth of insight

Strengthen our position as an authoritative, trusted and independent voice

Increase our visibility, influence and relevance

Be a model organisation for the public sector in Wales and beyond

Contents

Introduction

This Outline Audit Plan specifies my statutory responsibilities as your external auditor and to fulfil my obligations under the Code of Audit Practice. It also sets out details of my audit team and key dates for delivering my audit team's activities and planned outputs. I intend to share a Detailed Audit Plan later in the year following the completion of my planning work. It will set out my estimated audit fee and the work my team intends to undertake to address the audit risks identified and other key areas of audit focus during 2025.

Adrian Crompton
Auditor General for Wales

My audit responsibilities

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness' and the regularity of income and expenditure, and the proper preparation of key elements of your Remuneration and Staff Report. I lay them before the Senedd together with any report that I make on them. I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material misstatements, that is, those that might result in a reader of the accounts being misled. The levels at which I judge such misstatements to be material will be reported to you in my Detailed Audit Plan.

I am also required to certify a return to the Welsh Government which provides information about the Health Board to support preparation of the Whole of Government Accounts.

Performance audit work

I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources. I do this by undertaking an appropriate programme of performance audit work each year.

My work programme is informed by specific issues and risks facing the Health Board and the wider NHS in Wales. I have also taken account of the work that is being undertaken or planned by other external review bodies and by internal audit.

Fees and audit team

In January 2025 I published the fee scheme for the year, approved by the Senedd Finance Committee. This sets out my fee rates. My fee rates for 2025-26 have increased by an average of 1.7% because of unavoidable inflationary pressures.

I will provide an estimate of your fee in my Detailed Audit Plan in April 2025, following completion of my detailed risk assessment.

Your engagement team:

Anthony Veale	**Engagement Director & Audit Director (Financial Audit)**
Dave Thomas	**Audit Director (Performance Audit)**
David Williams	**Audit Manager (Financial Audit)**
Anne Beegan	**Audit Manager (Performance Audit)**
Eleanor Ansell	**Audit Lead (Financial Audit)**
Urvisha Perez	**Audit Lead (Performance Audit)**

We confirm that our audit team members are all independent of the Health Board and your officers.

Audit timeline

We set out below key dates for delivery of our audit work and planned outputs.

Planned output	Work undertaken	Report finalised
2025 Outline Audit Plan [1]	January - February 2025	February 2025
2025 Detailed Audit Plan	February – April 2025	April 2025
Audit of financial statements work: • Audit of Financial Statements Report • Opinion on the Financial Statements.	May – June 2025	June 2025
Performance audit work: • Structured Assessment, incorporating a deeper dive into estates management. • All-Wales thematic review of the local delivery of cancer services, following on from my recent report on national strategic leadership arrangements for cancer. • In terms of local project work, my early planning work suggests there would be value in following-up the recommendations I made in my 2022 Review of Quality Governance Arrangements. However,	Timescales for individual projects will be discussed with you and detailed within the specific project briefings produced for each study, although my overall aim will be to substantially complete the delivery of the Performance Audit work in this plan by the end of March 2026.	

Planned output	Work undertaken	Report finalised
my planning work is on-going and might also highlight other areas worthy of review. Therefore, the exact focus of my local project work will be confirmed in my detailed Audit Plan in April 2025.		

[1] We also audit the Health Board's Charity's annual accounts. As for past years, there will be a separate audit plan for the audit. It is therefore not covered in this audit plan.

Audit quality

My commitment to audit quality in Audit Wales is absolute.

I believe that audit quality is about getting things right first-time.

We use a three lines of assurance model to demonstrate how we achieve this.

We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD[1] and our Chair acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.

.

Our People

The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality

The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance

The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

[1] QAD is the Quality Assurance Department of ICAEW.


Archwilio Cymru
Audit Wales

3.5

11:05, 0 Mins

3.5 - Review of Urgent and Emergency Care

Anne Beegan, Urvisha Perez

DEFERRED to 15 April 2025 meeting

For assurance

3.6

11:05, 0 Mins

3.6 - Planned Care Review

Anne Beegan, Urvisha Perez

DEFERRED to 15 April 2025 meeting

For assurance

3.7

11:05, 0 Mins

3.7 - Review of Arrangements for Capital Programme Prioritisation

Anne Beegan, Urvisha Perez

DEFERRED to 24 June 2025 meeting

For assurance

4

11:05, 0 Mins

4 - NWSSP – Audit and Assurance Services - Internal Audit (Part 2)

4.1

11:05, 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 2025.pdf

4.1 IA Plan Progress Report February 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 February 2025
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)
Er Sicrwydd/For Assurance

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 24/25.

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 for 2024/25 year and the outcomes of the finalised audit reports.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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. 3.17 This will be achieved by: 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; 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; 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; 3.17.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and 3.17.5 annual review of the effectiveness of internal audit.
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 2025

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS

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 2024/25 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	
Mortuary Services (Joint SBUHB)	Limited	
Health & Safety	Limited	
Management of Bed Capacity	Limited	
IT/Digital - Data Quality & Use of Data	Limited	
Targeted Intervention Governance	Reasonable	

3. Internal Audit Plan 2024/25 - Planning and Delivery Update

3.1 The assignment status schedule at Appendix A sets out the status and planned timelines of all audits in the 24/25 plan.

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	ARAC
Learning lessons	WIP	Field work in progress, Impacted by other audit work.	Apr
Elective Waiting List Management	WIP	Field work in progress, Impacted by other audit work.	Apr

Financial Management	WIP	Field work in progress, Impacted by other audit work.	Apr
Performance Management	Initial Draft	Field work Complete.	Apr

3.3 As a result of ongoing planning discussions, and at the previous meeting of the Committee we have included within the plan a follow up audit of Discharge Management. This will be planned to be completed prior to the completion of the Annual Report & Opinion for 24/25.

3.4 The planning process for the development of the Internal Audit plan for 25/26 has commenced, with the plan be considered at the Executive Team, prior to being presented to the April meeting of the Audit & Risk Assurance Committee for approval.

3.5 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 meeting and some Committees have been observed. Ongoing liaison meetings with Counter Fraud, Audit Wales and Health Inspectorate Wales have also continued.

Appendix A – HDUHB Internal Audit Plan 2024/25 – Assignment Status Schedule

Audit Output	Outline timing	Planned ARAC	Executive Lead	Progress Status	Assurance	H	M	L
Governance – Executive Team working	Q2-3	Feb	Corporate Governance /CEO	Planning				
Targeted Intervention Governance	**Q1-3**	**Feb**	**Chief Executive**	**FINAL**	**Reasonable**		**2**	
Annual Planning	Q3	April	Strategy & Planning	WIP				
Cash Management	Q2/3	Oct	Director of Finance	FINAL	Substantial	-	-	-
Financial Management	Q2/3	Feb	Director of Finance	WIP				
UHB Procurement - Contract Management	Q3/4	Apr	Director of Finance	Planning				
Performance Management Arrangements	Q3/4	Feb	Director of Finance	Initial Draft				
Speaking up safely	Q3/4	Oct	Nursing, Quality & Patient Experience	FINAL	Reasonable	1	3	
Learning lessons	Q3	Feb	Nursing, Quality & Patient Experience	WIP				
Falls Management	Q2	Oct	Nursing, Quality & Patient Experience	FINAL	Reasonable	1	4	
Cleanliness / Cleaning Standards	Q3/4	Apr	Chief Operating Officer	Planning				
Discharge Management	Q3/4	Dec	Chief Operating Officer	FINAL	Limited	2	2	-

Management of Bed Capacity	**Q2/3**	**Feb**	**Chief Operating Officer**	**FINAL**	**Limited**	**4**	**1**	
Medical Workforce (Medical Locums Planned Care)	Q3	Feb	Medical Director	WIP				
Nursing Management	Q2	Oct	Nursing, Quality & Patient Experience	Final	Limited	3	1	-
Estates Facilities directorate			Chief Operating Officer	Defer 25-26				
Revised Operational Governance Arrangements			Chief Operating Officer	Defer 25-26				
Nurse staffing Act	Q2	Aug	Nursing, Quality & Patient Experience	Final	Reasonable		3	
Job Planning	Q4	Apr	Medical Director	WIP				
Elective Waiting List Management	Q3/4	Feb	Chief Operating Officer	WIP				
Mortuary Services (Joint SBUHB)	**Q3**	**Feb**	**Allied health Professionals & Health Sciences**	**FINAL**	**LIMITED**	**4**	**5**	
Primary Care Strategy including Managed Practices	Q4	Apr	Primary, Community and Long Term Care					
Health & Safety	**Q2**	**Feb**	**Allied health Professionals & Health Sciences**	**FINAL**	**Limited**			
Ultrasound Corporate Risk	Q2	Aug-oct	Chief Operating Officer	Final	Reasonable	-	2	
Emergency and Business Continuity Planning	Q2	Oct	Director of Public Health	Final	Reasonable	1	2	-

Digital strategy	Q3/4	Apr	Director of Finance	Scope Agreed				
IT/Digital - benefits realisation	Q2/3	Oct	Director of Finance	FINAL	Substantial	-	-	-
IT/Digital – Data Quality/Use of Data	**Q2/3**	**Feb**	**Director of Finance**	**FINAL**	**Limited**	**3**	**1**	
Withybush General Hospital - RAAC.	Q3/4	April	Chief Operating Officer					
Estates Assurance – Energy Management	Q3	Feb	Chief Operating Officer	FINAL	Reasonable	-	8	-
Capital Systems	Q2/3	Dec	Chief Operating Officer	FINAL	Reasonable	-	4	-
Continuing Health Care		May/June						
Follow Up Discharge Management		June	Chief Operating Officer					

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4.2

11:10, 20 Mins

4.2 - Health and Safety (Limited Assurance)

James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Tim Harrison (Hywel Dda UHB - Head of Health, Safety and Security), Adam Springthorpe (Hywel Dda UHB - Health & Safety Manager), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)

For assurance

Attachments

4.2 Health Safety Final IA Report.pdf

Health & Safety

Final Internal Audit Report

2024/25

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2425-23
Fieldwork	July - November 2024
Executive Sign Off	15 January 2024
Audit Committee	February 2025
Executive Lead	James Severs, Director of Therapies & Allied Health Professionals
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the arrangements for ensuring compliance with Health & Safety regulations.

Overview

We have concluded **limited** assurance on this area. The matters requiring management attention include:

- Lack of oversight of (non-mandatory) H&S training participation rates *[Finding 1 – Medium]*
- Insufficient monitoring of actions arising from H&S site visits, significant volume of outstanding actions and weakness in the methodology for prioritising actions *[Finding 2 – High]*
- Non-compliance with RIDDOR reporting timescales *[Finding 3 – Medium]*
- Poor Executive director attendance at Health & Safety Committee *[Finding 4 – Medium]*
- Gaps in assurance reporting to the Health & Safety Committee *[Finding 5 – High]*

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

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Health & safety policies and procedures are in place and appropriate training is provided to staff	1	**Reasonable**
2	Mechanisms are in place to identify, raise awareness and monitor compliance with regulatory requirements	2, 3	**Limited**
3	Risks are managed effectively, with actions arising from internal and external reviews monitored through to implementation	-	**Substantial**
4	Governance structures are appropriate and effective, with mechanisms for regular reporting and escalation of key health and safety matters to the Health Board	4, 5	**Limited**

Management Actions

2 High Priority

3 Medium Priority

Themes

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Health & Safety - At a Glance

Statutory & Mandatory Training *[see Objective 1]*

Competence Name	Compliance
Moving and Handling - Level 1	80%
Violence Against Women, Domestic Abuse and Sexual Violence	82%
Health, Safety and Welfare	86%
Fire Safety	89%
Violence and Aggression - Module A	93%

Internal H&S Inspections *[see Objective 2]*

	Acute	Other	Total	%
Total areas	409	173	582	100%
Visited 2023-2024	58	66	124	21%
Not Visited 2023-2024	107	351	458	79%
Planned 2024-2025	49	23	72	16% (of 'not visited')

		Areas Inspected	Total Actions	Resolved	Managed Risk	Unresolved
Acute	Bronglais	17	181	0	16	165
	Glangwili	23	46	0	10	46
	Prince Philip	8	220	0	30	188
	Withybush	10	107	0	9	98
	Other	66	907	11	95	593
	Total	**124**	**1461**	**11**	**160**	**1090**

H&S Incidents April 2023 – July 2024 *[see Objective 2]*

	Level of Harm			
Status	None/Low	Moderate	Severe	**Total**
New Incident	20	6	1	27
Under Investigation	3	6	0	9
Management Review	119	33	5	157
Closed/Awaiting Closure	1897	78	5	1980
Total	2039	123	11	**2173**

Top Categories

Behaviour (including V&A)	60%
Accident, Injury	23%

Top Sub-Categories

Patient clinically challenging behaviour	25%
Aggressive / threatening behaviour	16%

89
RIDDOR Reportable Incidents

Findings & Agreed Action Plan

Objective 1: Health & safety policies and procedures are in place and appropriate training is provided to staff	**Reasonable**

Overview / Summary of Observations

In accordance with the Health & Safety at Work Act 1974, the Health Board has a documented Health & Safety Policy which was reviewed and updated in September 2024. The H&S Policy is supported by a suite of policies, procedures and guidance documents available to staff via the intranet.

The HS&S Team maintains a Regulation Compliance List mapping regulations to policies. Comparison of the H&S policy with policies of neighbouring health boards did not identify any gaps. We identified that the intranet links to two policies required updating – this was highlighted to management and addressed during audit fieldwork.

Statutory and mandatory training compliance rates exceed the target 85% for all courses except Moving & Handling, which had an 80% compliance rate at the time of fieldwork. *See **page 2** for details.*

The Health, Safety & Security (HSS) Team have developed additional bespoke training courses including a Managers Health & Safety Induction course covering all aspects of health and safety, and specific in-person courses on manual handling and violence and aggression. Available courses are advertised on the intranet, via the 7-minute briefings and through HS&S Team attendance at the directorate governance groups. These courses are not mandatory. Attendance is recorded, but the groups/roles that require training have not been defined or quantified. **[Finding 1]**

Policy is clear that managers and supervisors are responsible for ensuring that staff receive sufficient training as to the hazards and risks of the activities that they perform and environments in which they work. The onus is on employees and their line managers to seek out and book relevant training, although the HS&S Team will also target 'hotspot' areas for training based on incident rates.

	Key Findings	Risk & Impact	Agreed Management Action
1	**H&S Training** A central record of training participants for the non-mandatory training courses is maintained, although monitoring or oversight of participation rates is not possible because the staff groups/roles that training is intended for have not been defined or quantified.	Staff are not appropriately trained, potentially increasing the risk of health & safety related incidents which could cause harm to staff or patients.	**Agreed Action:** Determine the staff groups/roles to be targeted for each H&S training course. Consider whether they should be mandatory, in order to ensure that staff are appropriately trained for their role. Quantify the individuals requiring training and monitor participation/uptake, with poor participation rates escalated to directorate governance groups where appropriate.
			Expected Evidence of Implementation: Target staff groups/roles, including the number of staff, identified for each H&S training course. Monitoring of course participation rates. Reporting to directorate governance groups, where appropriate.
		Medium Priority	**Officer:** Tim Harrison, Head of Health Safety & Security **Target Implementation Date:** 31 July 2025
	Theme: Training & Development	Control Design	

Objective 2: Mechanisms are in place to identify, raise awareness and monitor compliance with regulatory requirements	**Limited**

Overview / Summary of Observations

The Health Board subscribes to Barbour – an external provider of regulatory information, guidance, standards and resources to support with health and safety compliance, including notifications of any changes to regulatory requirements. The Regulation Compliance List maps regulations to policies and sets out the monitoring arrangements. There is a dedicated health and safety section on the intranet, providing contact details for the HS&S Team, links to policies procedures and guidance, an overview of key regulations and a comprehensive suite of resources to support compliance. The HS&S Team also produce Quarterly 7 Minute Briefings providing staff with a one-page overview of key health and safety updates, Local Safety Notices and forthcoming training.

The HS&S Team aim to carry out site visits of all Health Board areas at least once every five years, with the current programme commencing in 2023. The visits are a visual inspection of premises and environment, culminating in a report to the responsible manager detailing any remedial actions. Actions reference the relevant policy/regulatory requirements and can relate to opportunities for improvement, minor or major non-compliance with policies and regulations. At the time of our review, 75% of actions were classed as *unresolved*. A follow up visit is undertaken in some circumstances, but reliance is placed on the site manager/lead to provide updates on implementation. **[Finding 2]**

Datix is configured to notify the team of any health and safety related incidents. There have been 2173 incidents between April 2023 – July 2024, 91% of these are closed or awaiting closure and 94% are recorded as resulting in no or low harm. There have been 89 RIDDOR incidents during the same period. *See **page 2** for details.* The H&S Team maintain a RIDDOR log to track compliance with reporting requirements. Both the log and our sample testing identified delays in reporting RIDDOR incidents to the Health & Safety Executive (HSE). **[Finding 3]**

Key Findings		Risk & Impact	Agreed Management Action
2	**Health & Safety Site Visits** The health and safety site visits database records site visits completed in 2023 - 2024 (124) and the number of remedial actions identified (1461). 21% of the identified Health Board areas have been visited to date, and 75% of resulting actions were classed as *unresolved* at the time of our review. *See **page 2** for details.* Actions are assigned a priority rating but this is based on how quickly an issue can realistically be addressed rather than the significance or urgency. A central log of actions is not maintained – these are detailed only within individual site reports, and actions are not monitored through to implementation by the H&S Team, with reliance placed on the site manager/lead to provide updates. Consequently, there is no oversight of the significance of issues raised or outstanding.	Non-compliance with health and safety regulations is not identified or addressed, potentially resulting in harm to staff or patients, HSE penalty and reputational damage.	**Agreed Action:** A central record of all actions arising from H&S Site Visits will be maintained to facilitate oversight, monitoring and sharing of lessons. The methodology for prioritising actions will be refined to ensure that actions are prioritised based on the significance of the associated risk and urgency of action required. A follow up process will be established to ensure the highest priority actions are promptly addressed or escalated where appropriate.
			Expected Evidence of Implementation: Log of actions arising from H&S Site Visits. Updated action priority methodology. Evidence of pro-active follow up of the highest priority actions – e.g. email correspondence, repeated site visits undertaken.
		High Priority	**Officer:** Tim Harrison, Head of Health Safety & Security **Target Implementation Date:** 31 July 2025
	Theme: Quality, Safety & Patient Experience	Control Design	

3	**RIDDOR Reporting** The HSE RIDDOR reporting procedure requires reporting within 10-15 days of the incident, depending on the nature of the incident. The RIDDOR log highlights 53% compliance with reporting requirements for April – December 2024. Sample testing of 20 RIDDOR reportable incidents (as categorised on Datix) identified six cases where the incident had been reported to HSE between 19 – 61 days following the incident. Delay in reporting the incident on Datix was a contributory factor, and the Datix records demonstrated delays in service areas providing the H&S Team with the additional information required for HSE reporting.	Non-compliance with HSE RIDDOR reporting requirements.	**Agreed Action:** The H&S Team will raise awareness of RIDDOR timescales and requirements at directorate governance groups, and set timescales for responding to information requests to support compliance with reporting deadlines. Delays will be escalated to service/directorate management as appropriate. **Expected Evidence of Implementation:** Evidence of awareness raising e.g. directorate governance group meeting minutes, training and other correspondence. Timescales for response to information requests stipulated in correspondence. Evidence of escalation of delays in responding. Improved compliance with RIDDOR reporting timescales.
		Medium Priority	**Officer:** Tim Harrison, Head of Health Safety & Security **Target Implementation Date:** 30 April 2025
	Theme: Reporting	Control Operation	

Objective 3: Risks are managed effectively, with actions arising from internal and external reviews monitored through to implementation — **Substantial**

Overview / Summary of Observations

Risks are captured on Datix at service/departmental level, directorate level and corporate level. There are five corporate and seven directorate (operational) risks assigned to the Health & Safety Committee, with evidence of regular reporting and monitoring of these. The HS&S Team have oversight of all risks within the 'Safety' domain on, and receive automated notifications when a new risk in that domain is added to Datix.

Actions arising from external reviews are captured on the Health Board's Audit Management & Tracking (AMaT) system with progress reported to the Audit & Risk Assurance Committee.

Withybush and Bronglais hospitals were subject to HSE inspection in March 2024 to assess the Health Board's management of RAAC and asbestos, with no issues identified.

Objective 4: Governance structures are appropriate and effective, with mechanisms for regular reporting and escalation of key health and safety matters	**Limited**

Overview / Summary of Observations

The Health & Safety Committee (HSC) is responsible for providing assurance to the Board around the UHB arrangements for ensuring the health, safety, welfare and security of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers contractors. Terms of reference were most recently updated and approved by the HSC in November 2024. HSC reports to the Board were confirmed to be consistent with minutes of committee meetings.

Review of the meeting papers and minutes for January – November 2024 noted poor attendance by some Executive Directors. **[Finding 4]**

Meeting agendas are broadly in line with the workplan. Comparison of the workplan and terms of reference identified gaps with the absence of reporting on incidents, inspections and training compliance. **[Finding 5]**

We also noted instances where the committee has been unable to take assurance on matters reported, due to lack of detail, conflicting information or the presenters inability to adequately answer questions. The HSC Self-Assessment Outcomes report includes actions to address these issues. The six-month update report to the HSC in November 2024 reports that these are mostly complete with one action not due until January 2025. Consequently, no further actions are raised in this regard.

In May 2024 executive responsibility for health, safety and security transferred from the Director of Nursing, Quality & Patient Experience to the Director of Allied Health Professions & Health Science. This prompted a review of governance arrangements undertaken by the Director of Corporate Governance, which identified:

- numerous health and safety sub-groups reporting to HSC or Quality, Safety & Experience Sub-Committee, none of which had been formally constituted as terms of reference were out of date, had not been approved by the host committee or reflected in the terms of reference of the host committee.
- inconsistency in membership and quoracy requirements, and meeting frequency

Sub-groups have now been rationalised, sit within the health and safety governance structure and strengthened terms of reference have been developed, although it was too early to review the operation of these groups. The Health & Safety Advisory Group has been disestablished and a new Health & Safety Sub-Committee created to focus on setting the direction for the remaining sub-groups. Terms of reference for the sub-committee were presented to the HSC in November 2024.

	Key Findings	Risk & Impact	Agreed Management Action
4	**HSC Attendance** Review of the meeting papers and minutes for January – November 2024 noted poor attendance by some Executive Directors/nominated representatives, with no medical representation present any meetings, and others attending only two of five meetings reviewed. The same was highlighted in the Committee Self-Assessment Outcomes report presented to the HSC in March 2024. HSC membership has been updated in the revised terms of reference (November 2024) with the addition of the Director of Corporate Governance and Director of Estates, Facilities &	The HSC is ineffective in discharging its duties and reporting assurance to the Health Board.	**Agreed Action:** Executive Director members of the HSC, as per the revised terms of reference, will be reminded of their duty to attend HSC meetings. Attendance will be monitored on an ongoing basis. **Expected Evidence of Implementation:** Improved HSC meeting attendance rates.

	Capital Management, and removal of the Assistant Director of Nursing. **Theme:** Governance	**Medium Priority** Control Operation	**Officer:** James Severs, Executive Director of Allied Health Professions & Health Science **Target Implementation Date:** 30 April 2025
5	**HSC Workplan / Assurance Reporting** Terms of reference state that the HSC is responsible for: *3.8 Ensure there is a process of review of accident, incident and notifiable disease statistics to keep an organisational focus on trends, ensure that corrective action is taken* Whilst we observed examples of ad hoc reporting of learning from specific incidents, there is no reporting of H&S incident numbers, themes or trends. *3.13 Ensure there is a process of review of the efficacy of the health, safety, fire and security training programmes and ensure this process is adequate to meet the Health Board's objectives and statutory requirements.* Whilst we observed ad hoc examples of reporting in relation to training provided in response to specific issues or incidents, there is no routine monitoring or reporting on H&S training compliance. *3.10 Ensure there is a process of review of findings of safety management system audits and seek assurance that corrective actions are put in place.* *3.18 Ensure there is a process of review of health and safety compliance across the whole of the Health Board's business undertakings, including through a programme of health and safety audits and agree and monitor KPIs for health and safety performance to ensure evidence of compliance with external standards and regulatory requirements* Site visits are undertaken (see Objective 2) but there is no evidence of reporting progress against the programme, actions identified or progress in addressing these (note Finding 3 re outstanding actions). There is no evidence of KPIs in place, or monitoring/reporting in this regard. We are aware of plans to develop a H&S dashboard following the Committee Self-Assessment. **Theme:** Reporting	The HSC is ineffective in discharging its duties and reporting assurance to the Health Board. **High Priority** Control Design	**Agreed Action:** The identified gaps will be reviewed and incorporated into the remit and workplan of the HSC or H&S Sub-Committee where appropriate. **Expected Evidence of Implementation:** Updated workplan demonstrating inclusion of the identified gaps. Meeting agendas, papers and minutes demonstrating monitoring and reporting in relation to the identified gaps **Officer:** James Severs, Executive Director of Allied Health Professions & Health Science **Target Implementation Date:** 30 April 2025

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

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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.

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

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

4.3

11:30, 20 Mins

4.3 - Data Quality (Limited Assurance)

James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance), Anthony Tracey (Hywel Dda UHB - Digital Director)

For assurance

Attachments

4.3 Data Quality Final IA Report.pdf

Data Quality

Final Internal Audit Report

2024/25

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2425-28
Fieldwork	04 October – 05 November 2024
Executive Sign Off	29 January 2025
Audit Committee	February 2025
Executive Lead	Huw Thomas, Director of Finance
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Executive Summary

Purpose

To review the structures and processes for ensuring data quality within the health board.

Overview

We have concluded **limited** assurance on this area. This is provided primarily due to persistent data quality issues within the health board, despite the Information Quality Assurance (IQA) team having good processes in place. The primary concern lies with a lack of accountability at service level, where data quality issues originate but are not being adequately addressed. Consequently, the IQA team's resources are constrained to overseeing ongoing issues in one key system, leaving them unable to manage or improve data quality across other systems.

The matters requiring management attention include:

- a gap exists in the resources needed to fully implement and maintain data quality standards across all health board systems.
- lack of accountability for data quality within service areas.
- absence of data quality metrics to aid performance monitoring.
- absence of a formal Information / Intelligence Strategy to ensure a coordinated and systematic approach to utilising intelligence across teams and services.

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

Scope & Assurance Summary

Objectives		Related Findings	Assurance
1	Guidance is in place that sets out the requirements and responsibilities for data quality across the health board.	-	**Substantial**
2	There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise.	1, 2	**Limited**
3	There is appropriate monitoring and reporting of data quality within the health board.	3	**Limited**
4	There is a structure within the health board to enable the coordinated use of its information for planning, reporting and decision making.	4	**Reasonable**

Management Actions

3	1
High Priority	Medium Priority

Themes

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Guidance is in place that sets out the requirements and responsibilities for data quality across the health board. **Substantial**

Overview / Summary of Observations

Our review of the Information Quality Assurance (IQA) policy positively notes that it has been designed to ensure that the importance of high-quality data is disseminated to all staff. It describes what is meant by high-quality data and clearly sets out the implications of poor data and information. It clearly defines the roles and responsibilities for maintaining, improving and monitoring data quality through a clear framework of accountability, inclusive of an escalation plan to address non-conformance with IQA requests to correct potentially erroneous data.

We identified no matters arising for this objective.

Objective 2: There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise. **Limited**

Overview / Summary of Observations

The Information Quality Assurance (IQA) team is established to emphasise the importance of addressing poor quality data at its source. Data quality tools are not utilised, as the priority remains on rectifying the data source rather than manipulating data through available tools. Due to limited resources within the team, the organisation has focused its quality assurance efforts on a single key system (Welsh Patient Administration System) rather than implementing quality assurance (QA) checks across all systems. This approach ensures that essential QA standards are maintained where they have the greatest impact. Regular checks are conducted by the IQA team which generates reports highlighting potential erroneous data, which are distributed to relevant services, prompting them to review and correct inaccuracies as needed. However, we note that engagement has been poor overall from services, which may indicate that they do not fully understand the implications of data inaccuracies. This limited awareness can lead to low prioritisation of data quality tasks and as the IQA team faces resource constraints, it limits their ability to provide services with the necessary support and guidance on data quality improvements. The IQA team's capacity to follow up on identified data issues as per the escalation plan is also limited, reducing their ability to drive timely corrections and reinforce data

quality expectations across the organisation. These issues have been captured within the IQA Improvement Plan and whilst actions have been identified to address, the lack of sufficient capacity is hindering its effective implementation.

As QA is limited to one system, other systems may lack the same level of data scrutiny, which could introduce risks of inconsistent data quality across the organisation. Whilst this selective approach reflects a resource-efficient strategy that balances quality with feasibility, further investment is required over time to ensure all critical systems receive adequate QA attention and staff are fully supported in understanding the significance of maintaining high data quality standards.

	Key Findings	Risk & Impact	Agreed Management Action
1	**IQA Resourcing** Whilst a comprehensive data quality policy and supporting guidance are in place, a gap exists in the resources needed to fully implement and maintain these standards across all health board systems. Although the framework provides clear expectations and procedures for ensuring data accuracy, consistency and completeness, there is insufficient resource to monitor, audit, and enforce these guidelines effectively. As a result, data quality efforts may be applied inconsistently, leading to variability in data reliability and undermining the overall effectiveness of the data governance framework. Linked to Key Finding 2, we note that responsibility for data quality lies at service-level. Their lack of action in addressing the data quality issues that they have created places undue strain on the IQA team.	Poor quality data leads to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.	**Agreed Action:** The IQA Team along with the Performance Team will design specific metrics for data quality and these will be used in directorate escalation meetings to provide a greater focus on data quality. The IQA will continue conduct regular audits and reviews of data quality practices at both the centralised and service levels.
			Expected Evidence of Implementation: Explore investment in automated data quality monitoring tools that can continuously check for data accuracy, consistency, and completeness. Develop an escalation process via "Our Performance Dashboard" Define clear roles and responsibilities for data quality at all levels of the organisation. Establish a reporting structure that ensures data quality issues are escalated and addressed promptly.
		High Priority	**Officer:** Director of Digital **Date:** April 2025
	Theme: Resourcing	Control Operation	

2	**Data Quality Corrections** The IQA team frequently brings data quality concerns to the attention of relevant services; however, these issues are not consistently resolved. The IQA Annual Report for 2023-24 indicates persistent problems with duplicate registrations in WPAS, with 59% occurring in A&E and Minor Injury Units. This challenge has been ongoing, and past interventions have yielded minimal lasting results. To foster accountability, monthly reports detailing names and numbers are shared with senior site managers, clinical leads, and supervisors at each location, however, this has had little impact to date.	Poor quality data leads to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.	**Agreed Action:** The IQA Team along with the Performance Team will design specific metrics for data quality and these will be used in directorate escalation meetings to provide a greater focus on data quality.
			Expected Evidence of Implementation: Further expansion of the "Our Performance Dashboard" to include directorate specific reports with actions which will be used in escalation meetings with operational teams.
		High Priority	**Officer:** Director of Digital **Date:** April 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: There is appropriate monitoring and reporting of data quality within the health board. **Limited**

Overview / Summary of Observations

The health board demonstrates a commitment to data quality through routine error identification processes. This includes the use of the Validation at Source Service (VASS) provided by Digital Health and Care Wales (DHCW), which enables users to review and assess the quality of data before submitting it to the national database. This allows for error minimisation and ensures that data aligns with required formats and national standards, leading to a baseline level of reliability.

Linked to Key Finding 1, resource and capacity limitations are hindering the health board's ability to advance its data quality practices. These constraints affect the development of more comprehensive data quality metrics and improvements to current monitoring efforts, creating challenges in moving beyond error identification to more proactive quality enhancement for all health board systems.

The IQA team has recently developed a self-service Data Quality dashboard accessible to all staff to review their blank outcomes, rather than the limited number of key staff who received email notifications and manual reports. It is anticipated that the dashboard will have a positive impact on the IQA team, reducing the current labour-intensive process which will enable them to focus on other data quality issues identified within their improvement plan, which includes further development of the Data Quality dashboard to incorporate wider data quality issues.

We observed regular comprehensive reporting from the IQA team to the Information Governance Sub Committee (IGSC), which in turn reports to the statutory committee Sustainable Resources Committee. However, we note that there are limited data quality metrics being reported outside of the IQA Annual Report.

Key Findings		Risk & Impact	Agreed Management Action
3	**Data Quality Metrics** Whilst the IQA team regularly reports to the IGSC, there are no established metrics to comprehensively measure and monitor performance across services e.g. error resolution rates, timeliness and accuracy levels. Whilst an escalation plan is in place, which requires non-responses from services to be formally reported to the IGSC, as noted in Key Finding 1, IQA team capacity constraints have hindered this process. Developing performance metrics presents an opportunity to reduce the labour-intensive element of the escalation process and enables proactive monitoring.	Poor quality data leads to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.	**Agreed Action:** The IQA Team to develop a streamline process to focus on the delivery of actions which will be reported to IGSC for monitoring and review.
			Expected Evidence of Implementation: Explore investment in automated data quality monitoring tools that can continuously check for data accuracy, consistency, and completeness to release the time of the IQA team
		High Priority	**Officer:** Director of Digital **Date:** June 2025
	Theme: Performance Monitoring	Control Design	

Objective 4: There is a structure within the health board to enable the coordinated use of its information for planning, reporting and decision making.	**Reasonable**

Overview / Summary of Observations

The health board has the Information Reporting Intelligence System (IRIS) in place which provides a suite of Power BI reports / dashboards fed from the data warehouse, which allows users to manage, analyse and visualise data to support decision-making, reporting and strategic planning. Known as the 'front door' to the data held by the organisation, dashboards are available for various areas within the organisation such as Admissions & Wards, Cancer Services, Outpatients, Referral to Treatment, Theatres & Endoscopy, which offer insight into key metrics.

The health board acknowledges that there is an undocumented roadmap regarding siloed information, with the goal of integrating these into IRIS, where they will have dedicated dashboards. Several services have expressed interest in sharing their reports via IRIS, which will allow increased transparency, accountability and collaboration. The aim is to differentiate these reports from those produced by Information Services, ensuring viewers recognise their ownership by the respective service. Information Services are currently transitioning from a generic email address to the IT Service Desk portal to handle requests for information and products. From 1st April to mid-October 2024, Information Services has received over 920 requests and linked to Key Finding 1, there is a challenge to keep up with increasing demand.

We positively note that a Data Science team is in place, enabling the use of predictive analytics to improve patient outcomes, operational efficiency and resource management. However, poor data quality limits the effectiveness of these initiatives, reducing their financial return and leading to potentially high investments with low impact.

The health board is progressing with the Local Data Repository / National Data Resource project, which will serve as a single source of truth for healthcare data across Wales.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Information / Intelligence Strategy** The health board does not currently have a formal information / intelligence strategy that outlines not only what the organisation aims to achieve with data but also how it intends to collect, manage, analyse and apply that data effectively to ensure a coordinated and systematic approach to utilising intelligence across teams and services. This absence impacts the ability to align efforts, prioritise key areas and effectively use data for decision-making.	Poor quality data leads to: • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage.	**Agreed Action:** The Digital Response requires refreshing, and "data" will be a key element to be document. As part of the data management and analytics plan, we will look to expand how the organisation will use this information to make informed decisions and create machine learning (ML) or generative artificial intelligence (AI)
			Expected Evidence of Implementation: Signed off Digital Response, which will outline how the Health Board will collect, manage, store, and use its data to achieve its business goals
		Medium Priority	**Officer:** Director of Digital **Date:** August 2025
	Theme: Strategy	Control Design	

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.

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

4.4

11:50, 0 Mins

4.4 - Financial Management

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

4.5

11:50, 0 Mins

4.5 - Performance Management Arrangements

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

4.6

11:50, 0 Mins

4.6 - Executive Team Working

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

4.7

11:50, 0 Mins

4.7 - Elective Waiting List Management

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

4.8

11:50, 0 Mins

4.8 - Learning Lessons

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

4.9

11:50, 0 Mins

4.9 - Medical Workforce (Medical Locums Planned Care)

James Johns (NWSSP - Internal Audit)

DEFERRED to 15 April 2025 meeting

For assurance

5

11:50, 0 Mins

5 - Financial Focus

5.1

11:50, 10 Mins

5.1 - Financial Assurance Report

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

5.1 SBAR Financial Assurance Report ARAC February 2025.pdf

5.1 Financial Assurance Report ARAC February 2025 (incl Appendix 1 - 3).pdf

5.1 Appendix 4 CF1 HLG01 Carms CC 2023-24.pdf

5.1 Appendix 4 CF2 HLG01 Carms CC 2023-24.pdf

5.1 Appendix 4 Qualification Letter -Carmarthenshire CC HLGO1 2023-24.pdf

5.1 Appendix 4 Signed Pooled budgets memorandum 2023-24.pdf

5.1 Appendix 5 Annual Voucher 2023-24 (wanless) signed.pdf

5.1 Appendix 5 CF1 HLG03 Carms CC 2023-24.pdf

5.1 Appendix 5 CF2 HLG03 2023-24 Carmarthenshire County Council.pdf

5.1 Appendix 5 HLG03 QL 2023-24.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim John, Senior Finance Business Partner (Accounting & 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 & Advise respectively) and the issues, which the Committee can take assurance from the actions being undertaken (Assure).

Alert:

a) The Committee is alerted to breaches of Standing Financial Instructions (SFIs), which are reported for the first time (Appendix 1).

Advise:

a) The level of staff overpayments is increasing, though the average recovery period continues to be at a reduced level when compared to the last financial year.
b) Losses exceeding £5,000 are detailed in section 2.4 of the report. These losses will require approval by the Committee.

Assure:

a) Activity ongoing to reduce non-compliance with No PO No Pay.
b) PSPP compliance remains on target for delivery for the year.
c) Single Tender Actions are carefully controlled.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to**:**

- **DISCUSS** the addition of reporting on breaches of SFIs as detailed in Appendix 1, which are reported for the first time.
- **TAKE ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy.
- **TAKE ASSURANCE** from the controls in place to manage Single Tender Actions.
- **DISCUSS** the staff overpayments and **SEEK ASSURANCE** that actions to control them are sufficiently embedded.
- **APPROVE** write off of loss exceeding £5,000 as detailed in section 2.4
- **SCRUTINISE** the award of contracts listed in Appendix 1.

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:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2c Workforce and OD strategy 6a Clinical services plan 8c Financial Roadmap
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 Termau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital BT PSBA – British Telecom Public Sector Broadband Aggregation 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 – Withybush General Hospital WRP – Welsh Risk Pool
Partïon / 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

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

1.1 Purpose

- The purpose of this report is to outline the financial assurances which the Audit and Risk Assurance Committee requires.

- The framework agreed is included below in Figure 1, and the remainder of the report is based on this.

Figure 1: Compliance requirements for the Audit and Risk Assurance Committee

Compliance requirement	Reporting	Frequency
Scheme of delegation changes	• Exception reporting for approval	As and when
Compliance with Purchase to Pay requirements	• Breaches of the No PO, No Pay policy • Instructions for noting • Public Sector Payment Policy (PSPP) compliance • Tenders awarded for noting • Single tender action • Breaches of Standing Financial Instructions (SFIs)	Bi-monthly
Compliance with Income to Cash requirements	• Overpayments of staff salaries and recovery procedures for noting	Bi-monthly
Losses & Special payments and Write offs	• Write off schedule • Approval of losses and special payments	Bi-monthly
Compliance with Capital requirements	• Scheme of delegation approval for capital	Following approval of annual capital plan
Compliance with Tax requirements	• Compliance with VAT requirements • Compliance with employment taxes	Bi-monthly
Compliance with Reporting requirements	• 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

2.1 Scheme of delegation changes

No changes.

2.2 Compliance with Purchase to Pay Requirements

2.2.1 No PO, No Pay Policy Adherence

The Health Board uses the All Wales No PO, No Pay Policy (revised and approved in September 2024) and has a zero-tolerance stance to any non-compliance. NHS Wales Shared Services Partnership (NWSSP) have a control implemented to ensure that if there is no purchase order in place for an invoice, that invoice is placed on hold until such time as an appropriate purchase order is put in place. No invoices are paid without a purchase order.

There is an exemption list as part of the No PO No Pay Policy, which allows for certain types of invoices to be paid without a purchase order. These invoices do not constitute non-compliance with the policy and are therefore not reported in this paper.

Excluding those invoices on the exemption list, a total of zero invoices with zero value have been paid without a purchase order since 31 August 2024, when the revised All-Wales No PO No Pay policy came into force, providing assurance of the robust process now fully implemented and adhered to across the health board and NWSSP.

Invoices on Hold (IOH)

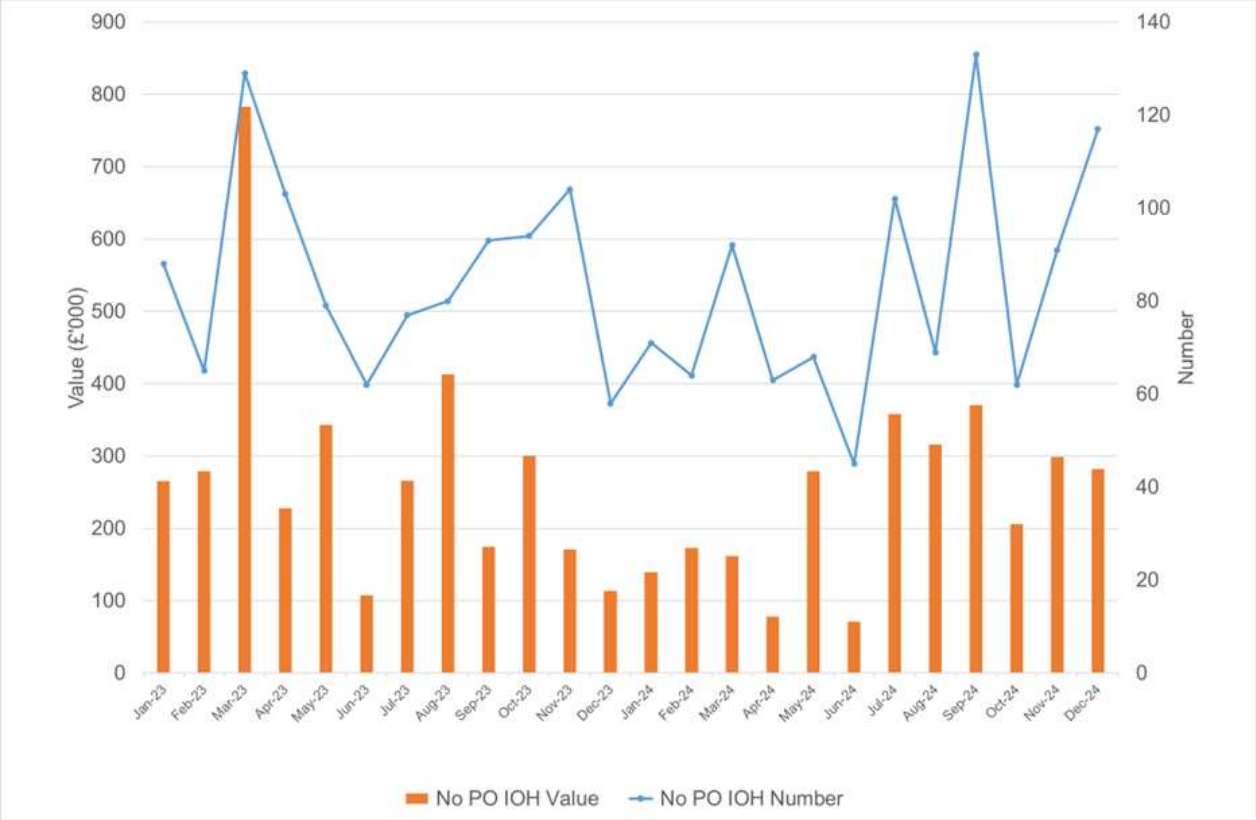
Whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH).

IOH can occur for two reasons. Firstly, Health Board Non-Compliance. The health board purchase requestor could have failed to raise a purchase order in the appropriate timeframe to provide it to a vendor in readiness for the supplier raising an invoice, resulting in the vendor presenting an invoice for payment without a purchase order referenced. Secondly, Supplier Non-Compliance. A supplier could have presented an invoice for payment without a purchase order reference, which they had been sent within the appropriate timeframes from the health board purchase requisitioner.

Figure 2 below illustrates the numbers and value of IOH as a result of no purchase order being quoted on the presented invoice. For the months of November and December 2024 there were a total of 208 IOH with a combined value of £581k. This compares to a total of 195 IOH on hold with a combined value of £576k for September and October 2024.

The cumulative position as at end of December 2024 had increased compared to at the end of October 2024; a total of 187 IOH with a combined value of £355k compared to 153 IOH with a combined value of £279k respectively.

Figure 2: Invoices on Hold awaiting a purchase order or credit note



Improving compliance with the No PO, No Pay Policy – reducing invoices on hold

As detailed above, there are two ways in which No PO No Pay non-compliance manifests itself, namely Supplier non-compliance and Health Board requisitioner and approver non-compliance.

Supplier Non-Compliance: The All-Wales Purchase to Pay (P2P) Governance group has confirmed that letters have been sent to all suppliers to remind them that their invoices will not be paid without a valid PO stated on an invoice. In addition, weekly emails will be sent to suppliers listing invoices that we cannot pay due to there being a lack of PO number stated.

Procurement, with the assistance of the Core Accounting Team (CAT) is reviewing suppliers which repeatedly non-comply, with a view to replacing them with an alternative supplier.

Below is a list of suppliers who frequently fail to provide a valid PO number on submitted invoices, together with the number and value of these invoices on a cumulative basis for this period and the actions being taken to improve:

Supplier	No. Inv	£
JUST WALES LTD	54	73,687.50
MARK HUNTER LTD TA TOTALLY WELSH	9	1,337.34
MEDINET CLINICAL SERVICES LTD	6	47,138.00
CEREDIGION CC	5	80,271.01

Supplier	Actions to improve:
JUST WALES LTD	SEE BELOW*****
MARK HUNTER LTD	The provider has been contacted and advised of NPNP Policy
MEDINET LTD	The service have been advised of ensuring that a PO is in place at the time of booking
CEREDIGION CC	The Ceredigion debtors team have been advised of the NPNP policy as well as the service leads for the charges

*****The local Procurement Team have sourced an alternative supplier, Health Courier Services (HCS). Where the use of HCS has been taken up within a service of the Health Board, there has been a reduction in the occurrence of non-adherence to the No PO No Pay policy and a cost saving. However, local Procurement are still in the process of ensuring that all services utilise HCS and not Just Wales Ltd.

Health Board Requisitioner and Approver Non-Compliance: As outlined above, during this reporting period CAT have allocated specific resource to clear aged IOH. In doing so CAT has reached out to non-complying areas within the Health Board to educate them on the importance of adhering to the new policy.

Work is now being undertaken by CAT to monitor directorates who do not comply with the policy and Service Delivery Mangers are being advised that they are failing to follow policy and assistance with any training that is required is offered.

Below are the five directorates with non-compliance in excess of £20,000 during the period ending December 24:

Directorate	No. Inv	£
Planned Care	20	82,574.59
Digital	5	70,974.15
Women & Children	3	28,155.79
Public Health	5	26,503.33
Mental Health & LD	3	21,370.50

2.2.2 Public Sector Payment Policy (PSPP) Compliance

The Health Board has a statutory responsibility to pay 95% of its non-NHS invoices within 30 days.

The Health Board successfully achieved its monthly PSPP target of paying 95% of non-NHS invoices for the months of November and December 2024 achieving 97.80% and 97.80% respectively. In addition, at the end of December 2024 the Health Board had met the target on a cumulative basis (96.40%).

Regarding the payment of NHS invoices, the Health Board paid 89.20% and 88.30% of these within 30 days for the months of November and December respectively.

The Core Accounting Team is continuing to spend time pursuing budget holders to authorise invoices promptly as e-mail requests from NWSSP Accounts Payable are often ignored. The team have also been providing training to areas where there are frequently high numbers of failures. This is in addition to contacting suppliers with invoices on hold without a PO, to help find the relevant PO or contacting the service users to raise a PO if required.

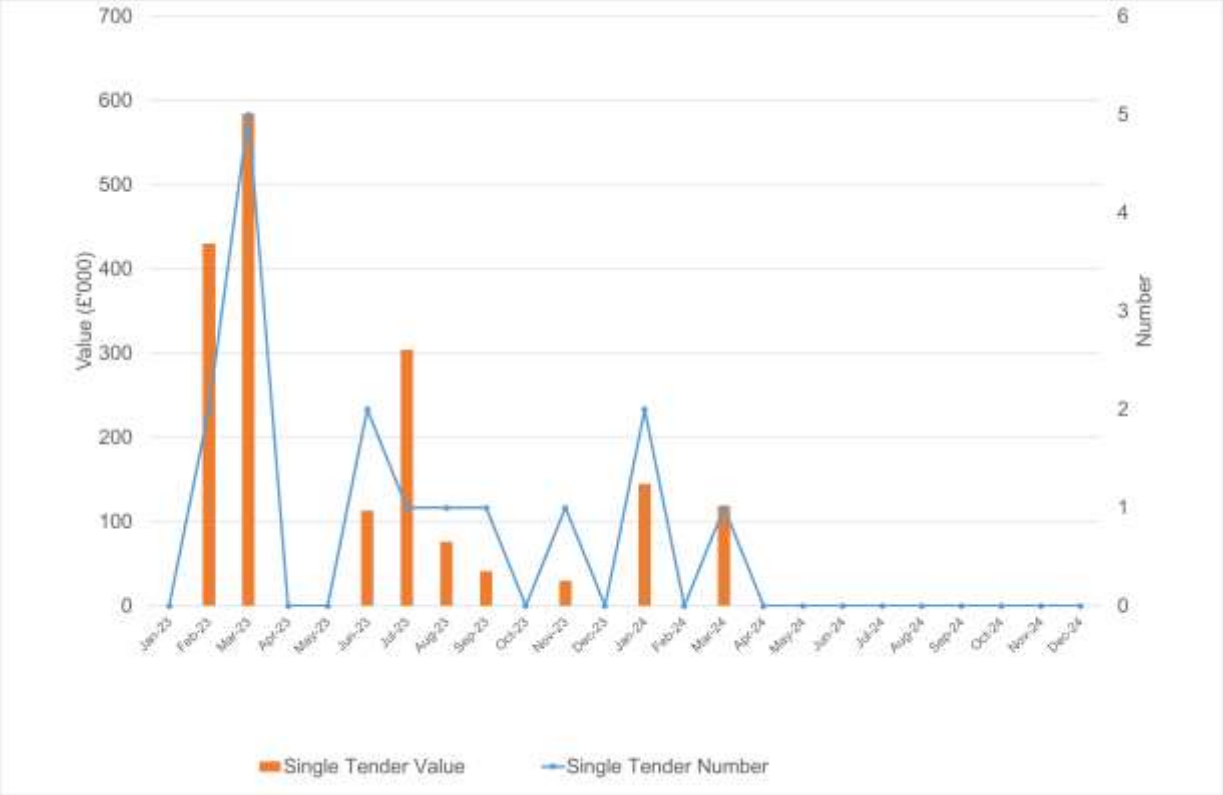
2.2.3 Single Tender Actions

The use of single tender waivers is carefully managed and controlled by the Health Board.

There were no Single Tender Actions (in excess of £25,000) during November and December 2024.

The graph (Figure 3) shows the trend of all Single Tender Actions (STA) approved from 1 January 2023 to 31 December 2024.

Figure 3: Numbers and value of Single Tender Actions



2.2.4 Tenders Awarded and Breaches of Standing Financial Instructions

There were 19 contracts awarded, including direct awards through framework and VEAT process during the period 1 November 2024 to 31 December 2024, totalling £17,742,940.

Details of these contracts, to the value of £25,000 and above, are provided in Appendix 1.

Standing Financial Instructions (SFIs) – SFIs detail the financial responsibilities, policies and procedures adopted by the Health Board. They are designed to ensure that our financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability.

Following a programme of work undertaken by Procurement, breaches of SFIs, to the value of £5,000 and above, will be reported to the Committee on a bi-monthly basis. This is the first time of reporting these breaches and therefore they have been reported retrospectively to the beginning of the current financial year 2024/25.

There were 34 breaches of SFIs totalling £487,680 during the period 1 April 2024 to 31 December 2024. Full details are provided in Appendix 1.

2.2.5 Consultancy contracts

There were 2 consultancy contracts awarded during November and December 2024, details of which are provided in Appendix 1, totalling £216,112.

2.3 Compliance with Income to Cash

2.3.1 Overpayment of Salaries

The Health Board has a duty to ensure that staff are paid appropriately, and that overpayments are not incurred.

Appendix 2 shows the volume and value of invoices raised in respect of overpayments for the period 1 November to 31 December 2024; 49 cases totalling £54,043, which represents 0.19% of the average monthly net pay costs.

In order to proactively address the issues leading to the overpayment of salaries, a combined Workforce and Finance Panel (in conjunction with relevant line managers) has been established to review on a quarterly basis, why overpayments have occurred and implement appropriate action to ensure future overpayments are minimised.

The first of these panel meetings was held in December; 13 meetings were originally arranged, 10 took place due to staff absence. The key points from the panel meetings were that:

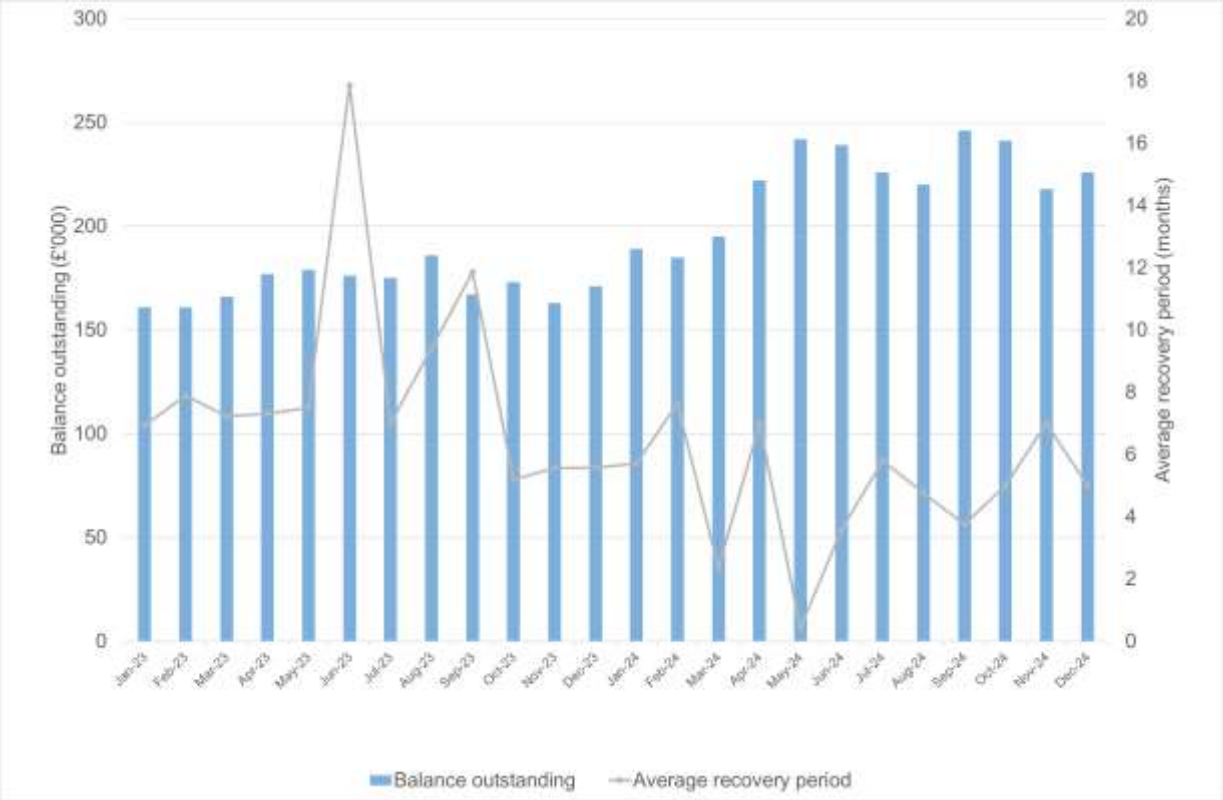
a) Lessons were learnt in terms of appropriate timescales to complete paperwork,
b) Any future queries on Change of Circumstances forms will be discussed with payroll,
c) Action plans will be put in place to mitigate the risks of future overpayments occurring.

All attendees recognised the need to improve the timeliness of completing termination forms and all assured the panel that there would not be any further instances. All attendees gave assurance that they would ensure better processes are put in place within their teams.

The graph below (Figure 4) demonstrates the total balance outstanding against the average recovery period. The average recovery period reflects the number of debts settled in the current period only. The total value raised in the period 1 November to 31 December 2024 was £54k compared to £78k in the period ended 31 October 2024.

The overall debt balance has decreased to £226k at the end of December 2024 compared to £241k at the end of October 2024, with the average recovery period remaining consistent at five months at the end of December.

Figure 4: Trend of aged overpayments and recoveries

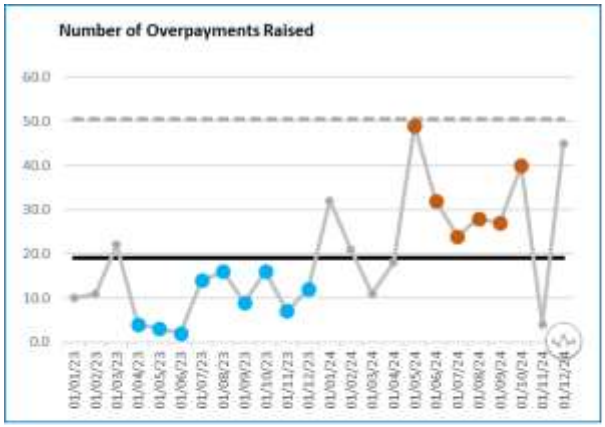


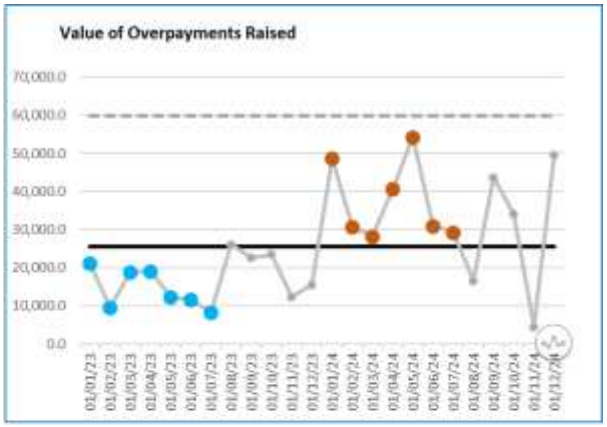
Further statistical analysis in respect of the overpayment of salaries is provided below:

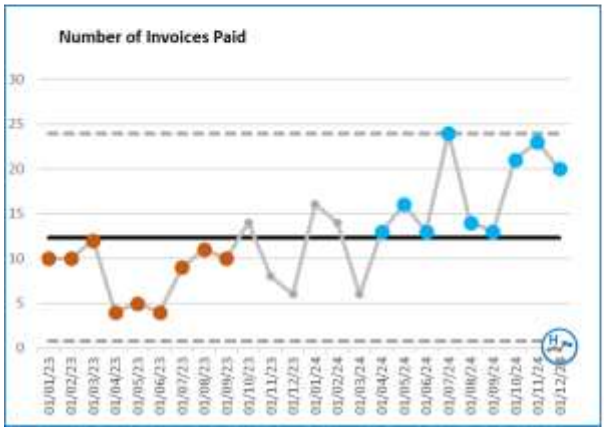
The four charts show the number and volume of invoices raised by the Health Board in respect of the overpayment of salaries during the period November 2022 to December 2024.

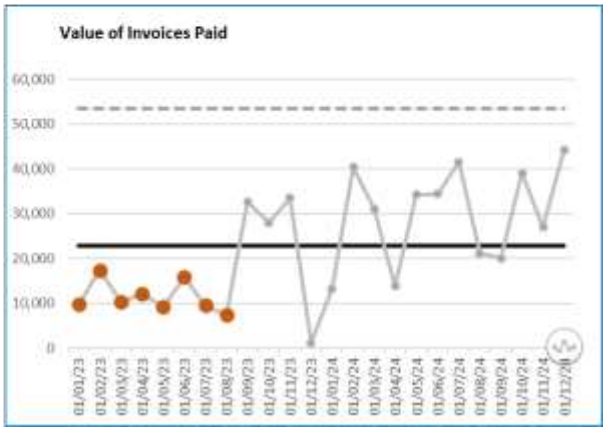
The rate at which the invoices have been raised varies based on the information gathered by the Payroll Department. The average number of invoices raised has increased to 19 invoices at the end of December 2024 compared to 18 invoices raised at the end of October 2024 and the average value per month has also increased to £26k at the end of December 2024 compared to £25k at the end of October 2024.

The rate at which the Health Board receives payment for these invoices has remained steady at an average of 12 invoices per month when compared to the end of the previous period at the end of October 2024. However, the average amount recovered per month has decreased from £24k to £23k since the end of October 2024.









2.3.2 Underpayment of salaries

NWSSP have provided details of emergency payments requested and paid in November and December 2024 for underpaid salaries, the total of which was £37,492.

Reasons for salary underpayments include:

- Wrong bank account details provided
- Incorrect recording of sick leave
- Late Authorisation of payment sent
- Late notification of return to work
- Incorrect Change forms

2.4 Losses and Special Payments for Approval

2.4.1 General Losses and Special Payments

Losses and special payments require the Audit and Risk Assurance Committee's approval given their contentious nature. There was one loss over £5k arising in the period 1 November to 31 December 2024 requiring the Committee's approval.

The loss in excess of £5k relates to the write off of a Debtors invoice for £6,137.00 in respect of an Overseas Patient. The patient was admitted to PPH in July 2023 with an appropriate invoice raised in August 2023 following discharge.

The invoice was passed over to the Health Board's debt collection agency in September 2023 for recovery. The debt collection agency has exhausted all avenues to recover the money and recommended the debt be written off.

Losses and write offs under £5k, as per requirement under FP02 – Income and Cash Collection, have been presented and approved by the Director of Finance and Chief Executive. In total these amounted to £50,449.

2.5 Compliance with Capital Requirements

No issues to report.

2.6 Compliance with Tax Requirements

2.6.1 Compliance with VAT Requirements

Within recent iterations of the Financial Assurance Report this section has described the latest position in respect of two long-running compliance items currently outstanding with HMRC, these being the VAT recoverability of charges under the all-Wales BT PSBA network contract and the final VAT recovery position of the Bronglais Hospital Front-of-House capital scheme. The Health Board has complied with all HMRC information requests connected with these items and both are currently with HMRC to consider its position further.

Both items are being managed on the Health Board's behalf by its external VAT advisors and have complex and technical VAT principles at their core. Our advisors have informed us that direct intervention by the Health Board at this time, in an attempt to expedite these items to a close, would not be appropriate and the Health Board would be better placed allowing these items to run to their natural conclusion.

As these items are slow-moving and likely to take many more months to conclude, only significant updates to each item will be reported within this section of this report going forwards.

2.6.2 Compliance with Employment Tax Requirements

No updates or issues to report.

2.7 Compliance with reporting requirements

IFRS 17 – Insurance Contracts. IFRS 17 Insurance contracts will be applicable in the public sector from 1 April 2025. The standard requires full retrospective adoption, so the transition date will be 1 April 2024 and it will have an impact on the accounting treatment for any organisation that has issued, or issues, a contract that meets the definition of an insurance contract.

Initial indications are that the Health Board has not issued any insurance contracts and Welsh Government have been advised accordingly. Audit Wales will confirm this during their external audit of the 2024/25 annual Accounts.

Pooled Budgets 2023/24 – details pertaining to pooled budgets between the Health Board and Carmarthenshire County Council with Appendix 4 for information.

Money Transfers – WANLESS Enablement, Carmarthenshire County Council 2023-24 – details pertaining to WANLESS Enablement between the Health Board and Carmarthenshire County Council with Appendix 5 for information.

Annual Accounts 2024/25 – Welsh Government have published the following draft submission dates:

- Draft Accounts package by **2 May 2024**
- Remuneration Report, Accountability Report and Performance Report by **9 May 2024**

2.8 Financial Compliance

The Finance Team is developing a reporting pack in respect of financial compliance.

The key systems feeds and journal processes have been mapped and the Accounts Payable system, Pharmacy system, Eden Dental Fees, Locum Accrual and PO Accrual reviews have been undertaken and completed. Internal Audit has been approached to ascertain their capacity to test the effectiveness of the controls that have been documented and access has been provided to the Accounts Payable system documentation to assist in their evaluation.

There are no further updates to report.

3.1 Recommendations

The Audit and Risk Assurance Committee is asked to:

a) Discuss the addition of reporting on breaches of SFIs as detailed in Appendix 1, which are reported for the first time
b) Take assurance from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy.
c) Take assurance from the controls in place to manage Single Tender Actions
d) Discuss the staff overpayments and seek assurance that actions to control them are sufficiently embedded.
e) Approve write off of loss exceeding £5,000 as detailed in section 2.4
f) Scrutinise the award of contracts listed in Appendix 1.

Appendix 1: Contracts awarded

Direct awards via Framework Agreement											
Period Covered by this report				1 Nov 2024	31 Dec 2024						
Reference	Framework Used & Reference	Supplier	Description	One off or Period		Value, exc VAT	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End						
HDD-DCO-22-24	Welsh Government National SLA for Tenovus Cancer Care / Lymphedema Network Wales	Tenovus Trading Limited	Tenovus Mobile Unit Hire	20/01/2025	20/05/2025	£42,453		N/A	N/A	Y	An extension to a direct award via Welsh Government National SLA for Tenovus Cancer Care / Lymphedema Network Wales framework has been awarded to Tenovus Trading Limited for the hire of a Tenovus Mobile Unit for 4 months. This contract award does not allow for an extension.
HDD-DCO-24-10	NHS Shared Business Services (SBS) Audio Visual Solutions and Integrated Operating Theatres 2 (SBS10245)	VitalHub UK Ltd	Intouch System Renewal	21/10/2024	20/10/2025	£32,600	Digital	No	N/A	Y	A direct award via NHS Shared Business Services (SBS) Audio Visual Solutions and Integrated Operating Theatres 2 (SBS10245) framework has been awarded to VitalHub UK Ltd for Intouch System Renewal for 12 months. This contract award does not allow for an extension.
HDD-DCO-24-18	National Procurement Service (NPS) - IT Products and Services (ii) (NPS-ICT-0094-19)	Softcat Plc	Rubrik Hardware and Support Upgrade	01/01/2025	01/10/2026	£244,478	Digital	No	N/A	Y	A direct award via National Procurement Service (NPS) - IT Products and Services (ii) (NPS-ICT-0094-19) framework has been awarded to Softcat Plc for Rubrik Hardware and Support Upgrade for 21

											months. This contract award does not allow for an extension.
HDD-DCO-24-17	NHS Shared Business Services (SBS) Digital Workplace Solutions (SBS/19/AB/WAB/9411)	TET Ltd	Freshservice Licence Renewal	20/12/2024	19/12/2027	£404,221	Digital	No	N/A	Y	A direct award via NHS Shared Business Services (SBS) Digital Workplace Solutions (SBS/19/AB/WAB/9411) framework has been awarded to TET Ltd for Freshservice Licence Renewal for 36 months. This contract award does not allow for an extension.
HDD-DCO-22-35	Health Trust Europe (HTE) Enterprise Level Information Communication Technology (ICT) Solutions (SF050716)	Softcat Plc	E-Job Planning Software Licences	31/12/2024	31/12/2025	£61,943	Digital	No	N/A	Y	An extension to a direct award via Health Trust Europe (HTE) Enterprise Level Information Communication Technology (ICT) Solutions (SF050716) framework has been awarded to Softcat Plc for E-Job Planning Software Licences for 12 months. This contract award does not allow for an extension.

Direct awards via VEAT process											
Period Covered by this report				1 Nov 2024	31 Dec 2024						
Reference	Framework Used & Reference	Supplier	Description	One off or Period		Value, exc VAT	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End						
HDD-VEAT-24-01	N/a	NuvoAir	NuvoAir Telehealth Monitoring in COPD and Difficult Asthma	01/11/2024	31/10/2025	£28,720	Primary Care	No	N/A	Y	A VEAT Notice was issued to confirm that NuvoAir were awarded a 12-month contract for NuvoAir Telehealth Monitoring in COPD and Difficult Asthma. This contract award does not allow for an extension.
HDD-VEAT-24-03	N/a	Paxman Scalp Cooling	Scalp Cooling System	13/01/2025	12/01/2030	£113,208	Charitable Funds	No	N/A	Y	A VEAT Notice was issued to confirm that Paxman Scalp Cooling were awarded a 60-month contract for the purchase and five-year maintenance and training for Scalp Cooling Systems. This contract award does not allow for an extension.

Contracts awarded post competitive tender										
Period Covered by this report			1 Nov 2024	31 Dec 2024						
Reference	Supplier	Description	One off or Period		Value, exc Vat	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	
			Start	End						Comment
HDD-MIN-56330	Softcat Plc	Data Centre Storage, Computing and Hypervisor Environment Replacement - GGH & WGH	01/11/2024	31/10/2029	£1,779,760	Digital	NA	Sep-24	Y	Following a competitive tender, Softcat Plc were awarded a 60-month contract for Data Centre Storage, Computing and Hypervisor Environment Replacement for Glangwili General Hospital and Withybush General Hospital. An option to extend the contract for a further 12 months is included in the award.
HDD-OJEULT-56102	Khan Dental Care	Provision of General Dental Services - Carmarthen & South Pembs	01/12/2024	30/11/2029	£5,000,000	Primary Care	NA	Sep-24	Y	Following a competitive tender, Khan Dental Care were awarded a 60-month contract for General Dental Services in Carmarthen & South Pembrokeshire. An option to extend the contract for a further 60 months is included in the award.
HDD-OJEULT-56102	Pentrepoeth Dental Practice (Gower Healthcare Dental Ltd)	Provision of General Dental Services - Carmarthen & South Pembs	01/12/2024	30/11/2029	£5,000,000	Primary Care	NA	Sep-24	Y	Following a competitive tender, Pentrepoeth Dental Practice (Gower Healthcare Dental Ltd) were awarded a 60-month contract for General Dental Services - Carmarthen & South Pembrokeshire. An option to extend the contract for a further 60 months is included in the award.

HDD-ITT-56843	PAPYRUS Prevention of Young Suicide	Provision of Suicide Prevention Services (2T's) Cluster	01/11/2024	31/03/2026	£89,252	Primary Care	NA	N/A	Y	Following a competitive tender, PAPYRUS Prevention of Young Suicide were awarded a 17-month contract for Suicide Prevention Services in the Towy Taf Cluster. An option to extend the contract for a further 12 months is included in the award.
HDD-OJEU-54290	Natural UK	Clinical Waste Home Collection, Transportation and Removal Service	01/01/2025	31/12/2027	£426,343	Estates	No	N/A	Y	Following a competitive tender, Natural UK were awarded a 36-month contract for Clinical Waste Home Collection, Transportation and Removal Services. An option to extend the contract for a further 24 months is included in the award.
HDD - OJEULT-57064	The Jac Lewis Foundation	Provision of a Mental Health Service in the Amman Gwendraeth Cluster	01/02/2025	31/01/2028	£225,000	Primary Care		N/A	Y	Following a competitive tender, The Jac Lewis Foundation were awarded a 36-month contract for Mental Health Services in the Amman Gwendraeth Cluster. An option to extend the contract for a further 12 months is included in the award.
HDD-MIN-57547	Healthcare Business Solutions	Insourcing of Trauma & Orthopaedic Procedures	24/12/2024	31/03/2026	£2,203,400	Scheduled Care	No	Dec-24	Y	Following a competitive tender, Healthcare Business Solutions were awarded a 15-month contract for Insourcing of Trauma & Orthopaedic Procedures. An option to extend the contract for a further 12 months is included in the award.
HDD-MIN-57777	Practice Plus Group	Outsourcing Ear, Nose, and Throat Procedures	24/12/2024	31/03/2025	£58,374	Scheduled Care	No	N/A	Y	Following a competitive tender, Practice Plus Group were awarded a 3-month contract for Outsourcing Ear, Nose, and Throat Procedures.

										This contract award does not allow for an extension.
HDD-MIN-57220	Lee Wakemans Ltd	Quantity Surveying Professional Services for Major Infrastructure Scheme	09/12/2024	31/03/2029	£475,000	Estates	Yes	N/A	Y	Following a competitive tender, Lee Wakemans Ltd were awarded a 52-month contract for Quantity Surveying Professional Services for Major Infrastructure Scheme. This contract award does not allow for an extension.
HDD-MIN-57668	SOFTWARE ONE UK LTD	Crowdstrike Licences	28/12/2024	31/12/2027	£618,893	Digital	No	N/A	Y	Following a competitive tender, SOFTWAREONE UK LTD were awarded a 36-month contract for Crowdstrike licences. An option to extend the contract for a further 12 months is included in the award.
HDD-OJEULT-57215	Kone Plc	Replacement Lift within Ward Four (4) at Glangwili General Hospital (GGH)	01/01/2025	31/08/2026	£173,723	Estates	No	N/A	Y	Following a competitive tender, Kone Plc were awarded a 20-month contract for Replacement Lift within Ward Four at Glangwili General Hospital. This contract award does not allow for an extension.
HDD-MIN-57914	Softcat Plc	Iboss Licence Solution	30/12/2024	31/03/2028	£549,458	Digital	No	N/A	Y	Following a competitive tender, Softcat Plc were awarded a 39-month contract for Iboss Licence Solution. An option to extend the contract for a further 24 months is included in the award.

Consultancy Contracts awarded										
Period Covered by this report			1 Nov 2024	31 Dec 2024						
Reference	Supplier	Description	One off or Period		Value, exc Vat	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
			Start	End						
HDD-MIN-56832	Opinion Research Services	Consultation and Engagement Consultancy Services	01/01/2025	31/12/2026	£104,992	Corporate	Yes	Nov-24	Y	Following a competitive tender, Opinion Research Services were awarded a 24-month contract for Consultation and Engagement Consultancy Services. An option to extend the contract for a further 12 months is included in the award.
HDD-ITT-57059	Hugh Irwin Associates	Quality Assurance Consultancy Services for Consultation and Engagement	01/01/2025	31/12/2026	£111,120	Corporate	Yes	Nov-24	Y	Following a competitive tender, Hugh Irwin Associates were awarded a 24-month contract for Quality Assurance Consultancy Services for Consultation and Engagement. An option to extend the contract for a further 12 months is included in the award.

Breaches of Standing Financial Instructions						
Period Covered by this report			01/04/2024		31/12/2024	
Month/ Year	**Supplier**	**Description**	**Value, exc Vat**	**Directorate**	**Comment**	**Actions taken to address**
April	eHealth Digital Media Ltd	To re-record commentary and amend film; To translate and replace existing English text into Welsh for hypertension films	£6,505	Primary Care	In the month of April 2024 a retrospective purchase order was raised to eHealth Digital Media Ltd for the payment of an invoice to re-record commentary and amend film; to translate and replace existing English text into Welsh for hypertension films. The total value of the purchase order was £6,505.00. This breach of Standing Financial Instructions sits within the Primary Care Directorate.	End User Educated
April	Interaction Method Paediatric Autism Communication Therapy (Impact) CIC	Pact training	£15,715	Therapies	In the month of April 2024 a retrospective purchase order was raised to Interaction Method Paediatric Autism Communication Therapy (Impact) CIC for the payment of an invoice for Pact training. The total value of the purchase order was £15,715.80.00. This breach of Standing Financial Instructions sits within the Therapies Directorate.	End User Educated
April	Medinet Clinical Services Ltd	Cardiology clinics at Bronglais General Hospital and Withybush General Hospital	£9,180	Unscheduled Care Glangwili	In the month of April 2024 a retrospective purchase order was raised to Medinet Clinical Services Ltd for the payment of an invoice for Cardiology clinics at Bronglais General Hospital and Withybush General Hospital. The total value of the purchase order was £9,180.00. This breach of Standing Financial Instructions sits within the Unscheduled Care Glangwili Directorate.	Procurement Activity Completed
April	Medinet Clinical Services Ltd	Neurology clinics	£13,000	Planned Care	In the month of April 2024 a retrospective purchase order was raised to Medinet Clinical Services Ltd for the payment of an invoice for Neurology clinics. The total value of the purchase order was £13,000.00. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	Procurement Activity Completed

May	Coach & Horses Surgery	Paper, use of photocopier and fax; rental of room for District Nurses; and Washroom Services	£9,878	Women & Children	In the month of May 2024 a retrospective purchase order was raised to Coach & Horses Surgery for the payment of an invoice for paper, use of photocopier and fax; rental of room for District Nurses; and washroom services. The total value of the purchase order was £9,878.27. This breach of Standing Financial Instructions sits within the Women & Children Directorate.	Breach Added to Procurement Workplan
May	DD Mechanical Ltd	Additional works to be carried out at Ty Bryngwyn Hospice	£6,302	Capital Expenditure	In the month of May 2024 a retrospective purchase order was raised to DD Mechanical Ltd for the payment of an invoice for additional works to be carried out at Ty Bryngwyn Hospice. The total value of the purchase order was £6,302.00. This breach of Standing Financial Instructions sits within the Capital Expenditure Directorate.	Procurement Buyers Reminded of Processes and Contracts
May	Lexis Nexis UK	Legal Fees	£18,550	Nursing	In the month of May 2024 a retrospective purchase order was raised to Lexis Nexis UK for the payment of an invoice for legal fees. The total value of the purchase order was £18,550.00. This breach of Standing Financial Instructions sits within the Nursing Directorate.	End User Educated
May	Medinet Clinical Services Ltd	Neurology clinics	£32,500	Planned Care	In the month of May 2024 a retrospective purchase order was raised to Medinet Clinical Services Ltd for the payment of an invoice for Neurology clinics. The total value of the purchase order was £32,500.00. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	Procurement Activity Completed
May	QBTech Ltd	License fees and yearly test fees	£14,021	Women & Children	In the month of May 2024 a retrospective purchase order was raised to QBTech Ltd for the payment of an invoice for license fees and yearly test fees. The total value of the purchase order was £14,021.28. This breach of Standing Financial Instructions sits within the Women & Children Directorate.	End User Educated
May	Stor A File Ltd	Retrieval of boxes	£5,151	Women & Children	In the month of May 2024 a retrospective purchase order was raised to Stor A File Ltd for the payment of an invoice for retrieval of boxes. The total value of the purchase order was £5,151.19. This breach of Standing Financial Instructions sits within the Women & Children Directorate.	Procurement Activity Underway

June	Civitas Law	Professional fees	£8,500	Workforce & Organisational Development	In the month of June 2024 a retrospective purchase order was raised to Civitas Law for the payment of an invoice for Professional fees. The total value of the purchase order was £8,500.00. This breach of Standing Financial Instructions sits within the Workforce & Organisational Development Directorate.	End User Educated
June	ETS Medical Ltd	Pathology transport	£13,082	Pathology	In the month of June 2024 a retrospective purchase order was raised to ETS Medical Ltd for the payment of an invoice for Pathology transport. The total value of the purchase order was £13,082.10. This breach of Standing Financial Instructions sits within the Pathology Directorate.	Procurement Activity Underway
June	S A Scaffolding Services Ltd	Continued rental of birdcage scaffolding	£8,080	Facilities	In the month of June 2024 a retrospective purchase order was raised to S A Scaffolding Services Ltd for the payment of an invoice for Continued rental of birdcage scaffolding. The total value of the purchase order was £8,080.00. This breach of Standing Financial Instructions sits within the Facilities Directorate.	Procurement Buyers Reminded of Processes and Contracts
July	Civitas Law	Professional fees	£12,849	Planned Care	In the month of June 2024 a retrospective purchase order was raised to Civitas Law for the payment of an invoice for Professional fees. The total value of the purchase order was £12,849.36. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action
July	Insight Direct (UK) Ltd	Concedo Eptura maintenance renewal	£20,265	Digital	In the month of June 2024 a retrospective purchase order was raised to Insight Direct (UK) Ltd for the payment of an invoice for Concedo Eptura maintenance renewal. The total value of the purchase order was £20,265.57. This breach of Standing Financial Instructions sits within the Digital Directorate.	End User Educated
July	Insight Direct (UK) Ltd	Maintenance For Nimble Hf40	£15,285	Digital	In the month of June 2024 a retrospective purchase order was raised to Insight Direct (UK) Ltd for the payment of an invoice for Maintenance for Nimble HF40. The total value of the purchase order was £15,285.44. This breach of Standing Financial Instructions sits within the Digital Directorate.	End User Educated

July	Lexis Nexis UK	Legal Fees	£5,103	Nursing	In the month of June 2024 a retrospective purchase order was raised to Lexis Nexis UK for the payment of an invoice for Legal Fees. The total value of the purchase order was £5,103.00. This breach of Standing Financial Instructions sits within the Nursing Directorate.	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action
July	Probo Medical Ltd	Payment for hire of ultrasound device	£6,000	Planned Care	In the month of June 2024 a retrospective purchase order was raised to Probo Medical Ltd for the payment of an invoice for Payment for hire of ultrasound device. The total value of the purchase order was £6,000.00. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	End User Educated
July	Skyguard Ltd	Mysos Subscription	£29,700	Nursing	In the month of June 2024 a retrospective purchase order was raised to Skyguard Ltd for the payment of an invoice for Mysos Subscription. The total value of the purchase order was £29,700.00. This breach of Standing Financial Instructions sits within the Nursing Directorate.	End User Educated
July	The Institute of Family Therapy	Course Fees	£6,600	Mental Health & Learning Disabilities	In the month of June 2024 a retrospective purchase order was raised to The Institute of Family Therapy for the payment of an invoice for Course Fees. The total value of the purchase order was £6,600.00. This breach of Standing Financial Instructions sits within the Mental Health & Learning Disabilities Directorate.	End User Educated
August	ECRI European Office	Medical Devices Alerts Workflow subscription	£9,465	Operations	In the month of June 2024 a retrospective purchase order was raised to ECRI European Office for the payment of an invoice for Medical Devices Alerts Workflow subscription. The total value of the purchase order was £9,465.00. This breach of Standing Financial Instructions sits within the Operations Directorate.	End User Educated
August	Impact Medical Ltd	Hire of a mobile lithotripter	£7,149	Planned Care	In the month of June 2024 a retrospective purchase order was raised to Impact Medical Ltd for the payment of an invoice for Hire of a mobile lithotripter. The total value of the purchase order was £7,149.30. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	Procurement Activity Completed

August	Medinet Clinical Services Ltd	Neurology clinics	£32,500	Planned Care	In the month of June 2024 a retrospective purchase order was raised to Medinet Clinical Services Ltd for the payment of an invoice for Neurology clinics. The total value of the purchase order was £32,500.00. This breach of Standing Financial Instructions sits within the Planned Care Directorate.	Procurement Activity Completed
August	SGS UK Ltd	UKMDR Medical Device, Recertification Audit, and Report Writing	£32,850	Operations	In the month of June 2024 a retrospective purchase order was raised to SGS UK Ltd for the payment of an invoice for UKMDR Medical Device, Recertification Audit, and Report Writing. The total value of the purchase order was £32,850.00. This breach of Standing Financial Instructions sits within the Operations Directorate.	Procurement Activity Underway
September	Multimedix Ltd	Technical Ultrasound and Quality Assurance Measurements of Ultrasound Systems and Probes	£47,656	Operations Management	In the month of September 2024 a retrospective purchase order was raised to Multimedix Ltd for the payment of Technical Ultrasound and Quality Assurance Measurements of Ultrasound Systems and Probes. The total value of the purchase order was £47,656. This breach of Standing Financial Instructions sits within the Operations Management Directorate.	Breach Added to Procurement Workplan
October	Health Education And Improvement Wales	Integrated Care GP Fellowship salary recharge for the period of 1st July 2024 to 2nd August 2024	£6,966	Primary Care	In the month of October 2024 a retrospective purchase order was raised to Health Education And Improvement Wales for the payment of Integrated Care GP Fellowship salary recharge for the period of 1st July 2024 to 2nd August 2024. The total value of the purchase order was £6,966. This breach of Standing Financial Instructions sits within the Primary Care Directorate.	End User Educated
October	Medoptimise Ltd	Medicines optimisation intervention subscriptions for 2024-2025	£10,782	Medicines Management	In the month of October 2024 a retrospective purchase order was raised to Medoptimise Ltd for the payment of Medicines optimisation intervention subscriptions for 2024-2025. The total value of the purchase order was £10,782 This breach of Standing Financial Instructions sits within the Medicines Management Directorate.	Procurement Activity Underway
October	Network For Practices Ltd	Training services (in-house sessions) for the 2Ts Cluster for the period of October 2024 and November 2024	£5,940	Primary Care	In the month of October 2024 a retrospective purchase order was raised to Network For Practices Ltd for the payment of Training services (in-house sessions) for the 2Ts Cluster for the period of October 2024 and November 2024. The total value of the purchase order was £5,940. This breach of Standing Financial Instructions sits within the Primary Care Directorate.	End User Educated

October	Prometheus Safe & Secure Ltd	Secure transport to transport a patient to out of area health care	£5,405	Mental Health & Learning Disabilities	In the month of October 2024 a retrospective purchase order was raised to Prometheus Safe & Secure Ltd for the payment of Secure transport to transport a patient to out of area health care. The total value of the purchase order was £5,405. This breach of Standing Financial Instructions sits within the Mental Health & Learning Disabilities Directorate.	End User Educated
October	SGS UK Ltd	ISO 13485 surveillance UKMDR accreditation with on-site visits in September 2024	£19,162	Operations Management	In the month of October 2024 a retrospective purchase order was raised to SGS UK Ltd for the payment of ISO 13485 surveillance UKMDR accreditation with on-site visits in September 2024. The total value of the purchase order was £19,162.50. This breach of Standing Financial Instructions sits within the Operations Management Directorate.	Breach Added to Procurement Workplan
November	Softcat Plc	Urgent maintenance cover for Citrix Pure storage	£11,622	Digital	In the month of November 2024 a retrospective purchase order was raised to Softcat Plc for the payment of Urgent maintenance cover for Citrix Pure storage The total value of the purchase order was £11,622.47. This breach of Standing Financial Instructions sits within the Digital Directorate.	End User Educated
November	Withers LLP	Legal services	£10,028	Nursing	In the month of November 2024 a retrospective purchase order was raised to Withers LLP for the payment of Legal services The total value of the purchase order was £10,028.00. This breach of Standing Financial Instructions sits within the Nursing Directorate.	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action
December	PKL Group (UK) Ltd	Hire of propane cylinder	£12,689	Capital	In the month of December 2024 a retrospective purchase order was raised to PKL Group (UK) Ltd for the payment of Hire of propane cylinder. The total value of the purchase order was £12,689.60. This breach of Standing Financial Instructions sits within the Capital Directorate	End User Educated
December	Stress Control Ltd	A three-year Stress Control community class license	£19,200	Mental Health & Learning Disabilities	In the month of December 2024 a retrospective purchase order was raised to Stress Control Ltd for the payment of a three-year Stress Control community class license. The total value of the purchase order was £19,200.00. This breach of Standing Financial Instructions sits within the Mental Health & Learning Disabilities Directorate.	End User Educated

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 Nov – 31 Dec 24		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	4,039.84	4
2	Late Notification of Changes	17,602.01	30
3	Late Notification of Termination	31,006.73	14
4	Late Notification of Absence	1,393.98	1
		54,042.56	49

Appendix 3: Losses and Special Payments over £5,000

	Period covered by this report:		1 November 2024 to 31 December 2024
Ref	**Losses and Special Payments Category**	**Value (£)**	**Explanation**
1	Overseas patient	6,137.00	Collection efforts exhausted; recommended to be written off by CCI
	Total Losses (for approval)		

Recommendation: Approve write off of loss as detailed in above table.

Archwilio Cymru
Audit Wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Certificate of the Auditor General for Wales

The Statement of Responsibilities of grant-paying and receiving bodies, the Auditor General for Wales and auditors who work under his arrangements for certifying claims and returns sets out the respective responsibilities of these parties. It also sets out the limitations of the responsibilities of the Auditor General for Wales and the auditors working under his arrangements.

I have examined the entries in this form ~~(which replaces or amends the original submitted to me / us by the receiving body dated _____)~~* and the related accounts and records of the receiving body in accordance with Certification Instruction A01, and have carried out the tests in Certification Instruction number HLG01 and obtained such evidence and explanations as I consider necessary.

Except for the matters raised in the attached qualification letter dated 20 December 2024

I have concluded that nothing has come to our attention to indicate that the claim or return:

- is not fairly stated; and
- is not in accordance with the relevant terms and conditions.

Signature

Name (block capitals)

JASON BLEWITT

(on behalf of the Auditor General for Wales)

Date 20-12-24

**Delete as necessary*

CF1 (5/16)

Archwilio Cymru
Audit Wales

Financial Audit Technical Group
Audit Wales
24 Cathedral Road
Cardiff
CF11 9LJ
telephone 029 20 320500
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email waogrants@audit.wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Covering sheet for claims or returns certified under the Auditor General's arrangements

Auditor's certificate re CARMARTHENSHIRE INTEGRATED COMMUNITY EQUIPMENT STORES
(name of the funder's grant programme and, if applicable, project name)

The enclosed document POOLED FUND MEMORANDUM ACCOUNT
(form number or if unnumbered, type of claim or return)

for the project/financial year ended 31 March 2024 (year)

has been certified on the request of CARMARTHENSHIRE COUNTY COUNCIL
(the grant receiving body)

This certificate is provided by an auditor working under the Auditor General's arrangements in accordance with the Statement of Responsibilities of grant-paying and receiving bodies, the Auditor General for Wales and the auditors who work for him in relation to grant claims and returns using CI HLG01 which was agreed with you.
(CI number)

You are asked to deal promptly with this certified document, taking account of any amendments and/or qualification letter noted below.

Your queries should normally be addressed to the grant receiving body because the claim or return read with the auditor's qualification letter should enable you to resolve outstanding issues. If exceptionally it is essential to address a query to the auditor, please address your query to Audit Wales at the above address, enclosing this form for identification purposes, together with the certified document if appropriate.

Please note: *Auditor to indicate by a tick if the option(s) applies*

Agreed amendments incorporated in the attached claim

☑ none (the claim entries are those originally made by the grant receiving body).

☐ the document replaces or amends the original and incorporates amendments made by the grant receiving body with auditor agreement which

* have no overall effect on entitlement

* increase the amount payable by _____ (name of party) by £ _____

* decrease the amount payable by _____ (name of party) by £ _____

** delete as appropriate*

Other matters for your attention

☐ none

☑ a qualification letter is attached setting out the other matters arising and the value of the matters raised is £ N/A (Errors found in the samples tested) and £ N/A (the extrapolated effect **if** further similar error(s) arose across the whole claim)

Only an original of this covering sheet confirms that:

- the enclosed document and any qualification letter have been sent direct to you by the auditor;
- the auditor has sent the grant receiving body a copy of the enclosed certified document, and any qualification letter in respect of it.

Auditor _____ *(Signature)* Date 20/12/24 CF2 ref AW/CA0025/24/3
Audit Wales /Firm and sequential no.

CF2 (5/16)

CFN issued N

Agreed amendments incorporated in the attached claim

Cells or lines amended	Reason for the amendment	Amount of amendment £	Basis of adjustment Actual / Extrapolated	Increase / Decrease
	N/A			

The effect of these amendments on the amount payable is shown on the front page.
However, for complex claims or returns, the table above does not show all of the consequential amendments arising on cells related to those originally mistated.

☐ See supplementary sheet for further amendments.

1 Capital Quarter / 1 Chwarter Cyfalaf
Cardiff / Caerdydd
CF10 4BZ
Tel / Ffôn: 029 2032 0500
Fax / Ffacs: 029 2032 0600
Textphone / Ffôn testun: 029 2032 0660
info@audit.wales / post@archwilio.cymru
www.audit.wales / www.archwilio.cymru

Mr Huw Thomas
Director of Finance
Hywel Dda University Local Health Board
Hafan Derwen
Jobswell Road
Carmarthen
SA31 3BB

Date issued: 20 December 2024

Dear Huw,

Carmarthenshire County Council: Pooled Budget (HLG01) 2023-24

I have certified the enclosed annual return in accordance with the Certification Instruction (CI) HLG01 subject to the following matters:

The Partnership Agreement in place is historic and is out of date

Test 2 of the Certification Instruction requires us to confirm that there is a signed Partnership Agreement in place. The Partnership Agreement that has been provided is from 2007 and was made between Carmarthenshire County Council, Carmarthenshire NHS Trust and Carmarthenshire Local Health Board. This local health board is now Hywel Dda University Health Board. This Agreement has been signed by the parties' officers that were in place at that time, dated 4th October 2007. There is no evidence that the Partnership Agreement has been updated since this date.

Furthermore, the Agreement is out of date since it refers to a historic budget as well as capital contributions from the Welsh Government and the Red Cross. These were related to initial set-up costs thus no longer being applicable.

Contributions are not in line with the Partnership Agreement

Test 6 of the Certification Instruction requires us to confirm that the Gross Funding on the Annual Return agrees with the Partnership Agreement.

As noted above, the Partnership Agreement is out of date and includes historic budget and contribution figures. As a result, the Gross Funding and contributions on the Annual Return do not agree with those in the Partnership Agreement. Therefore, we are unable to confirm that Test 6 of the Certification Instruction has been met.

Similarly, Test 7 of the Certification Instruction requires us to confirm that all budget amendments, whether to changes in contributions or to project expenditure, have been given prior written approval. Since the contribution values do not agree with the Partnership Agreement, and we have only seen minutes from May 2020 thus not relating to the 2023-24 budget and contributions, we are unable to confirm that Test 7 of the Certification Instruction has been met.

You are invited to consider the facts stated above and consider what action, if any, you choose to take.

Yours sincerely

Jason Blewitt

Audit Manager

POOLED FUND MEMORANDUM ACCOUNT for the period 1st April 2023 to 31st March 2024

Carmarthenshire Integrated Community Equipment Stores (CICES)

	£	£	
Gross Funding			
Carmarthenshire County Council	415,748.00		
Hywel Dda Local Health Board	648,940.00		
		1,064,688.00	A
Expenditure			
Gross Expenditure	2,143,761.73		
less Miscellaneous Income	-1,079,073.73		
Net Expenditure		1,064,688.00	B
Net overspend		0.00	B-A

CERTIFICATE OF CHIEF FINANCE OFFICER

I certify that the above pooled fund memorandum account accurately discloses the income received and receiveable and expenditure incurred in accordance with the partnership agreement, as amended by any subsequent agreed variations, entered into under section 33 of the National Health Service(Wales) Act 2006.

Signed.....Date.....30/07/24

Chief Financial Officer

SECTION 28A ANNUAL VOUCHER: FINANCIAL YEAR 2023-24

CARMARTHENSHIRE COUNTY COUNCIL

To be completed by 30th September of the following financial year

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2024

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No. and title of Expenditure Project	**Revenue Expenditure** £	**Capital Expenditure** £	**Total** £
Wanless			
Enablement	480,122	0	480,122
	480,122	**0**	**480,122**

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions including any cost variations, for each scheme agreed by the Hywel Dda Health Authority in accordance with Directions made by the National Assembly for Wales under Section 28A of the NHS Act 1977 as substituted by Section 1 of the Health and Social Services Adjudication Act 1983 and amended by Section 29 of the Health Act 1999.

Signed: ..... Deputy S151 Officer

Date: 08/10/24

Local Authority Chief Financial Officer (Section 151 Appointment) or Chairman of Voluntary sector organisations, as appropriate (see paragraph 6(2) of Directions).

Certificate of Auditor appointed by the Audit Commission

I/We have examined the entries in this form and the related accounts and records of the authority and have carried out the tests specified in Instruction No ..... prepared by the Audit Commission for its auditors and such other tests as I/we consider necessary and I/we have obtained such explanations as I/we consider necessary. (Subject to the observations in the attached report dated).

I am/We are of the opinion that:

- that the entries are fairly stated
- that the expenditure has been properly incurred in accordance with the Memorandum of Agreement signed by the Health Authority

Date.....

Auditor.....

Archwilio Cymru
Audit Wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Certificate of the Auditor General for Wales

The Statement of Responsibilities of grant-paying and receiving bodies, the Auditor General for Wales and auditors who work under his arrangements for certifying claims and returns sets out the respective responsibilities of these parties. It also sets out the limitations of the responsibilities of the Auditor General for Wales and the auditors working under his arrangements.

I have examined the entries in this form ~~(which replaces or amends the original submitted to me / us by the receiving body dated _____)~~* and the related accounts and records of the receiving body in accordance with Certification Instruction A01, and have carried out the tests in Certification Instruction number HLG03 and obtained such evidence and explanations as I consider necessary.

Except for the matters raised in the attached qualification letter dated 13 January 2025.

I have concluded that nothing has come to our attention to indicate that the claim or return:

- is not fairly stated; and
- is not in accordance with the relevant terms and conditions.

Signature

Name (block capitals)

JASON BLEWITT

(on behalf of the Auditor General for Wales)

Date 13-1-25

**Delete as necessary*

CF1 (5/16)

Archwilio Cymru
Audit Wales

Financial Audit Technical Group
Audit Wales
24 Cathedral Road
Cardiff
CF11 9LJ
telephone 029 20 320500
fax 029 20 320600
email waogrants@audit.wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Covering sheet for claims or returns certified under the Auditor General's arrangements

Auditor's certificate re NHS WALES ACT 2006 & SECTION 34 MONEY TRANSFERS (HLG03)
(name of the funder's grant programme and, if applicable, project name)

The enclosed document SECTION 28A ANNUAL VOUCHER 2023-24
(form number or if unnumbered, type of claim or return)

for the project/financial year ended 31 March 2024 (year)

has been certified on the request of CARMARTHENSHIRE COUNTY COUNCIL
(the grant receiving body)

This certificate is provided by an auditor working under the Auditor General's arrangements in accordance with the Statement of Responsibilities of grant-paying and receiving bodies, the Auditor General for Wales and the auditors who work for him in relation to grant claims and returns using CI HLG03 which was agreed with you.
(CI number)

You are asked to deal promptly with this certified document, taking account of any amendments and/or qualification letter noted below.

Your queries should normally be addressed to the grant receiving body because the claim or return read with the auditor's qualification letter should enable you to resolve outstanding issues. If exceptionally it is essential to address a query to the auditor, please address your query to Audit Wales at the above address, enclosing this form for identification purposes, together with the certified document if appropriate.

Please note: *Auditor to indicate by a tick if the option(s) applies*

Agreed amendments incorporated in the attached claim

☑ none (the claim entries are those originally made by the grant receiving body).

☐ the document replaces or amends the original and incorporates amendments made by the grant receiving body with auditor agreement which

* have no overall effect on entitlement

* increase the amount payable by _____ (name of party) by £ _____

* decrease the amount payable by _____ (name of party) by £ _____

** delete as appropriate*

Other matters for your attention

☐ none

☑ a qualification letter is attached setting out the other matters arising and the value of the matters raised is £ N/A (Errors found in the samples tested) and £ N/A (the extrapolated effect **if** further similar error(s) arose across the whole claim)

Only an original of this covering sheet confirms that:

- the enclosed document and any qualification letter have been sent direct to you by the auditor;
- the auditor has sent the grant receiving body a copy of the enclosed certified document, and any qualification letter in respect of it.

Auditor _____ *(Signature)* Date 13-1-25 CF2 ref AW/CA0025/24/4
Audit Wales /Firm and sequential no.

CF2 (5/16)

CFN issued N

Agreed amendments incorporated in the attached claim

Cells or lines amended	Reason for the amendment	Amount of amendment £	Basis of adjustment Actual / Extrapolated	Increase / Decrease
	N/A			

The effect of these amendments on the amount payable is shown on the front page.
However, for complex claims or returns, the table above does not show all of the consequential amendments arising on cells related to those originally mistated.

☐ See supplementary sheet for further amendments.

1 Capital Quarter/ 1 Cwr Dinas
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Mr Huw Thomas
Director of Finance
Hywel Dda University Local Health Board
Hafan Derwen
Jobswell Road
Carmarthen
SA31 3BB

Money Transfers – WANLESS Enablement, Carmarthenshire County Council 2023-24

Date issued: 13 January 2025

Dear Huw

I have certified the enclosed annual voucher in accordance with Certification Instruction (CI) HLG03 subject to the following matters:

There was no signed Memorandum of Agreement in place

CI paragraph 6 requires us to confirm that there is a signed Memorandum of Agreement (MoA) for each scheme listed in the Voucher, in the required format and valid for the period of the voucher. There was no signed Memorandum of Agreement in place for 2023-24. We have been provided with a Service Level Agreement (SLA) for the service in 2021-22, which has been signed but not dated.

We are further required to confirm that only expenditure allowed as eligible under the agreement have been included on the annual voucher. Given that there is no approved MoA for 2023-24, this has not been possible. However, we can confirm that expenditure included on the voucher is in line with the 2021-22 SLA (signed but not dated).

Contributions are not in line with the Memorandum of Agreement

CI test 6 requires us to confirm that the Gross Funding (including contributions) on the voucher agrees with the terms outlined in the agreement.

As noted above, there is no signed MoA for 2023-24 therefore we have not been able to agree the funding contribution to an agreement. The £480,122 Health Board contribution is 41.53% of the total eligible expenditure as in line with the 2021-22 SLA agreement noted above, and is the amount invoiced and included on the annual voucher.

We also note that the SLA states that the funding contributions will be invoiced on a quarterly basis, in arrears. The funding contributions for 2023-24 were invoiced in full by the council on 2nd August 2024.

You are invited to consider the facts stated above and consider what action, if any, you choose to take.

Yours sincerely

Jason Blewitt
Audit Manager

cc Chris Moore, Director of Corporate Services and s151, Carmarthenshire County Council

5.2

12:00, 5 Mins

5.2 - Annual Statement of Financial Procedures

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

5.2 Annual Statement of Financial Procedures ARAC February 2025.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Statement of Financial Procedures
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim John, Senior Finance Business Partner (Accounting & 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 2025/26.

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 Sustainable Resources Committee before they are shared on the intranet and implemented across the Health Board.[1]

It is proposed that 10 procedures are reviewed during 2025/26 – 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 Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / 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 Sustainable Resources 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 2025/26	Planned Review date	Category/Team
1032	Treatment of private patients, control of admission and collection of income	**June 25**	**Non-contracted Activity**
093	Disposal of surplus & Obsolete furniture, equipment, sale of scrap and other waste materials	**Aug 25**	**Capital**
973	Cash procedure	**Aug 25**	**Financial Accounts**
082	Oracle E-Business Suite - System Access and Ledger Security Financial Procedure	**Aug 25**	**Systems**
420	Charitable Funds: Financial Administration and Governance Procedure [2]	**Oct 25**	**Charitable Funds**
050	Cash Imprest Accounts – Rehabilitation Monies Financial Procedure	**Nov 25**	**Financial Accounts**
070	Hospital Travel Cost Scheme Financial Procedure	**Nov 25**	**Core Accounting Team**
051	Income and Cash Collection Financial Procedure	**Nov 25**	**Financial Accounts**
078	Patient Property and Monies Financial Procedure	**Nov 25**	**Financial Accounts**
1049	Use of consultancy procedure	**Dec 25**	**Financial Accounts**

[2] This procedure is approved by the Charitable Funds Committee

5.3

12:05, 5 Mins

5.3 - Counter Fraud Update

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

For assurance

Attachments

5.3 SBAR Counter Fraud Update ARAC February 2025.pdf

5.3 Counter Fraud Update ARAC February 2025.pdf

5.3 Appendix 1 - NFI Checklist.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, 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:	3. Striving to deliver and develop excellent services 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:	Counter Fraud Workplan
Rhestr Termau: Glossary of Terms:	CF – Counter Fraud CFS Wales – Counter Fraud Services Wales FRA – Fraud Risk Assessment LCFS – Local Counter Fraud Specialist/s LPE – Local Proactive Exercise PPV – Post Payment Verification NHS CFA – NHS Counter Fraud Authority NWSSP – NHS Wales Shared Services Partnership
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 11 February 2025

The NHS Protect Standards are set in four generic areas:

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

AREA OF ACTIVITY	Resource Allocated (days) 2023/24	Resource Used (days) as at 28/01/2025	Resource Used (Percentage as at 28/01/20254)
STRATEGIC GOVERNANCE	40	37	92%
INFORM AND INVOLVE	85	77	90%
PREVENT AND DETER	120	96	88%
HOLD TO ACCOUNT	175	150	85%
TOTAL	**420**	**312**	**85%**

Work Area	*Summary of work areas completed*
Inform and involve	• All new inductees have completed the Health Board's induction programme and the Counter Fraud mandatory training programme. The Health Board's Learning and Development Department are currently undertaking a review of Mandatory Training and have queried with Counter Fraud as to whether the existing Counter Fraud E-Learning package needs to remain mandatory. In response, Counter Fraud have advised Learning and Development that the e-learning package currently in place needs to remain mandatory. The package provides the Health Board with assurance that relevant training is both provided and completed by all employees, ensuring compliance with both Government Functional Standards and Welsh Government directions. Counter Fraud have been asked to present their case to the Mandatory Training Group on 4 February 2025. A verbal update of the outcome will be provided to the Committee. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme and the Overseas Nurses Induction. • Alerts associated with emerging risks have been communicated to key stakeholders; these included information on fraudulent transactions via credit card machines and a recent threat associated with persons unknown impersonating medical professionals to work agency Nurse and HCSW shifts. • Counter Fraud currently sit on the quarterly HDdUHB Local Intelligence Network (LIN), during 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	• 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.

Partial data associated with the 2024/25 NFI was released towards the end of December 2024, with the remaining data being released week commencing 13 January 2025. In preparation, Audit Wales asked that a self-appraisal checklist is completed and shared with ARAC. In response, Appendix 1 has been completed and submitted for the Committee's attention.

Historically, work associated with the initiative has been undertaken by Counter Fraud and NWSSP; however, as highlighted in the checklist, assistance will be required from other departments to facilitate its completion.

- A pro-active exercise has commenced into governance procedures surrounding Right to Work checks undertaken by contractors who are awarded work via NWSSP design for life construction frameworks. Further details are included within the In-Committee report.
- Earlier in the year, a Fraud Risk Assessment was undertaken in connection with a Fraud Prevention Notice linked to Impersonating Medical Professionals. In recent weeks, further alerts from NHS England have identified that this issue remains prevalent and therefore a review of the risk will take place, and the effectiveness of the Health Board's controls reviewed by way of three exercises:
    1. Undertake a review of the existing Risk Assessment - a copy of the completed risk assessment has been appended to the In-Committee report. The risk has been assessed as low.
    2. Two workers, one shift - this exercise will look to review the Health Board's internal systems, specifically scenarios where two persons are said to have worked the same shift. In these circumstances, there is a risk that a person with genuine credentials will have booked and been allocated a shift, but a different

	worker arrives on the day. The risk is that this person is unknown to the Health Board and is impersonating another. The exercise will look to demonstrate that Wards / Nurse Bank are allocating one person per booking reference and where the shifts are split, a rationale for doing so is being recorded on the rostering system. 3. Identification Checks - the exercise will look to verify the identity of those on duty on specific times and dates. A sample of workers will be identified as working via an agency on a given date. Counter Fraud will then attend the sites and verify the identity of those working by way of examining identification badges and cross referencing with known data supplied by the Nursing agency concerned. As part of this exercise, Health Board employees responsible for inducting new agency staff at a ward level will be reminded of the need to undertake an appropriate local induction, which should include the checking of identity / identification and appropriate uniform.
Hold to Account	• 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. CFS Wales have produced their quarterly report, which has been appended to the In-Committee report. • The LCFS attended a quarterly PPV meeting, during which issues relating to current error trends were raised and discussed, with a view to identifying potential risk areas. These meetings will continue throughout the year.

Report Provided by:
Ben Rees - Lead Local Counter Fraud Specialist
For presentation; 11 February 2025

Report agreed by:
Huw Thomas
Director of Finance

Archwilio Cymru
Audit Wales

National Fraud Initiative Self-Appraisal Checklist

Date issued: November 2024

Version: Final

Document reference: 4608A2024.

Contents

About the National Fraud Initiative

1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems, which might suggest the existence of fraud or error.

2 Fraud, error, and overpayment outcomes valued at £7.1 million were recorded by participants for the NFI 2022-23 exercise. Beyond any financial savings, the benefits of participation and reviewing data matches include the assurances that NFI results can provide around systems of internal control. NFI results may also highlight areas for improvement.

3 The Public Sector Fraud Authority (PSFA) – part of the UK Government's Cabinet Office and HM Treasury – oversees the 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.

4 The Auditor General has mandated that unitary local authorities, NHS bodies, police forces, and fire and rescue authorities participate in the NFI. Other organisations participate on a voluntary basis, such as the Welsh Government and some Welsh Government arm's length bodies.

5 Information about the NFI is also available on the Audit Wales website.

About this document

6 The NFI is one aspect of an organisation's counter-fraud arrangements. We have prepared this checklist to help participating bodies self-appraise how they are engaging with the NFI.

7 We encourage all participating bodies to complete the checklist and present it to those charged with governance to support scrutiny of their NFI arrangements.

Self-appraisal checklist

Leadership, commitment, and communication				
		Yes / Partly / No	**Comments / action required**	**If action is required, who by and when?**
1	Are we committed to the NFI? Has the council / board, those charged with governance and senior management expressed support for the exercise and has this been communicated to relevant staff?	Yes	Activity associated with the NFI, namely Payroll related matches, is included in the Counter Fraud Service annual work plan. NHS Wales Shared Services Partnership undertake work associated with Procurement on behalf of each NHS Wales Health Board. Work will commence on publication of the data and will continue throughout the year.	Counter Fraud and NWSSP Procurement will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.
2	Have we committed specific resources to support the overall management of the NFI? If information is available, how much time was spent by the Key Contact on the last exercise, and how much has been allocated for the next exercise?	Yes	Counter Fraud Specialists, of which there are two, will undertake the necessary work, which is categorised as Preventative Activity. Whilst there is not specific allocation for NFI on its own, a total of 120 days has been allocated to all Preventative activities.	Counter Fraud and NWSSP Procurement will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.

3	Is our NFI Key Contact the appropriate officer for that role, i.e. has sufficient authority to ensure the NFI exercise is delivered effectively?	Yes	The Key contact is currently the Head of Local Counter Fraud Services, who will report on the progress of activity undertaken to the Audit, Risk and Assurance Committee (ARAC).	Not applicable
4	Does internal audit, or equivalent, monitor our approach to NFI and our main outcomes, ensuring that any weaknesses are addressed in relevant cases?	Yes	Where an offence or risk is identified, the matter is reviewed and if applicable reported to ARAC and the appropriate service lead in line with Health Board risk management procedures.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative, with feedback provided to ARAC via an in-committee report.
Planning and preparation				
5	Do we plan properly for all aspects of the NFI exercise and set our own internal deadlines?	Yes	As previously stated, activity associated with the exercise has been included within the Counter Fraud annual work plan, with regular progress reviews being undertaken throughout the year.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.
6	For the NFI 2024-25 exercise, did we provide all NFI data on time using the secure data file upload facility properly?	Yes	Yes, NWSSP submitted data for all NHS Wales Health Boards and all payroll data was obtained directly from ESR via each health board's VPD code.	Actions to be completed by NFI and NWSSP Procurement in compliance with guidance provided.
7	For the NFI 2024-25 exercise, did we confirm promptly (using the online facility on the secure website) that we have met the fair processing notice requirements?	Yes	We confirm that all appropriate steps have been taken to inform individuals about the collection and use of their personal data in accordance with the requirements of the General Data Protection Regulation and the Data Protection Act 2018 and, in particular, to inform individuals that personal data will be disclosed to fraud prevention (and/or detection bodies) for the purpose of assisting the prevention and detection of fraud.	Actions were undertaken by counter Fraud in August and September 2024 and documented within NFI.

8	Do we review our Data Quality results before starting our investigations?[1]	Yes	Yes, this will be completed following NFI's publication of the data, which is expected sometime on or after the 20 December 2024.	The LCFS is to review data quality by the end of January 2025.
9	Do staff take time to read the guidance that is provided on how to follow up the NFI matches (which are especially important for those users encountering the NFI for the first time), and do they consult the NFI team if they are unsure about how to record outcomes?	Yes	NFI training has been provided to both Counter Fraud Specialists. Where assistance is sought, access to NFI is granted and relevant training is provided.	Not applicable.
10a	Have we considered using the point of application data matching service offered by the NFI team (App Check) to improve internal controls and prevent fraud and error from happening?	Yes	Upon review, current App Check services allow HDdUHB to undertake payroll to payroll checks, which are already part of the exercise data provided. It appears from the literature provided by NFI, App Check is more relevant to those charged with processing benefit, housing, or other claim applications, such as blue badge applications.	Not applicable.
10b	If not using App Check, is there a clear rationale for this?	N/A	Currently available, however, only Payroll Data is viewable / provided by NFI.	Not applicable.
Effective follow-up of matches				
		Yes / Partly / No	**Comments / action required**	**If action is required, who by and when?**

[1] The Data Quality module could indicate that there are issues with the data submitted that may have affected some of the matches. The module can be accessed from the relevant National Exercise page of the web app.

11	Have we documented our approach for risk assessing data match reports and investigating data matches?[2]	No.	This activity will be undertaken following release of the data and analysis of the risks identified.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.
12	Does our approach give priority to local fraud risks?[3]	Partly.	Where applicable, all risks will be managed, however, where a local risk is identified and an investigation instigated, priority will be given to prevent loss or further offending.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.

[2] We do not expect organisations to look at every data match or report. Instead, they should prioritise which matches to look at and the order in which they are followed up. They may want to assess your matches by fraud risk area and then by match risk scores. Alternatively, they may want to set up bespoke filters using the filter tool. Matches not investigated should be Closed – Not Selected for Investigation.

[3] We suggest that the NFI Key Contact (with support from Internal Audit/Counter Fraud) should review the organisation's overall control environment and systems. Existing internal audit reports and/or your organisation's risk register should assist this review. We advise prioritising data match reports that are linked to areas that have unknown or weak internal controls or areas that have had historical instances of fraud. Organisations should also look back to see which reports in a previous exercise gave them outcomes.

13	Does our approach give priority to following up high-risk matches, those that become quickly out of date and those that could cause reputational damage if a fraud or error is not stopped quickly?[4]	Yes	As above. In addition, NFI attribute a risk score to each match identified by them. As such, all payroll matches for completion by Counter Fraud will be processed in order of priority, from high to minimal risk (as risk scored by NFI).	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.
14	Are sufficient resources and expertise available at the right time to maximise the outcomes of the NFI exercise?[5]	Yes	Both data set and investigative leads have been appointed. NWSSP Procurement taking the lead on all procurement related data match sets and Counter Fraud on all Payroll data match sets. Please note, should NWSSP procurement identify a match of concern, the matter will be raised with both the NWSSP and HDdUHB Counter Fraud specialist. Where no criminal activity is suspected, but honesty and integrity issues linked to an employee have, a report will be completed, and a referral made outside of NFI to the relevant service lead and Workforce & OD department.	Counter Fraud, Workforce & OD and NWSSP Procurement will undertake necessary actions in line with the required timeline outlined by the initiative.

[4] Use the tools within the web application, such as the filter and sort options or data analysis software, to help prioritise matches deemed the highest risk.

[5] When nominating users to investigate matches, organisations should choose the person with the most knowledge about the dataset. For example, trade creditors matches are best dealt with by a nominated person in internal audit or the accounts payable team. We also suggest assigning a user to act as lead dataset contact for each dataset your organisation submits, so that, if necessary, other NFI participants can contact the most suitable person to assist their investigation. If organisations do not nominate a lead dataset contact, the default contact will be the Key Contact.

15	Does the Key Contact coordinate investigations across internal departments to prevent duplication of effort or delays in identifying overpayments and ensure all relevant actions are taken, for example, organising joint investigation of single person discount matches involving housing benefit?	Yes	Yes, all criminal investigations, where the Health Board is the victim of a crime, are investigated by Counter Fraud. Where a criminal offence has not been committed, but integrity issues linked to an existing employee have, the matter will be referred to the Health Boards Workforce & OD department for review. Additionally, all cases are referred to Counter Fraud Services Wales for review, who will, if applicable, take ownership of the investigation should the necessity arise. All cases that are selected for investigation are monitored by Counter Fraud Services Wales, who will review and if applicable authorise progression to the Crown Prosecution Service or closure of the case.	Counter Fraud and where necessary, Workforce & OD, will complete necessary actions in line with the required timeline outlined by the initiative.
16	(In health bodies) Are we drawing appropriately on the help and expertise available from NHS Counter Fraud Service Wales?	Yes	As above.	As above.
17	Are we investigating the circumstances of matches adequately before reaching a 'no issue' outcome, in particular?	Yes	With regards to Payroll data, a process of review is undertaken which looks to identify lines of enquiry associated with both criminal offences and issues where applicable, internal disciplinary matters. All outcomes are recorded on NFI, this includes the need for a Workforce & OD referral and or identification of any system weaknesses.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.
18	Do we review how frauds and errors arose and use this information to improve our internal controls?	Yes	Where system weakness or risks are identified, outcomes are recorded and where appropriate reported to ARAC. This process will include, where applicable, a risk assessment of any weaknesses identified and appropriate controls to mitigate future occurrence. Note, any risk identified will need to be reviewed and if applicable recorded in line with Health Board procedures. Any risk theme identified by the LCFS will be recorded,	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any

			reported to ARAC, and communicated to the risk owner for an assessment.	assistance will be made in writing and outcomes recorded.
19	Are we taking appropriate action in cases where fraud is alleged (whether disciplinary action, penalties/cautions or reporting to the Police or NHS Counter Fraud Service Wales) or errors are identified, e.g. recovering funds?	Yes	Yes, all criminal investigations where the Health Board is the victim are investigated by Counter Fraud. Where a criminal offence has not been committed, but integrity issues have, the matter will be referred to the Health Board's Workforce & OD department for review. Additionally, investigations commenced are referred to Counter Fraud Services Wales for monitoring and review.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.
20	Do we respond promptly to enquiries from other organisations that take part in the NFI?[6]	Yes	Requests from third parties are actioned as soon as possible and where applicable, statements are provided from the Counter Fraud Specialist.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative. However, assistance to complete tasks will be required from various departments within the organisation. Any assistance will be made in writing and outcomes recorded.
Recording and reporting				

[6] The web application shows the number of shared comments which require a response (Outstanding Actions). These responses should be prioritised if they relate to an ongoing investigation so that it can be progressed promptly.

		Yes / Partly / No	Comments / action required	If action is required, who by and when?
21	Are we recording outcomes properly in the secure website and keeping it up to date?	Yes	Outcomes will be recorded in line with NFI guidance. Where a criminal case is instigated, the investigation will be logged centrally via Clue 3, a crime management tool used by CFS Wales and the Counter Fraud Authority.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.
22	Do we provide appropriate and regular feedback to senior management, board / council members and those charged with governance on NFI activity and outcomes?	Yes	Bi-monthly NFI update reports will be submitted to ARAC via the in-committee session. This will include details of any criminal investigations commenced during the reporting period.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.
23	Do we provide those charged with governance assurances that the reasons for fraud and error happening are understood and that action is taken to address them and improve internal controls?	Yes.	Quarterly NFI update reports will be submitted to ARAC via the in-committee session. This will include details of any criminal investigations commenced during the reporting period.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.
24	Where we have not submitted data or not used the matches returned to us, e.g. council tax single person discounts, are we satisfied that alternative fraud detection arrangements are in place and that we know how successful they are?	Not applicable.	Required data is submitted and reviewed.	Not applicable
25	Do we publish, as a deterrent, internally and externally the outcomes of the NFI exercise?	Yes.	As stated, bi-monthly updates on progress undertaken by Counter Fraud will be provided to ARAC via the in-committee session. This will include details of any criminal investigations commenced during the reporting period. Upon conclusion of a successful criminal case, details of the offence are publicised via awareness materials. In addition, Counter Fraud will publicise any other non-criminal outcomes upon conclusion of the exercise.	Counter Fraud will complete necessary actions in line with the required timeline outlined by the initiative.

26	If, out of preference, we record some or all outcomes outside the secure website, have we planned to inform the NFI team about these outcomes?[7]	Not applicable.	All outcomes will be recorded on NFI, unless the outcome date falls after the closure of the exercise.	Not applicable

[7] Although preferable for all NFI work to be recorded within the secure web application, we appreciate there may be instances when organisations need to do work on the matches outside it. As soon as data is extracted from the secure NFI web application organisations are responsible for the security of the data, including avoiding inappropriate disclosure and ensuring it is destroyed when no longer needed. Therefore, we only advise exporting data when it is essential to do so.

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We welcome correspondence and telephone calls in Welsh and English. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

6

12:10, 0 Mins

6 - Assurance and Risk

6.1

12:10, 10 Mins

6.1 - Audit Tracker

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

For assurance

Attachments

6.1 SBAR Audit Tracker ARAC February 2025.pdf

6.1 Audit Tracker Assurance Report February 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Audit and Risk Assurance Committee (ARAC) with progress in respect of the implementation of recommendations from audits and inspections across the Health Board.

Cefndir / Background

Audits, inspections and reviews play an important independent role in providing the Board with assurance on internal controls and that systems and processes are sufficiently comprehensive and operating effectively. Therefore, it is essential that recommendations from audits, inspections and reviews are implemented in a timely way.

Asesiad / Assessment

The attached report will aim to provide assurance on the progress in respect of the implementation of recommendations from audits and inspections, and provide assurance on the effectiveness of the internal escalation framework arrangements in respect of driving improvements in the Health Board's progress in implementing recommendations from auditors.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
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)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
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:	Not Applicable
Rhestr Termau: Glossary of Terms:	ARAC – Audit and Risk Assurance Committee AW – Audit Wales (previously WAO (Wales Audit Office)) BGH – Bronglais General Hospital CIW – Care Inspectorate Wales CHC – Community Health Council DU – Delivery Unit GGH – Glangwili General Hospital GIRFT – Getting It Right First Time HEIW – Health Education and Improvement Wales

	HIW – Healthcare Inspectorate Wales HSC – Health & Safety Committee HSE – Health and Safety Executive HTA – Human Tissue Authority IA – Internal Audit IRMER – Ionising Radiation (Medical Exposure) Regulations MH&LD – Mental Health & Learning Disabilities MHRA – Medicines and Healthcare Products Regulatory Agency MWWFRS – Mid & West Wales Fire & Rescue Service NQPE – Nursing, Quality & Patient Experience PHW – Public Health Wales PPE – Post Project Evaluation PPH – Prince Philip Hospital PODCC – People, Organisational Development & Culture Committee PSOW – Public Services Ombudsman for Wales RCP – Royal College of Physicians SDM – Service Delivery Manager UHB – University Health Board USC – Unscheduled Care WGH – Withybush General Hospital WLC – Welsh Language Commissioner W&C – Women & Children WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Governance / Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
Gweithlu: Workforce:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: Risk:	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is not addressing any gaps in control and identified risks are not being managed.

Cyfreithiol: **Legal:**	No direct impacts from this report however late or non-delivery of recommendations from audits and inspections could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: **Reputational:**	As above.
Gyfrinachedd: **Privacy:**	No direct impacts from this report
Cydraddoldeb: **Equality:**	No direct impacts from this report

Purpose of the report

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 external recommendations as raised by auditors, inspectorates and regulators.

Context

The Health Board is currently in Targeted Intervention (TI) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, service delivery and organisational performance. In order to achieve de-escalation from TI, the Health Board have to meet set criteria, which includes:

- 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; and
- Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.

Overview

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, with evidence requested to be uploaded to demonstrate their progress and full implementation.

AMaT allows 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**. The criteria for this system is as below:

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (*AMAT Status: Complete and awaiting approval / Fully Complete*)
Amber	Recommendation is currently in progress, and within the agreed **original** timeframe for implementation (*AMAT Status: Partially Complete / In Progress*)
Red	Recommendation is in progress, but has exceeded its agreed **original** timeframe for implementation (i.e. overdue) (*AMAT Status: Overdue / Partially Complete (Overdue)*)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation. Due to current system limitations, the action title has been amended to include the phrase "external" to denote this status. (*AMAT Status: In Progress*)

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 AMaT's 'Inspection Recommendations and Actions' module by both the Assurance and Risk Team and QAST.

For the purpose of this report, data reported is as at the most recent analysis point at the time of preparation (31 December 2024).

	August 2024	December 2024	Trend	Variation*
Total number of reports	**174**	**187**	N/A	N/A
Number of overdue reports	54 (31%)	71 (38%)	↑	■
Number of reports overdue by more than 6 months	34 (20%)	33 (18%)	↓	■
Total number of recommendations	**1,499**	**1,638**	N/A	N/A
Number of Green recommendations (completed)	840	997	↑	■
Number of recommendations classified as 'External'	48	35	↓	■
Number of open recommendations	**611**	**641**	↑	■
Number of Amber recommendations (in progress and in line with original timescales)	369	332	↓	■
Number of Red (overdue) recommendations	242	274	↑	■
Number of recommendations overdue by more than 6 months	121	118	↓	■
Number of recommendations without revised timescales (N/K)	106	157	↑	■

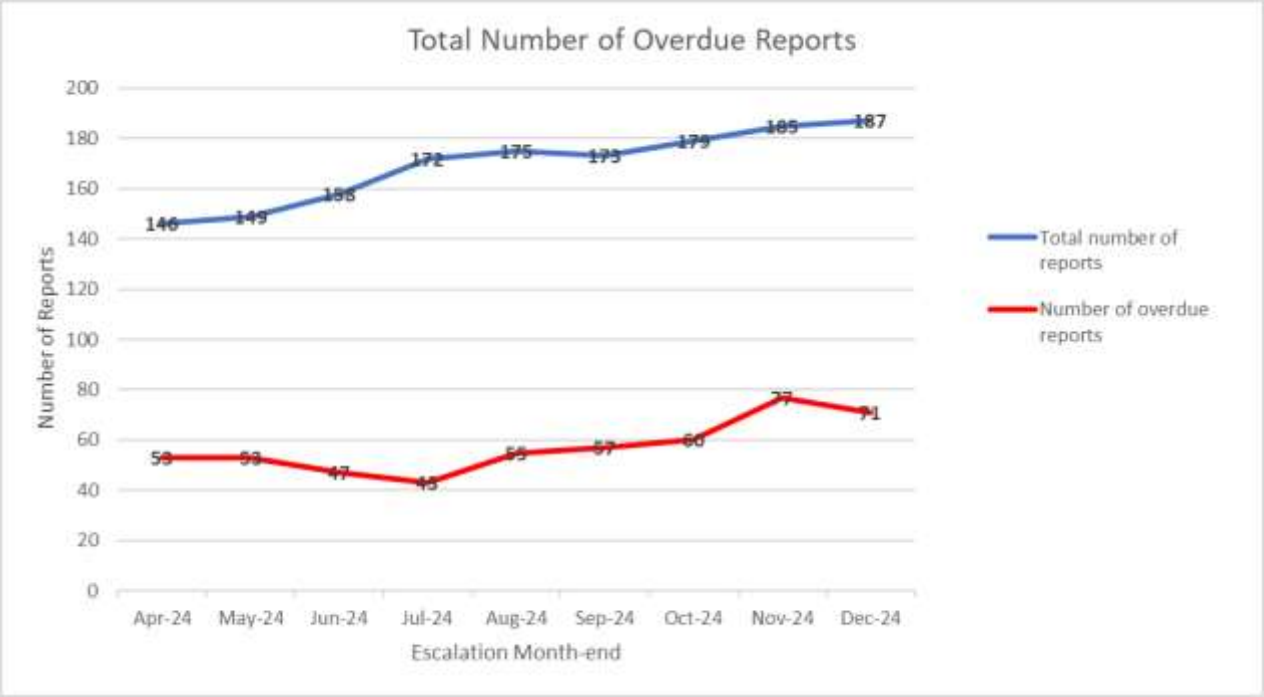
*A summary of the variation icons as below:

Variation	■	Concerning trend = a decline that is unlikely to have happened by chance
	■	Usual trend = common cause variation / a change that is within our usual limits
	■	Improving trend = an improvement that is unlikely to have happened by chance

A breakdown per auditor / inspectorate / regulator is provided overleaf.

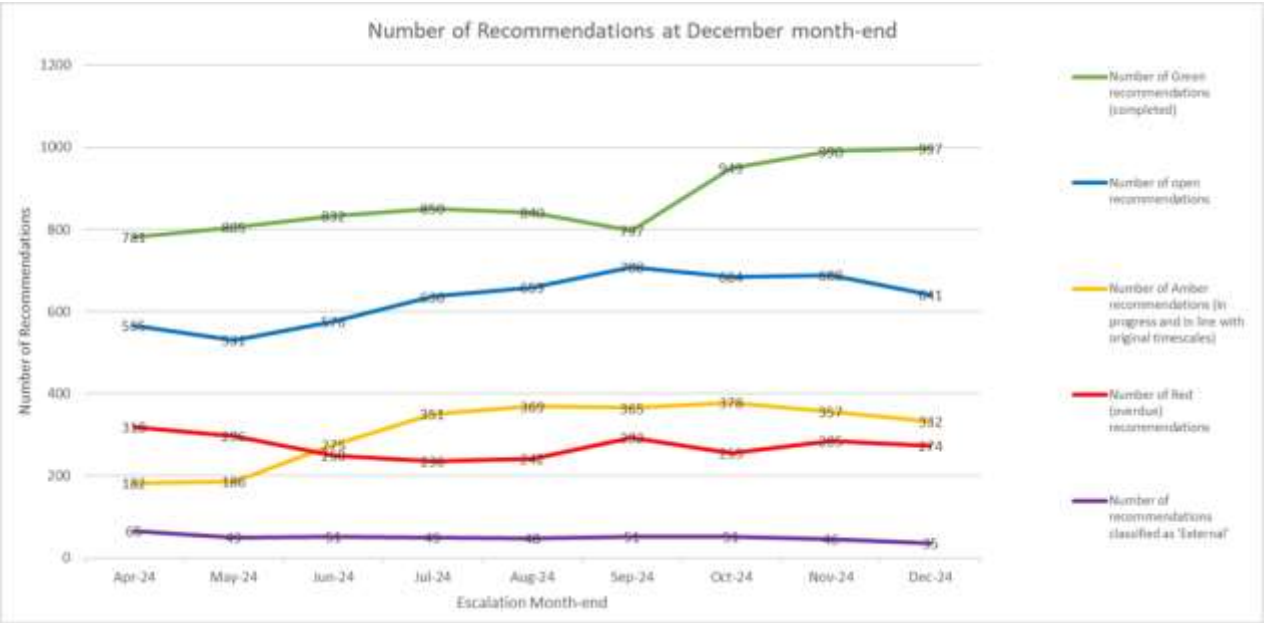
Inspectorate / Regulator	Open reports as at month-end August 24	Open reports as at month-end December 24	Open reports which are overdue	Red recommendations	Red recommendations overdue by more than 6 months
Audit Wales (AW)	10	10	5	7	5
Care Inspectorate Wales (CIW)	2	3	3	8	2
Health Education and Improvement Wales (HEIW)	3	3	2	7	4
Health Inspectorate Wales (HIW)	14	11	6	37	34
Human Tissue Authority (HTA)	1	1	1	2	0
Internal Audit	29	33	14	35	17
Llais	4	1	1	2	2
Mid and West Wales Fire and Rescue Service (MWWFRS)	78	95	21	67	2
Natural Resources Wales	0	1	1	17	0
NHS Wales Cyber Resilience Unit	1	1	0	0	0
NHS Wales Executive	8	4	3	12	6
Peer Reviews	11	10	7	39	38
Public Services Ombudsman for Wales (PSOW) – S21	5	5	2	5	0
Public Health Wales	1	1	1	0	0
Royal Colleges	1	1	1	2	2
Shared Services Partnership	1	3	0	13	1
Welsh Risk Pool (WRP)	2	1	1	2	2
Welsh Language Commissioner (WLC)	1	1	1	0	0
Welsh Government	2	2	1	19	3
TOTAL	**174**	**187**	**71**	**274**	**118**

Overdue reports



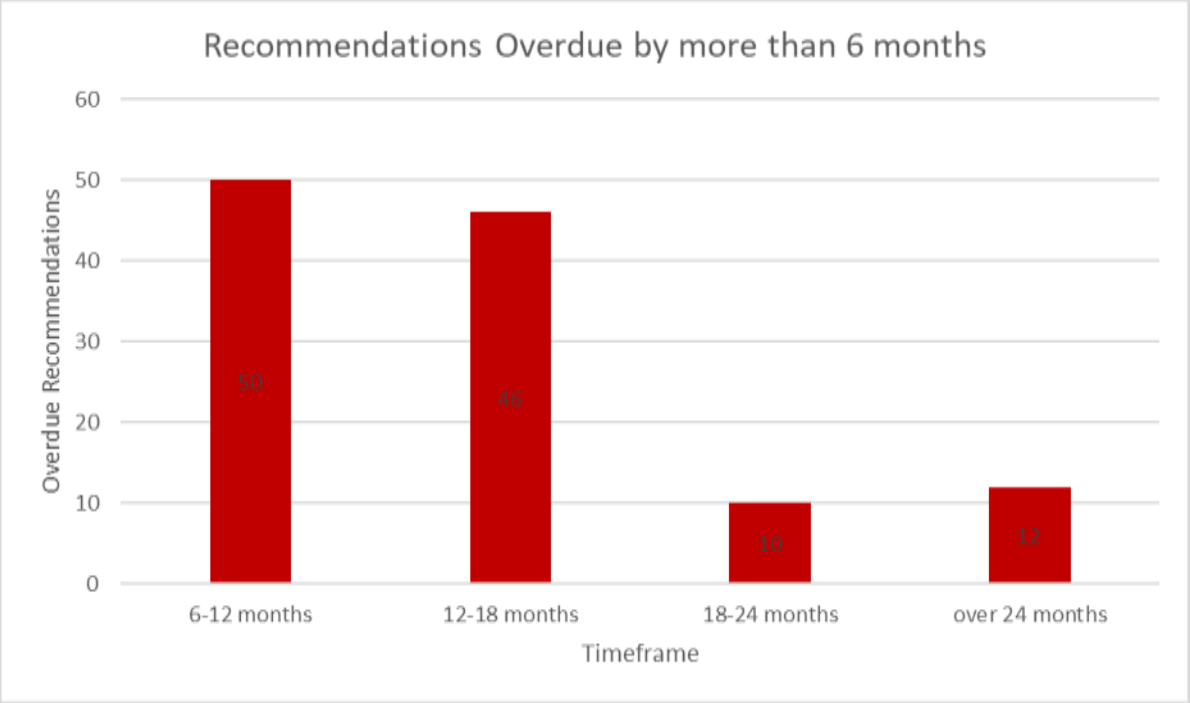
There has been an increase in the total number of open reports and overdue reports since the previous report presented in October 2024, with a notable increase in November 2024, primarily due to an increased number of Letters of Fire Safety received in July 2024, having passing their original completion date of 3 months.

Overdue recommendations



The graph above illustrates the trend in the number of overdue recommendations. The fluctuating performance of the number of overdue recommendations, along with a consistent trend in the number of recommendations overdue by more than 6 months (see graph below) suggests that the Health Board is not consistently achieving a sustainable reduction in the closure of overdue recommendations, and therefore minimal improvement in addressing long-standing recommendations. This is a result of historical reports where unrealistic timescales were

originally provided in management responses to recommendations, and recommendations which cite financial challenges as a barrier to their implementation. This is further exacerbated by current resource and capacity challenges within services, and ageing estate and infrastructure.

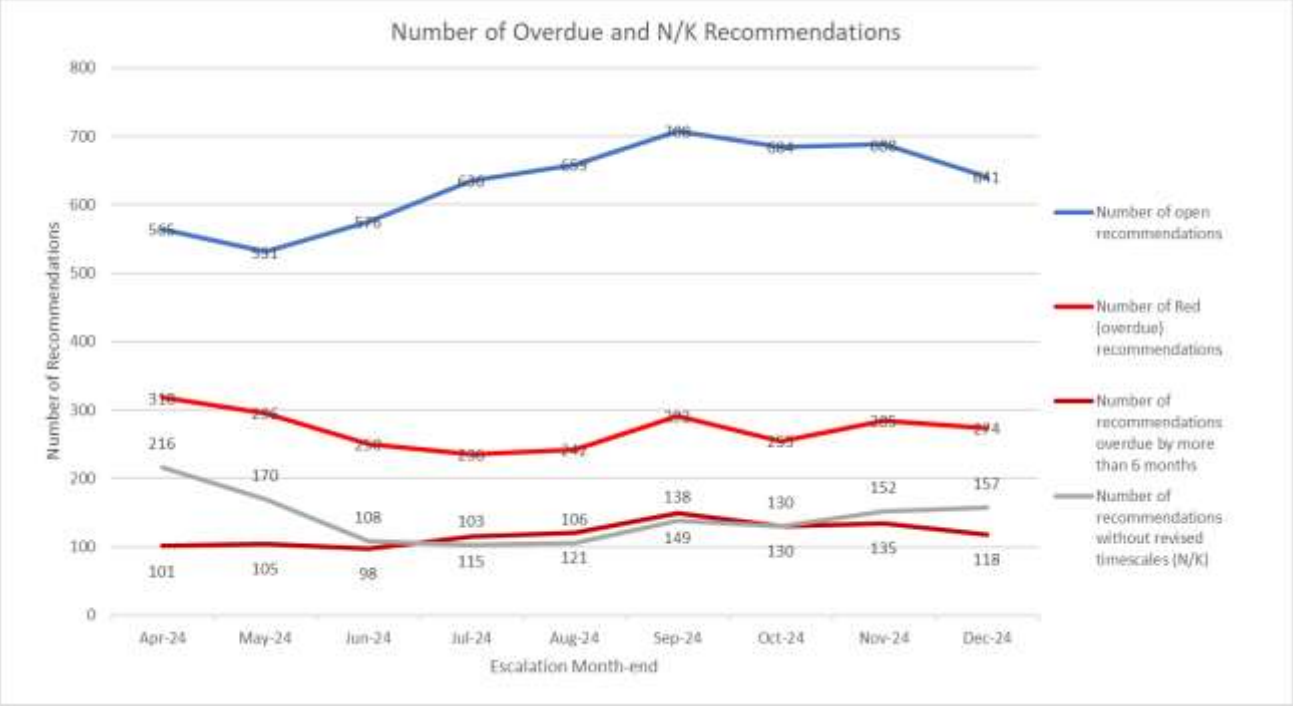


Of all 118 recommendations overdue by greater than 6 months, 32% are attributable to Mental Health and Learning Disabilities, and 31% to Planned Care. Of the 12 recommendations noted as being overdue by greater than 24 months, 7 are attributable to the Ophthalmology service, and a further 3 to Mental Health. These Directorates have been in Level 3 for the Governance domain within the Health Board's internal escalation framework since April 2024, with focussed support provided to these Directorates during November and December 2024 (detailed later in the report).

Analysis of the recommendations overdue by greater than 6 months per regulator highlight that 34 (29%) are from reports issued by Health Inspectorate Wales (HIW), 26 of which are overdue within the 12-18 month time-frame. A further 27 (23%) recommendations are from Getting It Right First Time (GIRFT) reports, all within either the 6-12 month or 12-18 month time-frame.

The Assurance and Risk Team will be reviewing the current escalation criteria within the Governance domain per the internal escalation framework to include more detail on those services with long-standing overdue recommendations, with these to be implemented during Q4 of 2024/25.

Recommendations without revised timescales



There were 157 (24%) recommendations without revised timescales as at December 2024 (August 2024: 121 (20%)).

Recommendations without revised timescales are mainly attributed to the following:

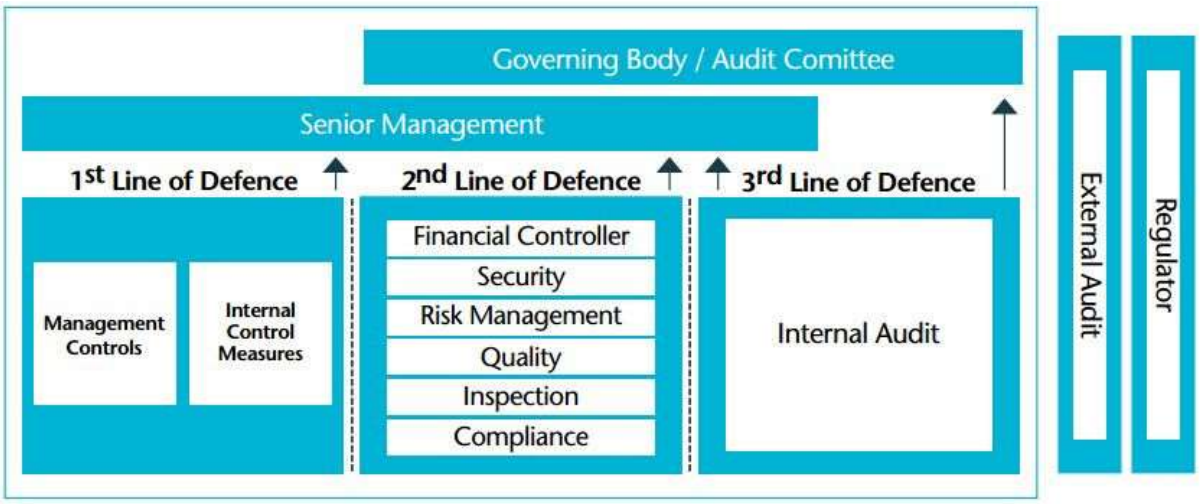
- Reliance on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems to inform revised completion dates;
- Recommendations previously noted as ‘complete’ being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- 27 recommendations lapsed since November 2024 which have yet to be updated with a revised completion date during December due to operational pressures;
- Directorates have reviewed recommendations but have not provided a revised completion date when providing progress updates. This may be due to a combination of factors including financial challenges / resource and capacity challenges which require resolution or clarification in order to provide revised dates. The lack of a specific ‘revised date’ field on the AMaT system, which could also serve as a prompt, may also be a contributing factor.

Directorates are able to note on AMaT the specific barriers to the full implementation of recommendations. Training materials and sessions highlight the requirement for recommendation owners to include revised completion dates where appropriate when providing progress updates. Guidance is also available on the team’s Sharepoint site. The Assurance and Risk team continue to remind services of the need to include revised completion dates within the Assurance and Risk overview reports presented to directorate quality governance groups, 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 has commenced to explore the opportunity to develop performance dashboards on the data captured on AMaT via 'Power BI' with colleagues in QAST and the Performance Team. This would provide services with improved oversight of their performance, including the number of recommendations without a revised timescale, and would support the internal escalation framework.

Three Lines of Defence

The Health Board operates within the widely accepted "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 responsibility is allocated for the management, reporting and escalation of the implementation of recommendations.



Operational Management (1st line)

First line of defence 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 implementation of recommendations is discussed by services and directorates via quality governance meetings for operational areas, or senior management meetings for corporate functions. The frequency of these meetings varies but are either monthly or bi-monthly. Local 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 to enable them to address any areas of concern.

The table overleaf provides a summary of open reports, and the status of recommendations per Directorate as per the internal escalation framework structure, further detail of which can be found later in the report.

Area	Total number of reports as at December month end 2024	Total number of recommendations as at December month end 2024	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6 months	Total number of N/K recommendations
Director of Operations					
Director of Operations *(including Central Operations, Acute Services, and USC: Health Board wide)*	6	44	11	10	0
Facilities	109	869	93	8	44
Mental Health and Learning Disabilities	8	148	44	36	32
Oncology	2	11	1	1	1
Pathology	2	26	15	3	15
Radiology	4	48	20	2	20
Planned Care *(including Audiology & Endoscopy)*	8	156	36	35	6
Unscheduled Care: Bronglais General Hospital	0	0	0	0	0
Unscheduled Care: Withybush General Hospital (*including Stroke and COTE)*	2	53	3	0	3
Unscheduled Care: Prince Philip Hospital (*including Diabetes and Respiratory)*	1	1	1	1	1
Unscheduled Care: Glangwili General Hospital *(including Cardiology, Gastro and Renal)*	0	0	0	0	0
Women and Children	2	27	0	0	0
Director of Primary, Community and Long Term Care					
Ceredigion *(including Palliative Care)*	0	0	0	0	0
Carmarthenshire	0	0	0	0	0
Pembrokeshire	0	0	0	0	0
Medicines Management	2	35	6	0	6
Primary Care Management *(Long Term Care and Chronic Conditions)*	1	4	2	2	1
Primary Care *(All other Primary Care services)*	3	8	1	0	1
Director of Finance					
Finance	2	11	0	0	0
Digital	3	18	6	6	3
Director of Nursing					
Nursing	11	58	10	2	7
Director of Public Health					
Public Health	2	7	2	0	2
Director of Strategy and Planning					
Strategic Planning	8	46	10	4	10
Director of Therapies and Health Sciences					
Therapies	0	0	0	0	0
Director of Workforce and Organisational Development					
Workforce and Organisational Development	3	16	1	0	1
Medical Director					
Medical	7	47	11	7	4
Corporate Services					

Area	Total number of reports as at December month end 2024	Total number of recommendations as at December month end 2024	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6 months	Total number of N/K recommendations
Governance	1	5	1	1	0
CEO Directorate	0	0	0	0	0
Total:	**187**	**1638**	**274**	**118**	**157**

Oversight of Recommendations (2nd Line)

Internal Escalation Framework

The Health Board has an internal escalation process, as part of the Directorate Improving Together (DIT) Framework, whereby Directorates are assessed on a monthly basis against the following six domains to drive improvement in performance:

- Quality;
- Governance;
- Workforce;
- Finance, Strategy and Planning;
- Fragile Services; and
- Performance and Outcomes.

The following ratings applied to each of the above domains:

Level	Definition
3	No assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
2	Limited assurance that the Directorate is managing their audits / inspections appropriately in terms of the scale, significance, timeliness and quality of response
1	Reasonable assurance that there are no significant concerns within the Directorate

The implementation of recommendations, as detailed within this report, is one of the criteria considered within the Governance domain. Consideration is also given for each Directorate with their risk management arrangements, the implementation of Welsh Health Circulars (WHCs) and Ministerial Directions (MDs), compliance with Freedom of Information requests, and the management and review of policies and procedures.

This in turn informs the wider escalation framework, where Directorates are assessed via the 3As assessment approach, and awarded an Alert, Advise or Assure status:

3A Status	Definition
Alert	There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action, or intervention required.
Advise	There are areas of concern where assurance has been taken on actions in place but requires closed monitoring. An early warning of an emerging and potentially serious concern.

Assure	There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Escalation meetings are held for Directorates where an 'alert' status has been awarded for three or more domains, chaired by the Director of Finance and report to the Targeted Intervention Working group. For those Directorates where less than three of the six domains within the internal escalation framework that have been awarded "no assurance", but are awarded a level 3 for Governance, the Director of Corporate Governance meets with relevant service leads to discuss concerns, and determine next steps for de-escalation. Whilst escalation meetings were stood down in November and December for Directorate Improvement Together Sessions to be held, additional support was provided by the Assurance and Risk Team to Planned Care and MHLD to:

- critically evaluate and review outstanding recommendations, allowing the identification of barriers to their implementation to date, and highlighting what measures are in place to manage the recommendation at present;
- review the current completion dates, and whether they required revision; and
- whether recommendations of a more historic nature are still valid.

Proposed amendments to agreed implementation timescales, will need to include a credible and deliverable plan to fully implement these recommendations within realistic timescales, will require the approval of the Executive Team. Proposals are due to be submitted for consideration and approval at Formal Executive Team in February 2025.

A summary of each Directorate's performance for the Governance domain since the previous report submitted to ARAC in October 2024 can be found in the following table:

Service	August 2024	September 2024	October 2024	November 2024	December 2024
Director of Operations	3	2	3	3	3
Facilities	2	2	2	2	2
Mental Health & Learning Disabilities	3	3	3	3	3
Cancer & Oncology	2*	2	2	2	1
Pathology	1	2	3	3	3
Radiology	1	2	2	3	3
Planned Care (incl. Audiology and Endoscopy)	3	3	3	3	3
Bronglais Hospital	1	1	1	1	1
Glangwili Hospital	1	1	1	1	1
Prince Philip Hospital	1	1	1	1	1
Withybush Hospital	1	1	1	1	1
Women & Children	3	3	3	3	2
Carmarthenshire County	1	1	1	1	1
Ceredigion County	1	1	1	1	1
Pembrokeshire County	1	1	1	1	1
Primary Care	1	1	1	1	1
Primary Care Management	1	1	1	1	2
Medicines Management	1	1	1	2	2
Director of Therapies and Health Sciences	1	1	1	1	1

Director of Finance	2*	2	2	2	2
Director of Nursing	2*	2	1	2	2
Director of Public Health	1	1	1	1	1
Director of Strategy and Planning	1	1	2	2	2
Director of Workforce & OD	1	1	1	1	1
Medical Directorate	1	2	2	2	2
Corporate Services	1	1	1	1	1

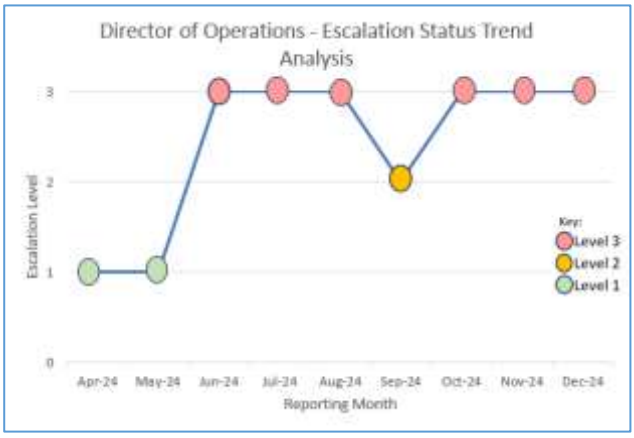
**Escalated for Governance due to factors outside the remit of this paper e.g. compliance with WHCs / timely review of policies*

Along with risk management, the implementation of recommendations as raised by inspectorates, regulators, auditors and peer reviews has been the dominant factor in assessing directorate'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 those Directorates who have been awarded either Level 3 or 2 status as at December 2024 is provided below, based on performance in the management of recommendations.

Level 3: Alert Status - Services with No Assurance

Director of Operations



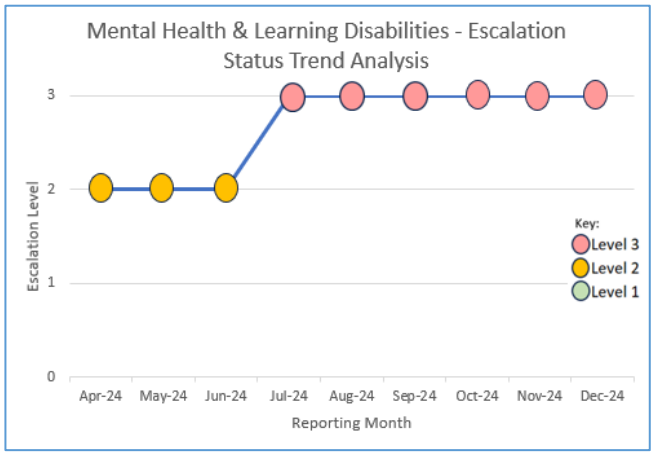
As at 31 December 2024, the Directorate had 6 open reports with 11 recommendations noted as overdue (25%), of which 10 were overdue by more than 6 months (23%). There are no recommendations without a revised completion date. 7 of the overdue recommendations relate to the Out of Hours Peer Review undertaken in April 2023. As of January 2025, the service has been re-aligned to Primary Care as part of the operational restructure, therefore going forward will be aligned accordingly for onward monitoring.

Escalation meetings were stood down during November and December 2024, with the meeting scheduled between the Chief Operating Officer, Director of Corporate Governance and the Assistant Director of Assurance and Risk for January 2025 postponed to 12 February.

The Assurance and Risk Team attend governance meetings for each operational area as part of the business partnering arrangements in place to ensure more detailed discussions are held regarding the progress of recommendations within the remit of the Chief Operating Officer. In addition, the Head of Assurance and Risk meets monthly with the Business and Governance Manager in Central Operations to provide an overview of progress being made in the implementation of recommendations.

Mental Health & Learning Disabilities (MH&LD)

As at 31 December 2024**,** MH&LD had 8 open reports, with 44 (30%) overdue recommendations, 36 of which by more than 6 months. 32 (22%) of their recommendations were without revised completion dates. Of the 8 open reports, a new HIW report re Bryngolau Ward, Prince Philip Hospital, has been added to the tracker, with 40 recommendations (3 of which are overdue). The Directorate have closed 5 reports since the previous report presented to ARAC, which had a total of 56 recommendations.



Additional scrutiny meetings took place in December 2024 in the absence of formal internal escalation framework meetings in November and December between MH&LD, the Assurance & Risk Team and the Quality & Safety Team (QAST). The Directorate are currently working on an SBAR summarising the progress made as a result of these meetings for presentation to Executive Team in February 2025 for consideration and approval of revised completion dates where appropriate.

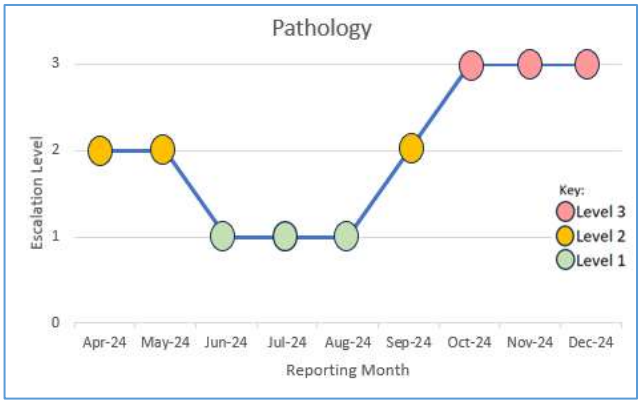
Barriers noted to the full implementation of recommendations include:

- provision of supporting evidence to enable formal approval of closure;
- funding constraints;
- lack of staff capacity to undertake project work;
- absenteeism of nominated recommendation owners (due to sickness/annual leave);
- reliance on supporting services to complete recommendations, i.e., Facilities and Women and Children's;
- implementation of national systems; and
- legacy of older report with unrealistic completion dates set.

Established governance arrangements are in place whereby the Assurance and Risk Overview Reports are presented by the Assurance and Risk Officer to MH&LD Quality Safety & Experience group and Business Planning and Performance Assurance Group (BPPAG) meetings. Regular monthly meetings are also held with the Assistant Director of Nursing MH&LD to review risks and recommendations and there is regular communication with the individual service leads, with advice and support provided by the Assurance & Risk Officer. The Assurance and Risk Overview reports are also submitted on a monthly basis, for information and review.

Pathology

As at 31 December 2024**,** 2 (100%) open reports are overdue, with 15 (58%) overdue recommendations, 3 of which by more than 6 months. 15 (58%) of their recommendations are without revised completion dates. This position has remained unchanged since the previous report presented to ARAC in October 2024.



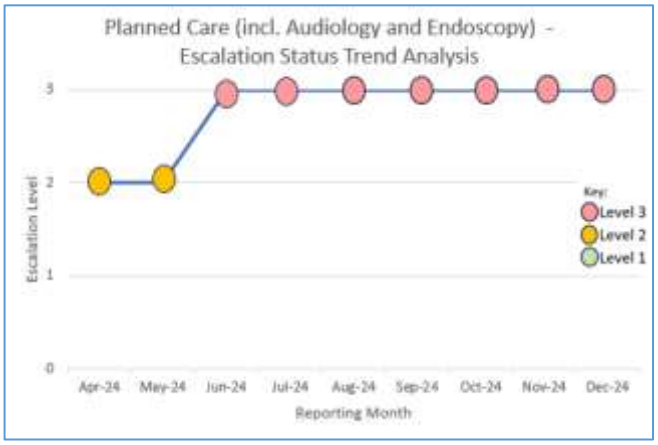
Barriers noted to the full implementation of recommendations include:

- absenteeism of nominated recommendation owners (due to sickness/annual leave);
- reliance on supporting services to complete recommendations, such as facilities, security; and
- implementation of national systems in order to further progress recommendations.

Established governance arrangements are in place whereby the Assurance and Risk Overview Reports are presented by the Assurance and Risk Officer to the Pathology Business Operation (PBO) meetings bi-monthly. There is regular communication with the individual service leads, with advice and support provided by the Assurance & Risk Officer. The Assurance and Risk Overview reports are also submitted on a monthly basis for information and review to service leads. An escalation meeting has been scheduled for the Director of Corporate Governance to meet with the Service Delivery Manager on 3 February 2025.

Planned Care *(including Audiology & Endoscopy)*

As at 31 December 2024**,** 36 (23%) recommendations were overdue, 22 relating to the Getting It Right First Time (GIRFT) report on Ophthalmology.



Whilst positive progress is noted from the previous report where 38% recommendations were overdue, the directorate does not meet the 20% target to be de-escalated to Level 2. The number of recommendations overdue by more than 6 months has increased from 21 (12%) at August month end to 35 (22%).

Barriers noted to the full implementation of recommendations include:

- Staffing challenges including difficulties recruiting substantive consultants and optometrists;
- delays in the rollout of national systems; and
- difficulties in balancing Ministerial Priorities against Eye Care Measures (tackling long waiting lists vs prioritising emergency patients).

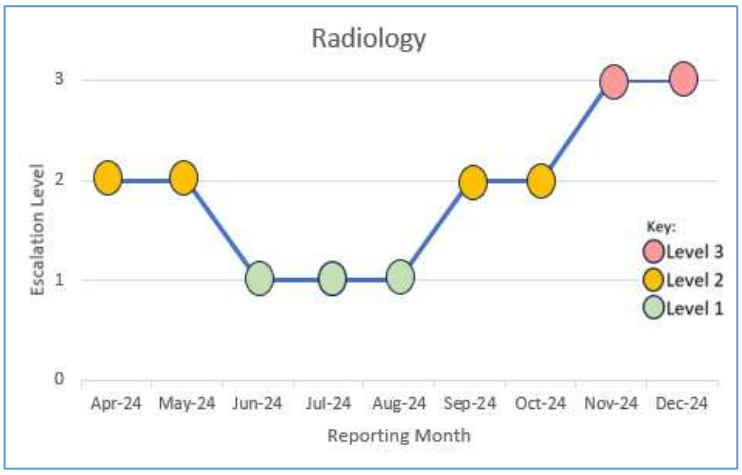
Bi-monthly Quality Safety and Experience meetings are in place, with a report provided by the Assurance and Risk Officer summarising open reports assigned to the Directorate, and recommendations that require updating. Where meetings have not been held, the paper is disseminated to attendees for information and action.

The Head of Assurance and Risk meets on a monthly basis with the Directorate's General Manager and Head of Nursing to review escalation outcomes and provide steer and support in order to achieve a de-escalated position in the near future.

Additional meetings took place in December 2024 between Planned Care and the Assurance & Risk Team. The Directorate are drafting a report summarising the outcome of this review for Executive Team in February 2025.

Radiology

As at 31 December 2024, 2 of the 4 open reports are overdue, with 20 (42%) recommendations overdue. 17 recommendations relate to the Natural Resources Wales report on "Withybush Hospital RSR Site Inspection follow up visit report", previously noted as complete by the Directorate and awaiting formal approval for closure. Further evidence has been requested to formally approve, therefore the report has been re-opened.



Bi-monthly Quality Safety and Experience meetings are in place, with a report provided by the Assurance and Risk Officer summarising open reports assigned to the Directorate, and recommendations that require updating. Where meetings have not been held due to availability, or where the report has not been formally presented at a meeting, a paper is disseminated to attendees for information and action.

Barriers to implementing recommendations include:

- Key staff absence;
- Operational pressures and lack of capacity to progress actions;
- Lack of Quality Leads; and
- Reliance on rollout of electronic referral system.

Services de-escalated from Level 3 to Level 2 since previous report to ARAC

Women & Children

As at 31 December 2024, an improved performance has been noted for the Women & Children's Directorate.

The Directorate have 2 open reports (August 2024: 4) 1 of which is fully complete and awaiting approval, and the other which is noted as overdue and has 1 outstanding recommendation with an 'external' status. All recommendations on the GIRFT report on Gynaecology have been noted as complete and are awaiting upload of evidence to AMaT before seeking formal approval for closure.

Monthly Quality Safety and Experience meetings are held (with the exception of September and December 2024), and a report provided by the Assurance and Risk Officer outlining progress and timescales of audits and inspections. There has been positive engagement from the Directorate, with an additional scrutiny meetings held in December 2024 with the Assurance & Risk Team to review outstanding recommendations.

Level 2: Advise Status - Services with Limited Assurance

The following services were awarded a Level 2: Advise Status as at December 2024:

Service	Reason for award of L2	De-escalation Criteria
Facilities	Governance arrangements: Concerns remain on the internal governance arrangements within the Directorate to identify and address issues within their responsibility	To achieve de-escalation to Level 1, the outcome and implementation of recommendations from the governance review is required to provide assurance.
Director of Finance	Improved position, however 6 recommendations (33%) are overdue, 28% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Medicines Management	17% of recommendations noted as overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Medical Directorate	23% of recommendations noted as overdue, 15% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Director of Nursing	Deteriorating position noted, with 10 recommendations (17%) overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Primary Care Management	2 recommendations (50%) overdue by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Director of Strategy and Planning	10 recommendations (22%) overdue, 9% by more than 6 months	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales

The Director of Corporate Governance has written to directorates where there has been limited progress in the previous 3 months to offer additional support.

Board and Committee Oversight

Responsibility for oversight of the timely implementation of external recommendations has been devolved to the Board Committees, Sub-Committees and Groups. On 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. It is recognised that this process is followed for reports issued by Internal Audit, External Audit, HIW and CIW. Since the previous report presented to ARAC, the process of obtaining formal approval for the closure of Peer Reviews has been strengthened, with the relevant Lead Executive required to confirm that all recommendations have been appropriately implemented. Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Thematic Analysis

As part of the second line of defence, themes are assigned to each recommendation, which allows the Health Board to analyse groups of similar recommendations.

The table below provides a thematic analysis for all open recommendations per theme as at month-end December 2024:

Theme	August 2024	December 2024	Trend
Fire	34%	37%	↑
Health and Safety	4%	12%	↑
Quality	8%	11%	↑
Safe	1%	6%	↑
Workforce	8%	7%	↓
Governance	10%	3%	↓
Patient Safety	5%	2%	↓
Finance	2%	2%	→
Training	3%	1%	↓
Performance	2%	1%	↓
Reputation	1%	1%	→
Infection Control	1%	1%	→
Information & Data Capture	1%	1%	→
Security	1%	1%	→
NICE/National Guidance	0.5%	1%	↑
Partnerships	0.5%	0.5%	→
Safeguarding	0.5%	0.5%	→
Capital	<0.5%	<0.5%	→
Estates	1%	<0.5%	↓
Medication	<0.5%	<0.5%	→
Environmental	<0.5%	<0.5%	↓
Service Delivery	11%	0%	↓
Consent and Mental Capacity	3%	0%	↓
IM&T	2%	0%	↓
Information Governance	0.5%	0%	↓

It is noted that 95 of the 187 (50%) reports currently open, have been issued by Mid and West Wales Fire and Rescue and Service (MWWFRS), resulting in a large proportion of recommendations being assigned the theme of “Fire”.

During quarter 3 of 2024/25 the Assurance and Risk Team commenced sharing recommendations with themed subject matter experts (replicating the process undertaken of

sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMAT.

Independent Assurance (3rd line)

The third line of defence are those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies. Since the previous report to ARAC in October 2024, the following report has been received by the Health Board relating to governance arrangements, specifically referencing arrangements relating to the tracking and implementation of recommendations, by external regulators and inspectorates:

- *Audit Wales – Structured Assessment 2024:* The report was presented to ARAC at its meeting in December 2024. A key focus of the review was on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, with specific focus on areas including corporate systems of assurance. AW concluded that the Health Board continues to have appropriate arrangements for corporate oversight of tracking recommendations.

Next steps

This report has identified a number of areas that could be strengthened, and further work is already underway to address these:

- To review the escalation criteria within the Governance domain of the internal escalation framework to consider the length of time recommendations have been overdue;
- Where system improvements have been identified in relation to the recording, reporting and monitoring implementation of recommendations on AMaT, to follow up requests with the national systems team to address these gaps;
- To work with the Performance Team and explore and confirm timescales, when capacity allows, to develop performance dashboards 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; and
- Further development of the Assurance and Risk Sharepoint site to provide guidance and support based to services and Directorates, including the development of material detailing the purpose and benefits of tracking recommendations and supporting processes within the Health Board to ensure transparency and accountability.

7

12:20, 0 Mins

7 - Governance

7.1

12:20, 0 Mins

7.1 - Minutes of the Meeting held on 10 December 2024

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

7.1 Unapproved ARAC Minutes 10 December 2024.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 10 December 2024
Venue:	Board Room, Ystwyth Building, St David's Park, Carmarthen and via Microsoft Teams

Present:	Cllr. Rhodri Evans, Independent Member (Committee Chair) Mr Maynard Davies, Independent Member (VC) Mr Michael Imperato, Independent Member (VC) Mrs Eleanor Marks, Vice-Chair, HDdUHB (VC) (part)
In Attendance:	Ms Urvisha Perez, Audit Wales (VC) Mr David Williams, Audit Wales (VC) Mr James Johns, Head of Internal Audit, NWSSP Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC) (part) Mr Eifion Jones, Internal Audit, NWSSP (VC) Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk Mr Huw Thomas, Director of Finance Mr Terry Slater, Local Counter Fraud Specialist (part) Mr Andrew Carruthers, Chief Operating Officer (part) Mr Gareth Cottrell, Deputy Chief Operating Officer Mr Lee Davies, Director of Strategy and Planning (part) Mr Shaun Ayres, Deputy Director of Operational Planning and Commissioning (VC) (part) Ms Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience (part) Ms Janice Cole-Williams, Assistant Director of Nursing (part) Ms Ceri Griffiths, Interim Assistant Director of Nursing (VC) (part) Mr Peter Skitt, County Director Ceredigion (VC) (part) Ms Mandy Davies, Assistant Director of Nursing and Quality Improvement (part) Mr Ian Bebb, Clinical Audit Manager (part) Mrs Lisa Gostling, Director of Workforce and OD/Deputy Chief Executive (part) Mr Robert Blake, Head of Culture and Workforce Experience (VC) (part) Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (VC) (part) Mr Paul Williams, Head of Property Performance (VC) (part) Mr Owen Harris, Energy and Environment Officer (VC) (part) Mr Simon Chiffi, Head of Operations (VC) (part) Mr Julian Wheeler Jones, Discretionary Capital Projects Manager (VC) (part) Ms Amanda Legge, NWSSP (VC) (part) Ms Sue Tillman, NWSSP (VC) (part) Ms Nia Rees, Assurance and Risk Officer (VC) (observing) Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(24)185	**Introductions and Apologies for Absence**	
	Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting. Members heard that there were some changes to the agenda order, to facilitate attendance by Executive Leads. Apologies for absence were received from: • Mr Winston Weir, Independent Member (Committee Vice-Chair) • Professor Philip Kloer, Chief Executive • Mr Ben Rees, Head of Counter Fraud • Mr David Butler, Internal Audit, NWSSP	
AC(24)186	**Declaration of Interests**	
	No declarations of interest were made.	
AC(24)187	**Minutes of the Meeting held on 15 October 2024**	
	RESOLVED – the Minutes from the meeting held on 15 October 2024 were approved as an accurate record.	
AC(24)188	**Table of Actions**	
	An update was provided on the Table of Actions from the meeting held on 15 October 2024 and confirmation received that outstanding actions had been progressed. In terms of matters arising: **AC(24)179** – Mr Huw Thomas advised that incorporating the Salary Overpayments dashboard into the internal TI escalation process is still being scoped. Further, when the information is distilled down, it becomes individually identifiable. However, Members heard that Mr Thomas is calling managers of those areas where there are overpayments of salary into meetings, the first of which are being held this afternoon. It was agreed that a further update would be provided to the February 2025 meeting.	**HT**
	AC(24)181 – the meeting outlined in the update had taken place on 3 December 2024. There had been detailed discussion around the potential to emphasise outstanding recommendations at internal escalation sessions. Miss Charlotte Wilmshurst and her team are undertaking an exercise to explore the reasons for outstanding recommendations, the findings of which will be presented to Executive Team and ARAC. There will be a meeting before Christmas between Cllr. Evans, Professor Philip Kloer and Mrs Wilson to discuss this matter further. *Ms Sharon Daniel and Ms Janice Cole-Williams joined the Committee meeting.*	

AC(24)171 – in terms of a further update on the actions in relation to the Falls Management Internal Audit report, Ms Sharon Daniel advised that the Senior Nurse Management Team (SNMT) meeting is scheduled for next week. The Falls Audit tool will be presented to that meeting. The team is still awaiting release of the National Audit of Inpatient Falls data and would update as soon as this is available. **SD**

AC(24)163 – with regard to the action to incorporate Referral to Treatment (RTT) performance scenarios into the planning for 2025/26, Mr Lee Davies advised that there will be choices required of the Board in this regard. The first iteration of RTT modelling had been presented to Executive Team; however, there is further work to be undertaken on the detailed capacity modelling. This will be considered again by Executive Team and will feed into the forward planning process. As has been noted, the organisation is ahead in terms of the Annual Plan process. Whilst this is a positive, it is impacted by a lack of available clarity at this stage in terms of Welsh Government requirements and financial allocation. In response to a query around the likely timing for provision of this clarity, Mr Lee Davies advised that the two will probably be the same date – 23 December 2024.

AC(24)189 Matters Arising not on Agenda

There were no other matters arising.

AC(24)190 Nursing Management (Limited Assurance)

Ms Sophie Corbett introduced the Nursing Management Internal Audit report, explaining that the purpose of the audit was to review the systems in place for rostering and absence management. Three high priority Matters Arising were identified, relating to annual leave utilisation outside of the permitted tolerance; lack of evidence to demonstrate approval of agency use; lack of evidence to demonstrate that sickness absence is being managed in accordance with the requirements of the relevant All Wales Policy. One medium priority finding had also been recorded. An overall rating of Limited Assurance had been concluded. Ms Corbett wished to highlight that the audit had taken place during a period of ongoing change. The report demonstrates improvements in terms of agency usage, and this should further improve. Initiatives are also underway around rostering. It is important to recognise that these changes are being made.

In response to a query around why the audit had focused only on Carmarthenshire, Ms Corbett advised that this had been the agreed scope. Carmarthenshire has been implementing changes to the escalation process and in nurse stabilisation measures. Ms Daniel thanked the Internal Audit team for their work. She confirmed that testing had focused on five areas of Carmarthenshire which were selected based on intelligence. The audit findings offer opportunities for improvement and Ms Daniel

recognised the organisation's responsibility to do so. There has been some stabilisation and there are opportunities to drive improvements in rostering and reliance on temporary staff. The current situation cannot continue, and proactive steps are available. New processes are in place, including around rostering and rostering efficiency tools, an Escalation Standard Operating Procedure (SOP) has been developed. This area will also be added to the audit programme. It is hoped that all of these measures will contribute to greater grip and control.

Ms Janice Cole-Williams confirmed that there has been a significant amount of work in this area. The organisation has started from a challenging position, including from a workforce viewpoint. However, it is now in a much improved place and further improvements are anticipated. This applies to both agency use and the general management of rostering. The staff stabilisation programme is almost complete across two counties (Carmarthenshire and Pembrokeshire), with only Ceredigion remaining. In terms of the Rostering Policy, there was a need to embed changes and the team plans to update this within the next three months. It is working with the Workforce team in this regard. An SOP has been developed for the escalation and booking of temporary staff, both in- and out of hours. This is currently out for consultation. There is close working with operational teams to ensure that expectations are clear. Scrutiny processes are being embedded. Audit and ongoing monitoring will form part of the Senior Nursing programme; there will be 3-monthly audits, with 'triggers' to undertaken more frequently if necessary. A number of concerns had been identified with regard to sickness management. These appeared to result from the changes to sickness reporting requirements during COVID-19, with the reversion to previous processes not necessarily having been recognised. The approval process for agency use has been changed to ensure a greater level of grip and control. When it has been established that the process is fully understood and being complied with, the previous arrangements will be reinstated. This will be monitored via the audit programme.

Mr Michael Imperato queried whether these issues are primarily procedural or (if not) the level of impact 'on the ground'. For example, whilst sickness absence levels are concerning, do these translate into an impact on patient care. Ms Cole-Williams indicated that they would translate. In terms of rostering efficiency and sickness management, there is a need to ensure staff are supported back to work, including into an alternative role if necessary. 'Housekeeping' is important in day-to-day roster management, in order to effectively manage the hours owed by and to staff. Effective management of these issues will lead to better quality of care, better staff wellbeing and better staff motivation. Referencing the additional allowance of 14.6% allocated as part of the Nurse Staffing Act; Ms Daniel highlighted that, should this be exceeded, it impacts on temporary staff usage. Members also heard that it is challenging to manage and plan

rosters efficiently when the organisation is carrying a number of vacancies. This should improve with better establishment levels.

Mrs Eleanor Marks expressed significant concern regarding the findings of the audit. Whilst accepting that actions have either been taken or are planned, she felt that there is a lack of evidence that these are impacting. Suggesting that there is a cultural element as well as a procedural one, Mrs Marks indicated that work is required around the culture of how wards are staffed and managed. Agreeing, Ms Daniel recognised the need to 'close the audit loop'. It is not acceptable to continue with current arrangements and expect a different outcome. Examples of good practice need to be shared and areas requiring support must be provided with this. It was reiterated that the areas audited had been specifically selected due to their performance.

Ms Cole-Williams advised that the team is working with the Workforce and OD team in regard to culture. There has been a focus on recruiting international nurses, which has not been without challenges in terms of rostering expectations. Whilst accepting these points, Mrs Marks still felt that there is a need for fundamental culture change. For example, an expectation that 'ad hoc' leave requests will be rejected, with requests to be submitted and agreed in advance. This is particularly timely, with Christmas and New Year approaching, when such requests are likely. Mrs Marks highlighted the need to tighten processes around rostering, as this aligns with Targeted Intervention and de-escalation requirements. Ms Daniel emphasised that everyone has different leadership abilities and styles. It is vital to ensure that staff skillsets are being utilised well and that staff are being supported to provide the appropriate working culture. Members were assured that conversations with staff around annual leave, including Christmas and New Year leave, start in April.

Mr Andrew Carruthers joined the Committee meeting.

Mr Thomas noted the clear link between staff management issues and finances. The Health Board has had a successful year in reducing nurse agency spend, and needs to ensure that resources are effectively deployed. Members were reminded that the Allocate system is being rolled-out; there has been an assumption that processes were being consistently adopted. Since the audit had returned a Limited Assurance rating, Mr Thomas anticipated that a follow-up audit would be required and queried the timescale for this, suggesting that it needs to be relatively soon. The need for a robust response plan was noted, together with a discussion at Executive Team to ensure that findings are addressed.

Mr Andrew Carruthers observed that there are also links to the Operational OCP and its implementation. He felt that, historically, the Health Board has not necessarily assisted individuals transition into management roles. It has also been assumed that they have knowledge of rostering. There needs to be a supportive package of training; rostering is a specific example, however,

there are other skills which could be included. Ms Cole-Williams endorsed this comment, advising that training for roster managers has been developed. Whilst staff are trained in using the Allocate system, this is not the same as being trained in rostering. The implementation of this training is not yet reflected in the audit findings; it is hoped that it would be included in any follow-up audit. Ms Daniel advised that training has also been incorporated into the STAR leadership programme, suggesting that more cohorts of this should be organised. **AC/SD**

Whilst Mrs Marks welcomed the promotion of nurses into management roles, she emphasised the need to put in place appropriate management training packages and managerial processes. There needs to be support for new managers, additional training for experienced staff. Mrs Marks also felt that the findings of this report need to be disseminated to emphasise why these issues are so important. Ms Daniel welcomed the Committee's feedback and agreed that actions need to be progressed at pace. On this topic, Cllr. Evans requested assurance that the proposed timescales for actions are realistic. In response, Ms Cole-Williams confirmed that they are. All actions are in progress and it is anticipated that they will be completed by the stated timescales. It is recognised, however, that there needs to be ongoing scrutiny and monitoring. To this, Ms Daniel added the need to ensure actions are impacting, and generating change.

Recognising that there are a number of concerning findings within the report, Cllr. Evans queried the best way to take this matter forward. Mrs Wilson suggested that it would be appropriate to 'Advise' the Board, with a recommendation that a follow-up audit be conducted within 6 months. This should have a wider scope, including oversight and across the whole Health Board. **JJ**

Decision: The Committee **NOTED** the Nursing Management (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Nursing Management (Limited Assurance) Internal Audit report, due to the findings and concerns highlighted therein.

Ms Sharon Daniel and Ms Janice Cole-Williams left the Committee meeting.

AC(24)191 Discharge Management Follow-up (Limited Assurance)

Mr Peter Skitt and Ms Ceri Griffiths joined the Committee meeting.

Mr James Johns introduced the Discharge Management Follow-up Internal Audit report, explaining that the purpose of the audit was to provide assurance on the controls and processes in place for the safe and efficient discharge of patients, including progress in implementing the actions to address issues identified in the previous audit report. Members heard that this report is the first in

a new reporting style, the background to which is provided in the Internal Audit Plan Progress Report. One difference is the 'agreed management actions', which it is hoped will prove helpful. For this audit, two high priority management actions had been identified, relating to incomplete and inaccurate information within the Frontier system, and limited discharge planning documentation within manual and electronic systems. Two medium priority management actions had also been identified, around adoption of national discharge guidance and development of a supporting toolkit, and development of a patient information leaflet. A rating of Limited Assurance had been returned.

Noting that the first audit had a rating of Limited Assurance and that the follow-up had returned the same rating, Cllr. Evans invited Mr Carruthers to comment. Whilst thanking the Internal Audit team for the report, Mr Carruthers expressed disappointment with its findings. He did feel, however, that there are a number of positive aspects and instances of progress made. For example, the optimal flow work has been embedded, which contributes significantly to patient flow and discharge processes. Mr Carruthers believed that there has been further progress since the audit in standardising processes across the Health Board, which represents a significant step. He acknowledged, however, that progress is taking longer than is desirable.

Mr Peter Skitt felt that it was important to note that, whatever actions are taken, the Health Board is currently using a number of separate systems, which results in duplication of effort. The introduction of eObservation and ePatient Flow systems will impact positively. As has been mentioned, the impact of work in relation to optimal flow is being seen. Whilst this is not at the pace wanted, the organisation is attempting to implement a number of changes within the Six Goals Programme, and these involve the same services and staff. Mr Skitt felt that improved levels of engagement is a significant positive step.

Ms Ceri Griffiths advised that the Discharge Strategy Task and Finish Group has now been established. Steps are being taken to standardise processes, and a discharge toolkit has been developed. The Health Board will be adopting the national discharge guidance; it is hoped that this will be implemented next week. A Sharepoint webpage has been developed and the toolkit will be rolled out. In response to a query around how the toolkit will be cascaded to staff, Ms Griffiths recognised that this would require individual engagement with services and staff. In terms of information provided to patients, a patient discharge leaflet has been developed, which will be issued to patients and their families on admission. This will serve to begin the conversation around discharge. The leaflet has been drafted and is out for comment with a patient group. It is intended to implement the leaflet from early next year.

With regard to Objective 2, Ms Griffiths advised that this was an area of limited assurance around accurate recording. There are,

as has been mentioned, multiple systems including whiteboards, Welsh Nursing Care Record (WNCR) and Frontier. Weekly and monthly audits are being undertaken on Frontier, which are showing a 15-20% improvement. Over 75% of all patients admitted in November have a discharge to recover and assess pathway allocated on admission. It is likely that the remaining 25% were day-case or one day Length of Stay (LOS) patients. The report is shared with operational teams, so they can undertake actions as required. Challenges remain, including at weekends. Again, Mr Imperato queried whether this is a procedural issue, or something which actively impacts and/or prevents patient discharge. In response, Ms Griffiths explained that the discharge process has become extremely complex for services, and there is a desire to simplify it and provide tools to assist. Together with this aim to reduce the complexity of discharge processes, there is also a need to ensure that staff understand their role in discharge. This involves a 'back to basics' approach, with an acceptance that discharge is everyone's responsibility and that discharge planning begins at the point of admission.

In terms of how outcomes and impact will be measured, Ms Griffiths advised that it is planned to revisit the assessment conducted in 2023. Improvement metrics have been developed and it is hoped that these will demonstrate progress. Mr Skitt highlighted the associated impact on LOS. Whilst discharge processes operate at ward level, it is important to identify leads. Various impacts will be measured. Referencing the graph under Objective 2, Mrs Marks noted the 27 service referrals not made. She enquired regarding the level to which this is dependent on care package shortages in the community, noting feedback from visits where staff are citing a lack of social care workers. Mr Skitt emphasised that the audit and actions are all focused on components of discharge management within the Health Board's control. If the organisation has inaccurate information, it cannot effectively manage the issue. This further enforces the need for clear accountability in discharge processes. Whilst LOS may be impacted by care package availability, internal processes are not.

Mr Carruthers highlighted that Pathway of Care Delays (POCDs) are assessed to be 50% caused by the Health Board and 50% by Social Care. This audit and report focuses on the Health Board issues. Historically and anecdotally, it has been challenging to secure staff engagement in discharge planning on admission due to a lack of confidence in the timeliness of processes. Improved engagement suggests a positive step forward. Returning to the issue of conversations around discharge, Mrs Marks suggested that at admission, most patients and their families are prioritising getting that individual well again. Many are unsure of the type of support they will receive and are concerned about how they will cope. Early conversations will allow them time to adjust. Mr Skitt agreed that preparations for discharge need to begin much earlier, and reiterated plans for a patient information leaflet. Members heard that the leaflet will help to focus on early discussions and emphasise a collaborative approach to discharge and patients'

needs. The leaflet will also contain information on sources of support. It will be important, however, to work with staff to ensure that they are adequately prepared and supported to conduct conversations on discharge.

Cllr. Evans requested assurance that the proposed timescales for actions are realistic. Ms Griffiths was confident that they are achievable, noting that all are already underway. Focusing on the agreed actions and their ability to impact positively on discharge, Cllr. Evans queried whether these are the correct actions, given that the follow-up audit has returned a second Limited Assurance rating. Ms Griffiths felt that they were, emphasising the need to return discharge processes to ward-level control, whilst recognising that this is the fundamental challenge. Mr Carruthers wished to highlight that there is a correlated improvement in performance, which is assuring, whilst accepting that this has not gone far enough. Members heard that – in POCDs – HDdUHB is one of the best performing Health Boards in Wales, and is being asked to share its learning.

Noting that there will be quality and safety implications for patients, Cllr. Evans committed to discuss the report's findings with Ms Anna Lewis, Quality, Safety and Experience Committee (QSEC) Chair. Due to level of concerns and second Limited Assurance rating, it was agreed to 'Alert' the Board, with a recommendation that a further follow-up audit be conducted before the end of the financial year. Mr Carruthers endorsed this course of action, stating that Welsh Government have indicated they wish to conduct a Deep Dive into this area in the new year. Noting that the Bed Management Internal Audit had been deferred to the next meeting, Mr Thomas enquired whether there was sufficient 'cross-over' to link this with a follow-up audit. In response, Mr Johns advised that the fieldwork for the Bed Management audit was already significantly progressed. In terms of feedback to the Board, Mr Maynard Davies suggested that the value of eObservations and ePatient Flow systems in improving discharge processes should be emphasised. Mr Thomas advised that the Board had approved these business cases subject to funding being secured. This has not been forthcoming from Welsh Government to date. It may be that this expenditure needs to be prioritised by the Health Board if it is viewed as essential. **JJ**

Decision: The Committee **NOTED** the Discharge Management Follow-up (Limited Assurance) Internal Audit report.

The Committee agreed to **ALERT** the Board in relation to the Discharge Management Follow-up (Limited Assurance) Internal Audit report, due to the findings and concerns highlighted therein.

Mr Andrew Carruthers, Mr Peter Skitt and Ms Ceri Griffiths left the Committee meeting.

AC(24)192 Escalation Status Update Report

Mr Shaun Ayres joined the Committee meeting.

Mr Lee Davies presented the Escalation Status Update Report, highlighting that this is of a different format, and that feedback would be welcomed. The reports which go to each Board level Committee have been streamlined to make them more focused on the relevant Committee's remit, and made more concise. For ARAC, there are no Targeted Intervention (TI) criteria under 'Alert', five criteria under 'Advise' and one criteria under 'Assure'. Members heard that a number of areas and actions are being progressed to strengthen arrangements and address as many criteria as possible. The Operational Governance structure is key to this. Members' attention was drawn to the letter from the NHS Wales Chief Executive which had been received and appended to the report.

Mr Shaun Ayres hoped that the new format is helpful to the Committee's discussions. He emphasised that there are some positives, particularly the clearer demarcation between Committees around de-escalation. Also, the summary reports provide greater oversight to Committees. Key challenges include inconsistent delivery against objectives and lack of clarity around key programmes and how these are delivered in the interim period. The organisation is moving towards an integrated framework; it is still currently in the position of having fragmented pieces of information without a cohesive approach. Members heard that an Internal Audit will assess the effectiveness of governance and performance frameworks. There is also the planned annual review of the Maturity Matrix. Finally, the revised Operational Governance structure will be in place by April 2025, which will provide further clarity, accountability and oversight.

Noting the five criteria in the 'Advise' category, Cllr. Evans enquired whether any additional actions are being taken to move these into 'Assure'. In response, Mr Ayres explained that the Maturity Matrix does not comprise only one action, it covers everything within the planning domain. It is important to ensure the governance around the programmes being taken forward, and that there is effective remedy and scrutiny if and when these go off track. Referencing the appended letter, Cllr. Evans queried how the five issues highlighted therein map against the Health Board's process and how they will be monitored. Mr Lee Davies advised that they map with the areas identified as 'Alerts'. It is a positive that the Health Board is now in a position whereby its own assessment broadly matches with Welsh Government's. each of these issues is covered by a TI criteria allocated to and monitored by a Board level Committee. An equivalent report to the one presented to ARAC will be considered by these Committees. Mrs Wilson indicated that the one exception to this is the final issue, around 'meaningful engagement with neighbouring organisations'. However, Members will be aware of significant work taking place on a regional basis.

With regard to Criteria 37 - Board's Duty of Quality in Decision-Making, Mr Maynard Davies queried whether the self-assessment is overly harsh. Referencing recent Board decisions regarding temporary service changes to Prince Philip Hospital Minor Injury Unit, Bronglais Hospital Paediatrics and Tregaron Hospital, it was suggested that quality of services is at the heart of these. Quality Impact Assessments had been conducted for all. Mr Maynard Davies noted that this is not mentioned and felt that the narrative could be more positive, even if the rating remained at 'Advise'. Cllr. Evans also noted that there was no timescale for this criteria. Whilst agreeing with Mr Maynard Davies, Mr Ayres indicated that the Health Board had not been sufficiently sighted on these service issues, meaning that it had effectively been 'forced' into the Board decision. This feeds into the timescale issue highlighted by Cllr. Evans. These are why this criteria has been rated 'Advise'. Mrs Wilson noted the link with Criteria 39, indicating that if there were effective risk assessments, the Health Board would be aware of such service issues in a more timely fashion.

Cllr. Evans enquired whether there will be a self-assessment of Criteria 38 rather than a total reliance on the Internal Audit. Mr Ayres confirmed that this would be the case, via the Maturity Matrix. The Executive Team will undertake the assessment, which will be independently audited. With regard to Criteria 39, it was queried whether this should be jointly owned with the Chief Operating Officer. Mr Ayres agreed, noting the inherent understanding around fragility. The proactive knowledge around how these risks are managed is likely to come from operational teams. It is recognised also, however, that support needs to be wrapped around this area. Mr Lee Davies emphasised that the service being provided is 'holding a mirror' to the TI criteria. They are owned by the Executives; however, the actions to address TI are a collective effort. Cllr. Evans welcomed the new report format, which he felt was very effective and assists ARAC in taking the required assurance.

Mr Imperato reminded Members of ARAC's overarching role in terms of providing assurance that the other Committees are undertaking theirs with regard to TI. Mrs Wilson was able to confirm that all Committees are doing so, and drew Members' attention to the explanation at the start of the report. She highlighted that this is the first new style report and suggested that consideration is required regarding how this assurance can be provided on a more formal level. It was suggested that a summary of the information being provided to each Committee could be included as part of the introduction. In the interests of transparency, Mr Ayres felt that one Committee where further work is required is QSEC, and emphasised that this will be an area of focus. Mrs Wilson agreed, noting that this had been recognised at the QSEC meeting last week. **SA**

Decision: The Committee **NOTED** the Escalation Status Update.

The Committee agreed to **ASSURE** the Board in relation to the Health Board's Escalation Status.

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

AC(24)193 All Wales NHS Audit Committee Chairs' Meeting Update

Cllr. Evans drew Members' attention to the All Wales NHS Audit Committee Chairs' (AWACC) update, which was provided for information. A further AWACC meeting is taking place this afternoon, with Mrs Wilson and Miss Charlotte Wilmshurst attending to demonstrate HDdUHB's Audit Tracker.

Decision: The Committee **NOTED** the All Wales NHS Audit Committee Chairs' Meeting Update.

AC(24)194 Committee Self-Assessment

Mrs Wilson presented the Committee Self-Assessment report, thanking everyone who had completed the questionnaire. There were four areas identified by Members for further focus:

1. Targeted Intervention – improvements have already been made and these should continue
2. Reporting to Board, and the need to highlight 'Alert' and 'Advise' issues – this is an area of planned focus
3. Report writing guidance – once the new operational structure is in place, more support will be provided to staff preparing reports
4. Discussions with auditors on audit plans which support the delivery of TI Domains

The recommendations will be taken forward and a further update will be provided in six months' time.

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

AC(24)195 Audit Wales Update Report

Mr David Williams introduced the Audit Wales Update Report, advising that in terms of financial audit work, the majority of the fieldwork for the Charitable Funds audit would be finished in time to enable reporting by the end of January 2025. Preparatory work for the main audit of Health Board accounts will begin in the New Year. In terms of performance audit, Ms Urvisha Perez advised that the Structured Assessment was complete and the report is presented for ARAC's consideration. The management response will come to the February 2025 meeting. Other performance audit work is at various stages of completion; it is thought that the Review of Urgent and Emergency Care will be ready for February

2025. Various factors have contributed to delays, including staff shortages, and these have impacted on progress of other reports also. Audit Wales is planning to employ a different approach for the Deep Dive review of investment in digital systems, with this based on a self-assessment. The review will be conducted across all health bodies and will begin in January 2025. Ms Perez drew Members' attention to Exhibit 3, highlighting in particular the report on the National Fraud Initiative. Whilst this contained no recommendations, it was expected that bodies will review the report and that Audit Committees will scrutinise its contents. A checklist is available, which organisations are encouraged to complete and share with their Audit Committee. Mr Thomas committed to take this forward via the Counter Fraud Update. **HT/BR**

Referencing the Digital Deep Dive, noting that this will be an All Wales audit, Mr Maynard Davies enquired whether examples of good practice will be shared. Also, whether it would be sensible to consider the effectiveness of cooperation mechanisms between Health Boards, such as the Digital Directors Group and All Wales Digital IMs Group. Ms Perez agreed to feed back these suggestions to the team planning this audit. **UP** Noting the intended format of a self-assessment, Mr Thomas observed that this has inherent risks. He enquired regarding moderation of self-criticism on an All Wales basis, to ensure that those who recognise risks and assess themselves most harshly do not automatically attract the most criticism. In response, Ms Perez suggested that this will be balanced to some extent by input from interviews, feedback, etc; however, would direct this comment to the relevant team. **UP** Members were assured that Health Boards would be involved in decisions around the review process.

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

AC(24)196 Structured Assessment 2024

Ms Perez presented the Structured Assessment 2024 report, which was positive overall. It contained a few recommendations, which were concerned with enhancements rather than addressing shortcomings. In terms of key messages:

- Overall, the Health Board's corporate arrangements continue to operate effectively, despite a period of significant change, with a small number of areas that could be further improved. Whilst the financial position for 2024-25 remains extremely challenging, the Health Board is taking positive steps to get onto a more sustainable footing.

- Whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.

- The Health Board continues to have appropriate arrangements for corporate oversight of risk, performance, tracking recommendations, and the quality and safety of services. The performance management framework, however, needs to be updated to reflect current performance arrangements, and more frequent updates on the implementation of the Quality Improvement Strategic Framework should be provided.

- Development and delivery of the Health Board's plans continue to be supported by appropriate oversight, underpinned by a pragmatic approach to addressing planning team capacity issues. There is scope to review well-being objectives as part of a planned long-term strategy refresh.

- Whilst the financial position for 2024-25 remains extremely challenging, the Health Board is taking positive steps to improve its financial position and to develop a roadmap to ensure financial sustainability. There remains a clear approach for financial planning and managing and monitoring the financial position, but there is a need to strengthen the approach to delivering cost savings opportunities.

Thanking Audit Wales for their collaborative approach to working with the Health Board, Mrs Wilson emphasised that the draft findings had been discussed with herself and the Director of Finance. The final report had then been considered by the Chair of ARAC, Chief Executive, Director of Finance and herself prior to presentation at today's meeting. In addition to addressing the recommendations made in the report, there needs to be consideration of the outstanding recommendations in the Operational Governance Arrangements review. Cllr. Evans added his thanks to the Audit Wales team, welcoming the positive report, which highlights the organisation's effective corporate working.

Mr Maynard Davies felt that it was important to note that the Health Board's financial position has changed since the report was prepared, due to a recent financial allocation. This had made a substantial difference to targets. He also enquired whether Audit Wales are content with the progress made on last year's Structured Assessment recommendations. With regard to the latter, Ms Perez noted that whilst there were a few outstanding, Audit Wales are content overall. Noting that there are a number of significant recommendations, Mr Thomas highlighted the need to reflect in particular on the timeliness of responses. Agreeing with Mr Maynard Davies, he queried whether the paragraph regarding the Health Board's financial position should be refined prior to the report's submission to Board, given that the changes are material. Mrs Wilson advised that this would need to be a decision made in discussion with Audit Wales, it being their report and presented as final. Ms Perez emphasised that any report represents a 'snapshot' in time, and indicated that the report should remain as is. It was agreed that the change to the Health Board's financial position can be drawn out in the covering SBAR and/or ARAC's Update Report to Board. **JW**

Members were reminded that the report is next presented to the Board at its meeting in January 2025, with the proposal that ARAC oversees delivery of its recommendations. The management response will be considered at ARAC's February 2025 meeting. It was agreed that outstanding recommendations from previous years' Structured Assessment reports should also be considered at that time.

Decision: The Committee **NOTED** the Audit Wales Structured Assessment 2024 Report.

AC(24)197 Review of Urgent and Emergency Care

DEFERRED to 11 February 2025 meeting.

AC(24)198 Clinical Audit Update

Ms Mandy Davies and Mr Ian Bebb joined the Committee meeting.

Introducing the Clinical Audit Update report, Mr Ian Bebb reminded Members that the programme for this year is in place and advised that the team is working on the 2025/26 programme. This will consist of mandatory and national audits, together with a local programme of audit work. Members' attention was drawn to implementation and use of the AMAT software and the continued funding for this system until January 2026. AMAT comprises various elements and modules and there are many users of the system across the organisation. Mr Bebb advised that the Health Board has been flagged as an outlier for two national audits: Epilepsy 12 (Paediatric) and National Joint Registry. Actions are already being taken to address this. Three audits are currently being flagged as a particular concern due to limited data collection; the issue is primarily lack of administrative resource.

There has been coordination with the relevant services, escalation to the relevant senior staff and it is understood that business cases are being prepared. It would be expected that a risk would be added to the risk register, for assurance that this is recognised. A table describing Clinical Audit Activity is included on page 3 of the report. The team is seeing a steady increase in the number of projects approaching completion, which is a positive trend. A table outlining the status of projects is also included on page 4. The team is working with services to encourage participation in clinical audits. The reduction in the number of local audits is probably a reflection of services' ability to conduct these. Mr Bebb concluded by highlighting the programme of Whole Hospital Audit Meetings (WHAM), at which a significant number of audits are presented.

Referencing the two audits against which the Health Board has been flagged as an outlier, Cllr. Evans enquired: whether the

escalation has worked; whether progress is being made and whether there are clear timelines for change. In response, Mr Bebb explained that the Epilepsy 12 audit concerns related to historic participation; the Health Board is already participating in this year's audit and is currently collecting data. There are plans to work with the service regarding the National Joint Registry audit. Ms Mandy Davies felt that, where there are concerns around non-participation in audits, services should be required to complete Quality Impact Assessments (QIAs) to enable an understanding of the impact on patients and care. The services in question will be requested to do so within the next month. Cllr. Evans and Mrs Wilson agreed that there are potential quality and safety implications involved with non-compliance. **MD/SD**

Welcoming the report, Mr Thomas indicated a need to reflect on feedback from services suggesting that they cannot participate in clinical audit without additional resource or investment. He had not received any such feedback directly, and emphasised that participation in clinical audit is a mandatory expectation across the organisation. Likewise, if AMAT is considered a priority to enable clinical audit, investment in it should be prioritised. As the AMAT system is utilised more widely than just for clinical audit, this would need to be a management decision discussed at Executive Team.

Noting the list of Mandatory National Clinical Audits and the indication of expected participation, Cllr. Evans requested clarification and assurance. In response, Mr Bebb explained that there is a generic clinical audit programme for Wales. If Health Boards offer a service contained within the list, participation becomes mandatory. Those marked 'not applicable' are because the Health Board does not provide that service. Those marked 'TBC' are because the team is awaiting information on whether the Health Board is participating.

In considering the category under which this item should be reported to the Board, clarification was requested around whether the escalation process is proving effective. Ms Davies and Mr Bebb confirmed that it is. There is a need, however, to understand what services mean when they report that they do not have sufficient resources and the impact of non-participation. Agreeing, Mr Thomas suggested that services are provided with sufficient resources, it is rather that they are prioritising other areas over clinical audit. He felt that this should be included as part of the internal TI escalation process and would discuss this further outside the meeting. **HT/SD**

It was agreed that there should be a further update on Clinical Audit at the April 2025 meeting to assess progress. **CM**

Decision: The Committee:

- **NOTED** the completion rates of audits and the continued improvements being undertaken
- **NOTED** the reduction in local forward planned audits for 2024/25 and the increase in mandatory projects

- **TOOK ASSURANCE** in the continued use of AMAT software and the funding until January 2026
- **TOOK ASSURANCE** from the continuation of the majority of mandatory national audits and the processes followed for the escalation of concerns (without exceptions)
- **NOTED** the current limited involvement of 3 of the NCAORP projects, which will be articulated further through the Scheduled Care risk registers and business cases
- **NOTED** the development of the 2024/25 programme
- **TOOK ASSURANCE** from the continued shared learning through WHAM
- **REQUESTED** a further update in April 2025

The Committee agreed to **ADVISE** the Board in relation to the Clinical Audit report, due to the concerns highlighted during discussion, with the intended action regarding a progress update to be noted.

Ms Mandy Davies and Mr Ian Bebb left the Committee meeting.

AC(24)199 Internal Audit Plan Progress Report

Mr Johns introduced the Internal Audit Plan Progress Report, which was of the usual format. The report includes, in Section 2, details of the six audits finalised since the previous meeting. In terms of progress, a couple of audits which were due to be reported to this meeting have been deferred. It is intended to deliver the remainder of the Internal Audit Plan on schedule. Members' attention was drawn to the planned audit on Continuing Health Care (CHC), facilitated by the deferral of the Operational Governance audit. Referencing earlier discussions, Mr Johns explained the rationale behind the new report style, which has been influenced by the new Internal Audit Standards and good practice in other reporting processes. As mentioned, one change is the Agreed Management Actions, which is supplemented by a new section to record the evidence Internal Audit expect to see to support implementation. Noting the deferred audit reports, Cllr. Evans requested assurance regarding delivery of the remaining Internal Audit Plan. Mr Johns explained the reasons for delays and confirmed that all reports will be completed in time to meet Head of Internal Audit Opinion timelines.

Decision: The Committee **NOTED** the Internal Audit Plan Progress Report.

Mrs Eleanor Marks left the Committee meeting.

AC(24)200 Speaking Up Safely (Reasonable Assurance)

Mrs Lisa Gostling, Mr Rob Blake and Ms Cathie Steele joined the Committee meeting.

Ms Corbett introduced the Speaking Up Safely Internal Audit report, explaining that the purpose of the audit was to review implementation of the NHS Wales Speaking Up Safely (SUS) Framework and assess its impact in promoting a culture that enables staff to raise concerns. It was emphasised that, to protect the integrity, anonymity and confidentiality of the Speaking Up Safely process, concerns themselves have not been reviewed. One high priority matter arising was identified around the lack of a single report of formal and informal raised concerns, and triangulation of lessons learned. Three medium priority matters arising were also recorded. An overall rating of Reasonable Assurance was awarded.

In the first instance, Cllr. Evans wished to formally congratulate Mrs Lisa Gostling on her appointment as Deputy Chief Executive. Noting that the completion date for two actions has already passed, he requested confirmation that these have been completed. Mr Rob Blake confirmed that this was the case, with Mrs Lisa Gostling adding that she was confident the remaining actions will be completed on time. Referencing Management Action 4.1a, Cllr. Evans noted the proposal to use the same paper for both the People, Organisational Development and Culture Committee (PODCC) and QSEC and requested assurance that this will meet requirements. Mr Blake explained that both formal and informal concerns will be collated into one report rather than two. Mrs Wilson agreed that consideration needs to be given to reporting requirements, whilst avoiding unnecessary duplication of effort. This can be taken forward outside the meeting, and resolved by the completion date for this action. **JW/LG**

Decision: The Committee **NOTED** the Speaking Up Safely (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Speaking Up Safely (Reasonable Assurance) Internal Audit report.

Ms Sophie Corbett, Mrs Lisa Gostling, Mr Rob Blake and Ms Cathie Steele left the Committee meeting.

AC(24)201 Energy Management (Reasonable Assurance)

Mr Paul Williams and Mr Owen Harris joined the Committee meeting.

Mr Eifion Jones introduced the Energy Management Internal Audit report, noting that the purpose of the audit had been to assess effective management and control of energy costs. Eight medium priority management actions were identified, around energy issue reporting; cost/benefit review of additional sub-metering; the proposed automation of payment processing; the scheme of delegation for payments; balancing automation efficiencies with any additional resource required for monitoring and reporting; a costed plan for phasing out fossil fuels; monitoring of expert

advisory recommendations. An overall rating of reasonable assurance had been determined.

Cllr. Evans noted that there were a number of management actions, given the overall Reasonable Assurance rating. In response, Mr Jones advised Members that there is benchmarking in place and the team was sufficiently assured that Reasonable Assurance was the correct rating.

Decision: The Committee **NOTED** the Energy Management (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Energy Management (Reasonable Assurance) Internal Audit report.

Mr Paul Williams and Mr Owen Harris left the Committee meeting.

AC(24)202 Capital Systems (Reasonable Assurance)

Mr Simon Chiffi and Mr Julian Wheeler Jones joined the Committee meeting.

Mr Jones introduced the Capital Systems Internal Audit report, noting that the purpose of the audit had focused on the selection, appointment and contractual arrangements applied to Capital and Estates projects. Four medium priority management actions were identified, around parental guarantees; anti-collusion/anti-corruption clauses in contracts; central maintenance of a Capital Contracts register. Reasonable Assurance has been concluded.

Mrs Wilson queried the allocation of Objective 5 to the Chief Executive's Office, suggesting that this be revisited. **EJ**

Decision: The Committee **NOTED** the Capital Systems (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Capital Systems (Reasonable Assurance) Internal Audit report.

Mr Simon Chiffi and Mr Julian Wheeler Jones left the Committee meeting.

AC(24)203 Cash Management (Substantial Assurance)

Mr Johns introduced the Cash Management Internal Audit report, noting that the overall objective of this audit was to review, assess and provide assurance over the arrangements in place for strategic cash management. No issues of significance had been identified. The cash risk is obviously ongoing and well documented. As a result, a rating of Substantial Assurance had been awarded.

Mr Thomas thanked the Internal Audit team for the report. He suggested that the Health Board has probably become more effective in managing cash largely because this has been so challenging. However, a rating of Substantial Assurance is helpful in providing Welsh Government with an assurance that the organisation is managing the cash it does have well.

Decision: The Committee **NOTED** the Cash Management (Substantial Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Cash Management (Substantial Assurance) Internal Audit report.

AC(24)204 Health and Safety

DEFERRED to 11 February 2025 meeting.

AC(24)205 Management of Bed Capacity

DEFERRED to 11 February 2025 meeting.

AC(24)206 Mortuary Services

DEFERRED to 11 February 2025 meeting.

AC(24)207 Financial Management

DEFERRED to 11 February 2025 meeting.

AC(24)208 Financial Assurance Report

Mr Thomas introduced the Financial Assurance Report, indicating that this is of the usual format. He indicated that overpayments of salary continue to increase and reiterated the intention to conduct short meetings with managers in the relevant services. A number of these meetings are taking place this afternoon. These will provide an opportunity to reinforce messages around overpayments and their causes, and seek assurances that there will not be a recurrence. Mr Thomas also drew Members' attention to updates around No PO, No Pay Policy adherence, Public Sector Payment Policy (PSPP) compliance and Single Tender Actions. Appendix 1 of the report details contracts awarded, to the value of £25,000 and above.

Referencing the meetings with managers around overpayments of salary, Cllr. Evans enquired regarding ongoing actions. He asked whether follow-up meetings are planned, or whether it is hoped that these will be enough to improve the situation. Mr Thomas recognised that the position around overpayments of salary is

unacceptable. There have not, however, previously been specific discussions on this topic with managers. The first ten meetings are taking place this afternoon, and the position will then be reviewed. He hoped that calling these meetings will alert managers to the fact that this issue is being focused upon.

Mr Maynard Davies welcomed the information on invoices on hold. Given the number of these, he queried whether they are having an adverse effect on operational budgetary management and/or whether suppliers are reluctant to provide services to the Health Board. Mr Thomas replied that he had not received reports to this effect to date.

Decision: The Committee:

- **TOOK ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy.
- **TOOK ASSURANCE** from the controls in place to manage Single Tender Actions.
- **DISCUSSED** staff overpayments and **TOOK ASSURANCE** that actions to control them are sufficiently embedded.
- **SCRUTINISED** the award of contracts.

AC(24)209 Counter Fraud Update

Mr Terry Slater joined the Committee meeting.

Presenting the Counter Fraud Update, Mr Thomas advised that this is the standard format. The team is probably ahead in terms of resource used, which is a testament to their efficient working, particularly in view of the increase in referrals. Members' attention was drawn to the pro-active exercise in relation to governance procedures surrounding Right to Work checks, which will be discussed further during the In-Committee session.

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

AC(24)210 Economic Crime and Corporate Transparency Act 2023: Guidance to Organisations on the Offence of Failure to Prevent Fraud

Mr Thomas introduced the report, advising that this relates to a new Act, which will become effective on 1 September 2025. The guidance provided outlines the duty placed on Public Sector organisations. An assessment conducted by the Head of Local Counter Fraud suggests limited impact on the Health Board. The NHS as a whole is probably relatively well-served in terms of Counter Fraud resources. The principles of the Act are already adopted and utilised, and the report is provided for assurance.

Decision: The Committee **CONSIDERED** the policies and procedures in place to counter fraud within the Health Board and **TOOK ASSURANCE** that these are adequate to show that

reasonable measures are in place to prevent the new offence of failure to prevent fraud.

The Committee agreed to **ASSURE** the Board in relation to this issue.

AC(24)211 **Risk Assurance Report**

Miss Charlotte Wilmshurst introduced the Risk Assurance Report, reminding Members that this and the Audit Tracker are presented to alternate meetings. Members heard that the Health Board has 577 open risks on the Datix Risk Module as at 31 October 2024. Since the introduction of the internal escalation framework, there has been an improvement in the timeliness of risk reviews. This is also reflected in the number of Directorates in Level 2 and 3 escalation; with none of the services escalated to Level 3 in the Governance domain on the basis of their risk management arrangements and performance. In terms of risk actions, whilst there has been some improvement, there are still issues with unrealistic timescales. In terms of age profile, a number of open risks pre-date 2020. Work is ongoing around implementation of the Risk Management Strategy and a second assessment of the Health Board's Risk Maturity is planned.

Mrs Wilson advised that Mrs Marks had submitted a comment and question prior to leaving the meeting, relating to Mental Health and Learning Disabilities (MHLD). Mrs Marks noted that this area is carrying a high number of risks, above tolerance. She was also conscious, from a variety of visits to the service recently, that demand continues to outstrip by capacity, and that people are waiting an unacceptably long time for diagnosis and treatment. Whilst aware of additional funding to help in the short term, Mrs Marks queried the actions being taken in the medium/longer term to reduce the risks in this area; address waiting lists; tackle vacancies; integrate across different parts of the Health Board and take a person-centric approach. She was cognisant that this may not be a question for ARAC. It was agreed that this query would be best directed to Mr Carruthers and Ms Liz Carroll. It was highlighted that the escalation process is effective only when there is a mutual commitment to change. In considering whether this matter should be escalated to the Board, it was agreed that it should be managed via the Table of Actions in the first instance. **AC**

Cllr. Evans enquired where risks sit and in response, Mrs Wilson advised that this depends on their impact. For example, those that relate to quality or safety are considered by QSEC. Those which are concerned with staff are considered at PODCC. Also of influence is whether they are at Directorate or Corporate level. Referencing page 13 and the three principal risks whose risk score has changed, Mr Maynard Davies enquired regarding the reason for the change in risk score of Risk 1196. Miss Wilmshurst advised that this was linked to the delays to timescales involving progress with the new hospital. Further detail was provided in the Board Assurance Framework report to Board in November 2024.

Decision: The Committee **TOOK ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements.

Whilst it was noted that none of the services are escalated to Level 3 in the Governance domain on the basis of their risk management, the Committee agreed to **ADVISE** the Board in relation to continued concerns around outstanding external audit recommendations.

AC(24)212 Post Payment Verification (PPV) Report

Ms Amanda Legge and Ms Sue Tillman joined the Committee meeting.

Mr Thomas presented the Post Payment Verification (PPV) Report, which is of the standard format. He assured Members that any concerns are escalated to the Primary Care team and/or Counter Fraud as necessary. Members noted that Practice 6 had been highlighted as of concern. Ms Amanda Legge explained that the reason for this anomaly was that the Practice had claimed under both minor surgery excision and treatment rooms, when it is only permitted to claim for one. Assurance was given that training has been provided to address this erroneous duplication in claims.

Cllr. Evans was pleased to note that processes are in place to address issues where they arise.

Ms Amanda Legge and Ms Sue Tillman left the Committee meeting.

AC(24)213 Primary Care PPV Report

Discussed as part of the above agenda item.

AC(24)214 ARAC Workplan 2024/25

The Committee received and noted the Audit Work Programme 2024/25, which would be updated in line with discussions and to align with Audit Wales and Internal Audit Plans.

AC(24)215 Any Other Business

There was no other business reported.

AC(24)216 Date and Time of Next Meeting

9.30am, 11 February 2025

7.2

12:20, 5 Mins

7.2 - Table of Actions

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

Attachments

7.2 Table of Actions ARAC 10 December 2024.pdf

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 10 December 2024

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(24)163	**15/10/2024**	**Escalation Status Update Report**	To incorporate RTT performance scenarios into the planning for 2025/26 and present options to Board, once the planning framework and the funding allocations have been received	**SA**	**January 2025**	10 December 2024 **In Progress** Development of the plan is well underway and Directorates have been asked to produce a first draft by 29 November 2024. The planning framework has not yet been received from Welsh Government. 11 February 2025 **Complete** Final plans are expected to be received on 24 January 2025. In line with the Welsh Government Planning and performance framework, Directorates have been asked to provide a definitive position on the level of performance delivery they can commit to achieving, informed by their respective priorities. Once the final iterations of the plan are received, these submissions will allow a clear and quantified view of service trajectories for 2025/26. Additionally, we have commenced a clear mapping exercise to distinguish those elements falling under Targeted Intervention (TI)

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						requirements versus standard Annual Plan commitments. This mapping will help confirm which actions are mandated by the TI framework and those that constitute normal operational or strategic priorities. It is anticipated that, once collated, this information will provide a transparent alignment between directorate-level performance targets TI objectives and our broader Welsh Government expectations.
AC(24)171	**15/10/2024**	**Falls Management (Reasonable Assurance)**	To take forward plans to include compliance with falls risk assessments in the nursing audit programme	**SD/MD**	~~**December 2024**~~ **February 2025**	10 December 2024 **In Progress** A draft Falls Audit tool has been developed and will be taken through SNMT with other Senior Nurse Manager Audit tools in December 2024 for sign off and aim to pilot in Q4. 11 February 2025 **Complete** The draft Falls Audit tool was discussed in SNMT in January 2025 and agreed in principle and as part of a wider piece of work around ensuring a standardised audit workplan.
			To establish how HDdUHB compares with other Health Boards in terms of numbers of falls	**SD/MD**	~~**December 2024**~~ ~~**February**~~ **June 2025**	10 December 2024 **In Progress** The National Audit of Inpatient Falls for 2024 has been completed and provides an All Wales position - we are waiting for our local HB data to be released to benchmark with other HBs - likely to be in Q4 now.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						There are currently no other national benchmarking processes in place. <u>11 February 2025</u> HBs across Wales are waiting for individual health board data to be released by NAIF – likely to be April 2025.
AC(24)179	**15/10/2024**	**Financial Assurance Report**	To introduce the Salary Overpayments dashboard into the internal TI escalation process	**HT**	**~~December 2024~~ February 2025**	<u>10 December 2024</u> **In Progress** Being scoped. Meetings with managers taking place. <u>11 February 2025</u> Owing to the relatively low incidence of overpayments, we have determined that incorporating the dashboard into the general "Our performance" dashboard and our escalation processes would result in personal identifiable information being available generally. An alternative approach has been developed for a panel, chaired by the Director of Finance, which calls in managers who have persistently overpaid staff to explain how this has happened and to receive assurances on how this will be avoided in the future. Relevant issues/information have been included within the Financial Assurance Report.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(24)188	**10/12/2024**	**Table of Actions - AC(24)179 (Financial Assurance Report)**	To provide a further update to the February 2025 meeting	**HT**	**February 2025**	See AC(24)179, above
		Table of Actions - AC(24)171 (Falls Management)	To provide further updates to the February 2025 meeting	**SD**	**February 2025**	See AC(24)171, above
AC(24)190	**10/12/2024**	**Nursing Management (Limited Assurance)**	To consider the content of training packages for managers, to include training in rostering and other skills	**AC/SD**	**February 2025**	A task and finish Group has been established. First meeting was held 24 January 2025. Roster training package prepared, recorded and circulated to all nursing roster managers. In person sessions also delivered. Unavailability monitoring dashboard being developed. In place for unscheduled care directorates with other directorates under construction. Monthly updates to Rostering Group. IA to be repeated in June 2025.
			To conduct a follow-up audit within 6 months, with a wider scope, including oversight and across the whole Health Board	**JJ**	**~~February~~ April 2025**	To be included in the Internal Audit Plan for 2025/26, which will be presented to ARAC at its April 2025 meeting for approval.
AC(24)191	**10/12/2024**	**Discharge Management Follow-up (Limited Assurance)**	To conduct a follow-up audit before the end of the financial year	**JJ**	**~~February~~ April 2025**	Follow up planned to be undertaken during April and May 2025, subject to progress of the management actions due for delivery by end of March 2025.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(24)192	**10/12/2024**	**Escalation Status Update Report**	To consider how the report can facilitate ARAC's overarching role in providing assurance that other Committees are undertaking theirs with regard to TI	**SA**	**February 2025**	**Complete** This has been incorporated into the February TI update report
AC(24)195	**10/12/2024**	**Audit Wales Update Report**	To take forward (via the Counter Fraud Update) the Audit Wales checklist in relation to the National Fraud Initiative	**HT/BR**	**February 2025**	**Complete** The final checklist is included in the Counter Fraud Update report for February 2025.
			For the Digital Deep Dive, to feed back suggestions regarding sharing good practice and cooperation mechanisms between Health Boards	**UP**	**February 2025**	**Complete** The Committee's suggestions and comments on plans for the review of investment in digital systems have been fed back to the development team for consideration.
			For the Digital Deep Dive, to feed back the suggestion regarding moderation on an All Wales basis	**UP**	**February 2025**	**Complete** The Committee's suggestions and comments on plans for the review of investment in digital systems have been fed back to the development team for consideration.
AC(24)196	**10/12/2024**	**Structured Assessment 2024**	To draw out the change to the Health Board's financial position in the covering SBAR and/or ARAC's Update Report to Board	**JW**	**February 2025**	**Complete** Included in the covering SBAR for Public Board
AC(24)198	**10/12/2024**	**Clinical Audit Update**	Where there are concerns around non-participation in audits, to require services to complete Quality Impact Assessments (QIAs)	**MD/SD**	**February 2025**	**Complete** QIA added to the new Clinical Audit escalation process. The Pilot will run until end of financial year, with proposal to implement from April 2025.
			To discuss outside the meeting including prioritisation of clinical audit	**HT/SD**	**February 2025**	**In Progress** A meeting has been scheduled for 10 February 2025 between the

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			(and resources for this) in the internal TI escalation process			Director of Corporate Governance, Director of Finance and Interim Director of Nursing, Quality and Patient Experience. A verbal update on the outcome of this meeting will be provided.
			To schedule a further update on Clinical Audit at the April 2025 meeting	**CM**	**February 2025**	**Complete** Forward planned for April 2025 meeting.
AC(24)200	**10/12/2024**	**Speaking Up Safely (Reasonable Assurance)**	To consider outside the meeting Management Action 4.1a (papers for PODCC and QSEC) and reporting requirements	**JW/LG**	**~~February~~ April 2025**	**In Progress** Speaking Up Safely reporting is scheduled for April 2025 PODCC and QSEC meetings.
AC(24)202	**10/12/2024**	**Capital Systems (Reasonable Assurance)**	To revisit the allocation of Objective 5 to the Chief Executive's Office	**EJ**	**February 2025**	**Complete** Relevant recommendation has been re-assigned to the Head of Information Governance
AC(24)211	**10/12/2024**	**Risk Assurance Report**	To direct the comment and query relating to MHLD to Mr Andrew Carruthers and Ms Liz Carroll	**AC**	**February 2025**	**Complete** The Executive Team continue to monitor progress with the MHLD Triumvirate through the escalation process. The new Deputy COO is spending targeted time with the Director of MHLD to support discussions around the services financial plan and key area of outstanding performance relating to ASD/ADHD.

7.3

12:25, 0 Mins

7.3 - Matters Arising not on Agenda

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

7.4

12:25, 20 Mins

7.4 - 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 - Deputy Director of Operational Planning and Commissioning)

For assurance

Attachments

7.4 Escalation Status Update ARAC February 2025.pdf

7.4 TI Reporting Framework Tracker January 2025.pdf

7.4 Slides from HDUHB for WG TI Jan 2025.pdf

7.4 2025-01-29 - JP to PK - following TI meeting 21 January 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

ARAC – 11th February 2025

Targeted Intervention Progress Report

Introduction

Key Highlights

- **Positive TI Audit -** The recent internal audit of Targeted Intervention arrangements provides assurance that the Health Board governance and oversight is reasonable. Furthermore, there are only 2 recommendations with 1 recommendation expected to be closed imminently.
- **Robust Governance -** The organisation has well-established reporting structures, ensuring that both progress and any lack of delivery are clearly highlighted and escalated.
- **Alignment with Welsh Government Feedback -** Our self-assessment of TI criteria is closely aligned to Welsh Government observations, demonstrating a consistent understanding of risks and progress.
- **Capacity/Capability Note -** Despite the robust governance frameworks, there remains a risk linked to resourcing the escalation role, currently reliant on a single individual.
- **Next Maturity Matrix Review -** Following last year's self-assessment in Q4 2023–24, the next full review of governance maturity is planned for Q4 2024–25 to align with end-of-year progress on the annual plan

Criteria 36 - Effective Oversight and Scrutiny

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Assure **Executive Lead**: Joanne Wilson

- **Summary of Current Status/Positive Audit Note -** Internal Audit findings confirm the Board and Committees maintain regular, open scrutiny (e.g. IPAR, Risk Register, Q&S Dashboards, Clinical Services Plan updates, GIRFT).
- **TI Pack Scrutiny -** TI packs are thoroughly reviewed across relevant committees, focusing on the de-escalation criteria.
- **Moving Forward -** Newly streamlined reports, with explicit reference to which committees own which TI criteria, bolster Board-level oversight and transparency.

Next Steps/Actions

1. **Embed Reporting Format -** Continue refining the six specific TI actions at ARAC.
2. **Summarise Assurances -** Provide brief updates from other committees to ARAC for overarching assurance.
3. **Committee Restructure -** Implement new Board Committee structure by April 2025 (approved in January 2025).

Evidence/Assurance - Internal Audit Report 2024/25 (favourable assurance on governance & reporting). Structured Assessment 2024 (notes openness and transparency).

Risk - (**Capacity) -** Reliance on a single point (Programme Director) for escalation oversight is being monitored.

Criteria 37 - Board's Duty of Quality in Decision-Making

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Sharon Daniel

Summary of Current Status - Clinical Fragility - Board decisions on temporary service changes are underpinned by Quality Impact Assessments.

Positive Audit Note - Audit feedback acknowledges the Board has a clear focus on patient safety and quality; however, further alignment across all pathways is needed.

Next Review - The next Maturity Matrix reassessment in Q4 2024–25 will consider any improvements in how quality data is integrated for all services (not just those in the CSP), using the new dashboard developed by the performance team.

Next Steps/Actions

1. **Deepen Integration -** Strengthen frameworks so that workforce, finance, resilience, and quality data are considered together for all services.
2. **Timelier Sight of Service Issues -** Ensure robust risk identification so the Board is not 'forced' into decisions on short notice.

Evidence/Assurance

- Complaints & Claims data (ongoing monthly).
- Risk Registers reflecting service fragility.
- QIAs for recent Board decisions (e.g. PPH MIU changes).

Risk - (**Capacity/Timing) -** Insufficient early sight of potential service issues if underlying risk assessments lag.

Criteria 38 - Programme and Performance Management Structure

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Audit & WG Feedback -** Positive progress in setting up structures; the new 100-day planning cycle helped clarify objectives, but there was inconsistent directorate engagement.
- **Capability/Capacity Risk -** A single Programme Director for TI escalation places strains on delivering the scale of change needed.
- **Governance Strength -** The next Internal Audit (scheduled by end of March 2025) will assess if new frameworks (Care Groups) for urgent care, cancer, and diagnostics delivery are adequately robust.

Next Steps/Actions

1. **Escalation Process -** Formal route for non-engagement to be agreed between the Programme Director TI and CEO/Deputy CEO (by 28 Feb 2025).
2. **Resource Review -** Assess if additional support is needed to address capacity constraints within the agreed programmes

Evidence/Assurance

- 100-day cycle post-programme review.
- Draft Internal Audit Report 2024/25 (Objective 1).
- WG feedback (21 January 2025).

Risk - **Single Point of Dependency**: Limited staff to coordinate cross-organisational transformation.

Criteria 39 - Risk Management Arrangements

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Joanne Wilson (with COO involvement)

Summary of Current Status

- **Robust Corporate Governance**: Internal Audit and Structured Assessments consistently confirm mature strategic and corporate risk management.
- **Operational Governance Gaps -** Capacity issues at the operational level can hamper timely action on identified risks.
- **Planned Improvements -** A revised operational governance structure—led by the COO—is scheduled for April 2025 to align front-line risk processes with strategic oversight.

Next Steps/Actions

1. **Support COO**: Ensure consistent governance across all directorates, bridging any operational vs. corporate gaps.
2. **Risk Mitigation Plans**: Develop more detailed, actionable mitigation plans for high-level risks, ensuring capacity is in place to deliver them.

Evidence/Assurance

- Corporate Risk Register, Datix, and Board Assurance Framework. Structured Assessment 2024 (mature approach to strategic and corporate risks).

Risk - **Operational Variability -** Some services lack dedicated capacity to fully address or escalate risks in a timely manner.

Criteria 40 - Governance and Assurance Systems

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Positive -** New governance structures facilitate clearer escalation of performance, quality, and resource issues.
- **Challenges -** Despite well-defined frameworks, some areas (e.g. cancer, diagnostics) are not improving as hoped, indicating potential system gaps or under-resourcing.
- **Audit Alignment -** The Internal Audit will also assess how effectively these structures drive performance improvements in 2024–25.

Next Steps/Actions

1. Effectiveness Review - Conduct a formal evaluation of how the governance frameworks support actual performance gains.
2. Directorate Engagement - Reinforce directorate-level accountability for meeting performance milestones.

Evidence/Assurance

- TI packs, committee reports.
- Ongoing Internal Audit and Maturity Matrix reviews.

Risk

- **Limited Improvement Trajectory -** If the frameworks are not universally adopted or fully resourced, performance in critical areas is likely to deteriorate or not improve in line with expectations.

Criteria 41 – Maturity Matrix Self-Assessment

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **First Self-Assessment (Q4 2023–24) -** Completed last year, providing a baseline of governance maturity.
- **Next Self-Assessment (Q4 2024–25) -** Planned for the end of this financial year to align with the close of the 2024–25 annual plan, capturing progress on key improvement actions.
- **Reasonable Assurance -** The TI Audit compliments this approach, acknowledging that the Health Board proactively reviews governance maturity rather than relying solely on external audit findings.

Next Steps/Actions

1. **End-of-Year Reassessment -** Repeat the self-assessment in Q4 2024–25, focusing on capacity, capability, and how effectively we address known fragmentation.
2. **Link to TI Delivery -** Ensure the maturity matrix directly informs strategic and operational planning for 2025–26.

Evidence/Assurance

- Governance Maturity Matrix from Q4 2023–24.
- Future Maturity Matrix outputs (Q4 2024–25).
- Welsh Government and Internal Audit feedback (January 2025).

Risk

- **Capacity -** If the single TI Programme Director remains the only escalation lead, the maturity improvements identified may not be realised at scale.

ARAC's Visibility across Targeted Intervention

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Why this approach?

ARAC needs better visibility of key "Alert" criteria but does not require a deep review of all 55 items.

Key proposal

1. Focus on "Alert" - Present only criteria at "Alert" status, grouped by the committee responsible.
2. Brief explanations on request - If ARAC needs more detail, a short update can be provided for any "Alert" criterion.
3. Regular summaries - ARAC will receive an "Alert" summary at agreed intervals, ensuring consistent oversight of the most urgent issues.

Outcome

- ARAC gains a high-level understanding of major risks.
- Committees continue to handle detailed scrutiny of each criterion.

Alert Criteria by Committee

Sustainable Resources Committee (SRC)

- Criterion 3: Annual plan with Board approval showing a substantial financial improvement trajectory that meets or exceeds the target control total.

ARAC's Visibility across Targeted intervention

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Strategic Development & Operational Delivery Committee (SDODC)

- Criterion 4: Submission of an acceptable annual plan in line with the current planning framework.
- Criterion 6: Board clarity on the organisation's strategic vision.
- Criterion 8: Delivery of annual plan commitments, especially ministerial priorities.
- Criterion 13: Maintain 60% Single Cancer Pathway (SCP) performance for three consecutive months.
- Criterion 17: Achieve a 15% reduction in follow-ups delayed by 100%, for three consecutive months, then maintain for three more (based on the November 2023 baseline).
- Criterion 18: Ensure 65% of R1 ophthalmology patients are seen within or no more than 25% over their target date, sustained for three months.
- Criterion 24: Reduce ambulance handovers over one hour by 11% for three consecutive months, then maintain for another three (based on Oct–Dec 2023 baseline).
- Criterion 25: Continue progress toward no more than 7% of patients waiting over 12 hours at each site and across the Health Board.
- Criterion 26: Ensure median time from ED arrival to assessment by a clinical decision maker is no more than 60 minutes.
- Criterion 27: Achieve a 5% continuous reduction in delayed care pathways for three consecutive months, then maintain for a further three (based on Oct–Dec 2023 baseline).

ARAC's Visibility across Targeted intervention

Quality, Safety & Experience Committee (QSEC)

- Criterion 34: Demonstrate that all external recommendations (Royal Colleges, HIW, etc.) are discharged, verified, or scheduled under the longer-term improvement plan.
- Criterion 52: Provide an effective response to external reports (Audit Wales, Ombudsman, Royal Colleges, HIW), leading to sustainable improvements.

People, Organisational Development & Culture Committee (PODCC)

- Criterion 45: Develop a sustainable workforce (improved retention, fewer vacancies, less agency use) and review workforce/clinician job plans annually to meet the annual plan requirements.

Conclusion & Next Steps

- **Positive Internal Audit -** Overall, the Health Board's governance and escalation frameworks for TI have been deemed robust, which should provide a reasonable confidence to both Board members and Welsh Government that the correct mechanisms are in place.

- **Targeted Focus -** Specific criteria remain on 'Advise' due to gaps in achieving consistent programme delivery, capacity constraints, and the need for further integration of data/oversight.

- **Moving Forward -** The April 2025 operational governance structure changes, plus the Q4 2024–25 self-assessment, offer clear opportunities to address these gaps and strengthen the Board's overall assurance position.

Action	Reporting Group	Committee	Status	Executive Lead	Summary of Current Status	Lead Executive Response (if applicabl	Documented Plan and	Actions Outstanding	Evidence and Assuran	Risk
Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers.	TI coordination group	ARAC	Assure	Joanne Wilson	Regular reports provided to Board and Committees include IPAR, Risk Register, Q&S Dashboard, Clinical Services Plan Updates, Deep Dive reports on specific issues, updates on GIRFT reports. Furthermore, the Targeted Intervention (TI) pack undergoes thorough scrutiny at committee level, with robust and regular discussions across relevant committees. Significant progress has been made to ensure that each committee focuses on the de-escalation criteria relevant to its remit, particularly within the Sustainable Resources Committee and the Strategic Development and Operational Delivery Committee. From the Draft Internal Audit Report 2024/25 (Objective 1, Key Findings on Governance & Reporting Arrangements): Following feedback from independent members at ARAC meetings, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing.	Positive feedback has been received by AW in Structured Assessment 2024 regarding the Health Board's openness and transparency in its reporting. The Board will be considering a new Committee structure at its meeting on 30 January 2025, with implementation planned from April 2025.	Board Committee Structure - Jan25 Board 1. Structuring reports by the six specific TI actions under ARAC's remit, ensuring that each action is clearly tracked, monitored, and reported. In addition, summary assurance from other committees will also to be provided – (complete) 2. Highlighting any variance or potential	Committee reporting in Dec/Jan25	Structured Assessment 2025 Committee Self Assessment feedback	N/A
Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.	TI coordination group	ARAC	Advise	Sharon Daniel	While there is clinical data supporting fragility within the CSP's scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model—integrating workforce pressures, financial assessments, service resilience, and patient accessibility—would help frame the Board's understanding and response to fragile services more effectively. This remains a priority to ensure alignment across all fragile pathways, especially in light of emerging configuration challenges.		1. CSP Updates, detailing areas of fragility. (On Track - on-going) 2. Complaints & Claims Data, regularly reported to relevant committees (On-Track -monthy)			No risk identified
Effective programme and performance management structure is in place which defines objectives of the improvement work has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective open and transparent reporting with effective Board oversight and a clear performance and delivery framework that drives improvement.	TI coordination group	ARAC	Advise	Lee Davies	Recent governance improvements have provided a strong foundation, with clear objectives defined across various programmes. However, translating these objectives into consistent delivery remains a challenge. While progress has been noted in financial delivery, limited improvement has been seen in areas such as cancer, urgent care, and diagnostics. In some cases, deterioration has highlighted gaps in the effectiveness of the performance and programme delivery framework. **Welsh Government Feedback (21 January 2025)** Welsh Government acknowledged our positive progress in meeting 2024–25 objectives but emphasised the importance of having adequate capacity and capability to deliver our 2025–26 annual plan. They underlined the need for sufficient organisational planning and oversight, given the scale and complexity of upcoming programmes. **Internal Audit Findings** From the Draft Internal Audit Report 2024/25 (Objective 1): A 100-day planning and delivery cycle of key programmes was introduced to aid in the planning, execution and oversight of critical change initiatives by 1st October 2024. The delivery cycle was supported by a documented enhanced scrutiny and rapid escalation process. Of the six programmes identified, a post-programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes, whilst there was little engagement from some directorates and services that resulted in no plan being presented or developed. Directorate and Service Engagement The post 100-day planning and delivery programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes and little engagement from some directorates and services that resulted in no plan being presented or developed, impacting on the Health Board's ability to deliver TI actions.	A review of the effectiveness of the new governance arrangements will be undertaken by Internal Audit, expected to be completed in March 25	**Action - Formal Escalation Process for Non-Engagement -** To address the incomplete plans and limited engagement in certain programmes, a formal escalation route between the Programme Director of Targeted Intervention and the CEO/Deputy CEO will be established. This process ensures that any directorate or service failing to provide complete, timely plans will be escalated for support and accountability. **Target Implementation**			No risk identified
Risk management arrangements are in place for identifying, recording managing risks across the organisation. 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 of fragile services provided by QSEC and Board.	TI coordination group	ARAC	Advise	Joanne Wilson	Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks. This framework is built on a well-established set of tools, such as the Board Assurance Framwork, Corporate Risk Register and Datix, complemented by structured directorate escalation meetings. These meetings cover six key risk areas, ensuring a comprehensive assessment of performance variations and emerging challenges. This systematic approach aims to promote a proactive culture of risk identification, where issues can be identified and addressed early. The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines, including the Quality, Safety, and Experience Committee (QSE), the Targeted Intervention (TI) Coordination Group, and the Audit and Risk Assurance Committee (ARAC). These governance structures allow the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services. This approach allows the Board to fulfil its role not only in terms of monitoring but also in challenging and supporting the development of mitigation strategies. Despite these established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation. It has been observed that while risks are being systematically recorded, there is sometimes a lack of capacity to manage the risks and the actionable plans tied to these risks. This gap can be addressed by focusing on the development of risk management plans that contain specific deliverables , measurable milestones, and clearly assigned responsibilities (subject to capacity) that are linked to the Health Board's agreed objectives. Strengthening these aspects will enhance the link between risk identification and tangible mitigation outcomes, promoting a more cohesive approach to risk management across the Health Board. Operational oversight has recently been improved through internal escalation processes that help identify operational issues and risks in a timely manner. However, governance arrangements at the operational level remain inconsistent, particularly across the Operations Directorate. The inconsistencies identified are currently being addressed through the introduction of a new operational governance structure. This revised structure, expected to be implemented by April 2025, will be led by the Chief Operating Officer, whose support will be crucial to ensure consistent application and monitoring across all operational teams. The objective is to align operational governance standards with the mature corporate governance practices already demonstrated by the Health Board, thus promoting a unified standard of governance across all tiers of the organisation. The corporate governance arrangements within the Health Board are mature and robust, a conclusion consistently reinforced through structured assessments. These assessments highlight that strategic and corporate risks are well-monitored, and there is a continuous effort to ensure alignment between strategic intentions and operational actions. However, to support future governance resilience, it will be crucial to focus on embedding consistent governance practices across all operational functions. This will ensure a consistent flow of information, from front-line operational risks to strategic oversight by the Board, thereby enhancing the Health Board's capacity to manage both immediate and long-term challenges.	Mature and robust corporate governance arrangements in place, with further work to develop consistent governance arrangements in the Operations Directorate	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Structured Assessment 2024 - the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.	N/A

Clear governance and assurance systems in place with performance (quality resource activity/outcomes) issues escalated appropriately through clear structures and processes.	TI coordination group	ARAC	Advise	Lee Davies	As above, the new governance arrangements are now well established and provide the mechanisms for seeking assurance and escalating as required. A review is required of the effectiveness of these mechanisms as, in areas like cancer, urgent care, and diagnostics, we've observed not only limited improvement but in some cases, a deterioration, highlighting potential gaps in the effectiveness of our programme and performance management. Although the structure defines objectives, the framework is not yet supporting the level of oversight required to ensure consistent delivery against these objectives.	As above	No risk identified
Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	TI coordination group	ARAC	Advise	Lee Davies	The Health Board undertook a self-assessment against an agreed governance maturity matrix in Q4 of 2023-24, providing a realistic view of the organisation's current position regarding governance maturity. This assessment has been crucial, particularly given the broader context of the annual plan recovery work undertaken during the summer of 2023 and the strategic preparations for the 2024-25 planning cycle. It offered a critical lens through which governance practices were evaluated, enabling an honest appraisal of strengths and areas needing enhancement. The maturity matrix framework provided clear insights, which have informed the Health Board's subsequent approach to improving its governance maturity. The assessment did not exist in isolation; rather, it has become a key reference point for ongoing organisational improvements. It has ensured that governance practices are continuously reassessed, with findings feeding into the decision-making processes to strengthen governance structures, align roles and responsibilities, and provide a clear direction for ongoing enhancement activities. In a manner similar to the Health Board's handling of the 56 de-escalation criteria under the Targeted Intervention (TI) framework, the maturity matrix serves as both a strategic and operational tool that reinforces decision-making processes. These processes ensure that both strategic and operational planning governance arrangements are not only reactive but also proactive, with an emphasis on anticipating challenges, promoting best practices, and ensuring alignment across critical areas of focus. The maturity matrix is thus integral to the Health Board's structured approach to organisational improvement, helping to drive alignment between strategic goals and operational practices. Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities. This continuous assessment cycle allows the Health Board to remain agile, capable of responding to both internal and external pressures, while still maintaining alignment with its strategic objectives. By leveraging the insights gained through the maturity matrix and aligning them with the strategic priorities identified in the 2025-26 annual plan, the Health Board aims to ensure that its governance arrangements not only meet current needs but are also future-ready. The next maturity matrix reassessment will take place following the completion of the 2025-26 annual plan. This reassessment will help to ensure that planning practices remain relevant and aligned with the evolving needs of the organisation. Furthermore, this will service as an improvement process ensures that governance structures are not static but evolve in tandem with the changing operational landscape and strategic ambitions of the Health Board. At the Welsh Government meeting on 21 January 2025, officials noted good progress for the 2024–25 objectives but emphasised the need for adequate capacity and capability to deliver the 2025–26 annual plan. This feedback is directly relevant to Criterion 41 because the next governance maturity matrix self-assessment will: Consider whether the capacity and capability challenges flagged by Welsh Government have been addressed, ensuring the organisation's governance is robust enough to execute complex programmes and mitigate emerging risks.	A further assessment will be made following the completion of the annual for 2025-26 (April 25)	N/A

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

Targeted Intervention Meeting

Hywel Dda University Health Board

21 January 2025

Hywel Dda University Health Board - Key Achievements to Date Summary

Executive Leadership and Governance

Leadership Stabilisation

- Successful appointment of permanent Chief Executive Officer (Professor Philip Kloer) and Deputy Chief Executive (Lisa Gostling)
- Completion of 11 key operational leadership appointments strengthening management capability across the Health Board
- Plans underway for permanent appointments to Executive Medical Director and Director of Nursing, Quality & Patient Experience roles

Governance Excellence

- Positive 2024 Structured Assessment with only three recommendations, highlighting strong corporate arrangements despite period of significant change
- Maintained robust Board and committee effectiveness with clear focus on transparency and continuous improvement
- Strengthened escalation arrangements for high-risk matters to Board level
- Implementation of new Internal Escalation Framework providing comprehensive assessment across six key domains

Financial Management and Control

Financial Grip

- Significant improvement in financial position, exemplified by reduction from £49.0m forecast deficit in Month 1 to £28.0m in Month 9
- Successful delivery of savings schemes with identification gap reduced to just £0.2m by Month 9
- Substantial reduction in agency spend, particularly in nursing, with nurse agency costs at three-year low

Variable Pay Control

- Elimination of off-framework nursing agency usage since June 2023
- Reduction in agency usage from 253 WTE (March 2023) to 104 WTE (October 2024)
- Cessation of planned nurse agency usage from November 2024 (except Bronglais General Hospital and Emergency Departments)

Workforce Stabilisation

Nursing Workforce

- Successful onboarding of 296 Internationally Educated Nurses
- Significant reduction in Band 5 nursing vacancies to near normal business levels
- Notable improvement in staff development with PADR completion rate increasing to 82.1%

Leadership Development

- Delivery of eight LEAP (Leadership Engagement with Awesome People) cohorts benefiting 92 senior leaders
- Establishment of 37-strong coaching network with 15 cohorts of 'The Coach Approach' programme delivered
- Launch of comprehensive online INFORM management resource programme

Hywel Dda University Health Board - Key Achievements to Date Summary

Service Improvements

Digital Transformation

- Implementation of new Patient Hub enabling digital patient communications
- Successful deployment of Electronic Document Management system with 400,000 patient records digitised
- Progress on Electronic Prescribing Medicine Administration and Electronic Observations projects

Quality and Patient Experience

- Maintained above 90% Friends and Family Test scores
- Development of comprehensive Quality Improvement Strategic Framework
- Progress on implementing Nurse Staffing Levels (Wales) Act with robust twice-yearly reviews

Clinical Services Planning

- Advancement from Options Development to Consultation phase of Clinical Services Plan
- Progress in Primary Care and Community Strategic Plan development
- Successful implementation of 50-Day Challenge and Winter Measures improving patient flow

Equality and Inclusion

- Implementation of new Strategic Equality Plan and Objectives
- Launch of Anti-Racism e-learning module with Board leadership commitment
- Development of local LGBTQ+ Action Plan with enhanced staff training and awareness programmes

Challenges and forward focus

Whilst recognising these achievements, the Health Board acknowledges ongoing challenges including:

- Need to further reduce sickness absence rates (currently 6.61% against 4.79% target)
- Continued work required on financial sustainability
- Ongoing focus on reducing waiting times and improving emergency care performance

The Health Board maintains a balanced approach to improvement, building on successes whilst actively addressing areas requiring further development.

Escalation status overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Escalation status levels overview as of 31 December 2024

1 Reasonable assurance 2 Limited assurance 3 No assurance

	Directorate	Quality	Governance	Workforce	Finance, Strategy and Planning	Fragile Services	Performance & Outcomes
Director of Operations	Director of Operations	1	3	2	3	1	n/a
	Facilities	2	2	3	3	1	3
	Mental Health & Learning Disabilities	3	3	2	3	2	3
	Cancer & Oncology	1	1	1	3	1	3
	Pathology	1	3	2	3	2	n/a
	Radiology	3	3	2	3	1	3
	Planned Care (incl. Audiology and Endoscopy)	3	3	2	3	2	3
	Bronglais Hospital	2	1	2	2	2	3
	Glangwili Hospital	2	1	2	3	3	3
	Prince Philip Hospital	2	1	2	3	1	3
	Withybush Hospital	2	1	2	3	2	3
	Women & Children	2	2	2	3	2	3
Director of Primary, Community and LTC	Carmarthenshire County	2	1	2	3	1	3
	Ceredigion County	2	1	2	3	1	3
	Pembrokeshire County	2	1	2	3	1	3
	Primary Care	2	1	2	1	2	3
	Primary Care Management	1	2	2	1	1	n/a
	Medicines Management	1	2	2	3	2	n/a
Other	Director of Therapies and Health Sciences	2	1	2	3	1	3
	Director of Finance	1	2	1	1	2	n/a
	Director of Nursing	2	2	2	3	1	3
	Director of Public Health	1	1	2	1	1	2
	Director of Strategy and Planning	1	2	1	2	1	n/a
	Director of Workforce & OD	1	1	1	1	1	n/a
	Medical Directorate	1	2	1	1	1	n/a
	Corporate Services	1	1	2	1		n/a

Our most challenged directorates (alert assessments):

- **Mental Health and Learning Disabilities** - significant gaps in savings plans, governance concerns for investigating complaints & incidents, overdue pay progressions, medical staff job planning and neurodevelopmental assessment capacity.
- **Planned Care** - governance concerns for investigating incidents, lack of compliance with external recommendations and WHCs, savings requirements for 2024/25 not met and 2025/26 savings requirement also at risk.
- **Radiology** – governance concerns for investigating incidents and reviewing risks, lack of compliance with HIW recommendations, end of year forecast of overspend, 2024/25 & 2025/26 savings not identified and demand outstripping capacity which is impacting on performance across cancer and other pathways.
- **Facilities** - strengthening needed of management/support capacity, poor compliance for workforce related measures, inconsistency in cleanliness audits of high-risk areas, variable pay spend need to be addressed and recurrent savings for 2025/26 not yet identified.
- **Glangwili Hospital** - overspend forecast and savings requirement not fully identified, clinical staffing and vacancy concerns in A&E and high numbers of ambulance delays and A&E wait breaches.

Widespread issues within the Finance domain (17 directorates level 3) and the Performance domain (16 directorates level 3).

Details of escalation status trends, escalation reasons and de-escalation criteria can be accessed via the Our Performance dashboard.

Domain 1: Finance, strategy and planning

Summary of Recent Progress (TI Criteria - 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Board has signalled an improved financial position, as reported in Month 9, going beyond the restated planned deficit and aligned target control total. This follows improvements in savings delivery, core underspends and a £32.5m funding allocation. Since the last meeting in September 2024, the below table summarises the improvements made.

Recent recovery actions have focused on the following to de-risk the financial plan:

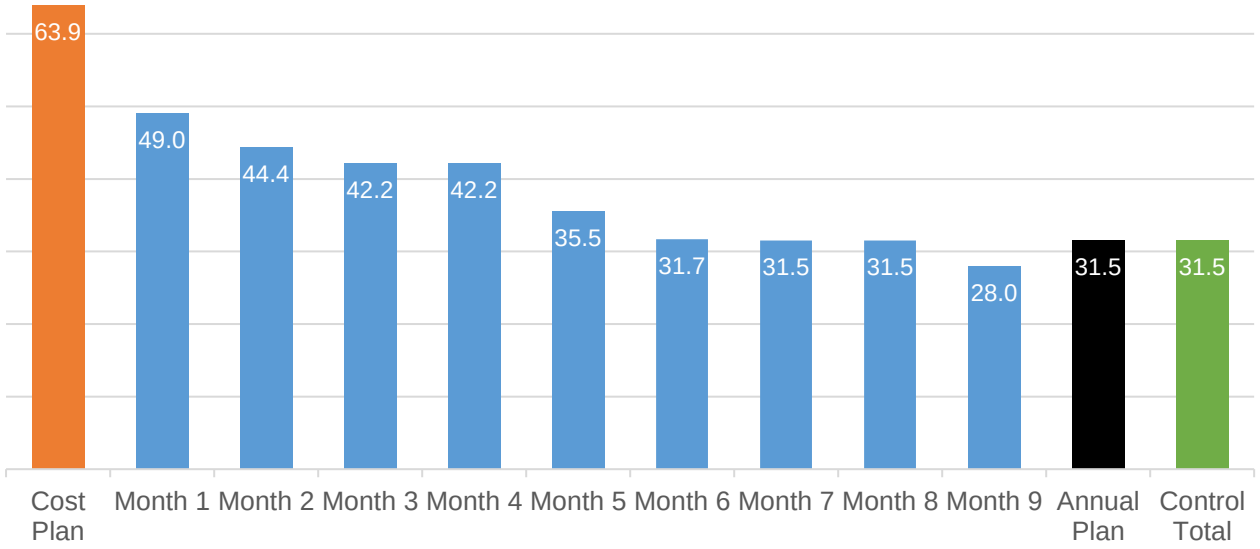
- Converting opportunity ideas (blue and red) at pace into credible and deliverable schemes (amber and green);
- Focused grip and control maintained through the internal escalation framework and the Financial Control Sub Group;
- Continued strides to onboard internationally recruited nurses to improve stability of wards and reduce the reliance on agency;
- Support directorates through the internal escalation framework, some of which continue to not have improvements plans in place;
- Identifying directorate savings including the implementation and delivery of plans to start before the end of this financial year.

Driver (£m) (Month 5 numbers restated for new funding)	**Month 5 Forecast**	**Month 9 Forecast**
Planned deficit	**31.5**	**31.5**
Unidentified / (Identified) savings gap / (improvement)	4.3	0.2
Under / (Over) Delivery of Savings Schemes	1.3	1.3
Core Operational Variation	(1.6)	(5.0)
Gross forecast	**35.5**	**28.0**
Future mitigating actions required to deliver Reported Planned Deficit	(4.0)	N/A (Improved beyond plan)

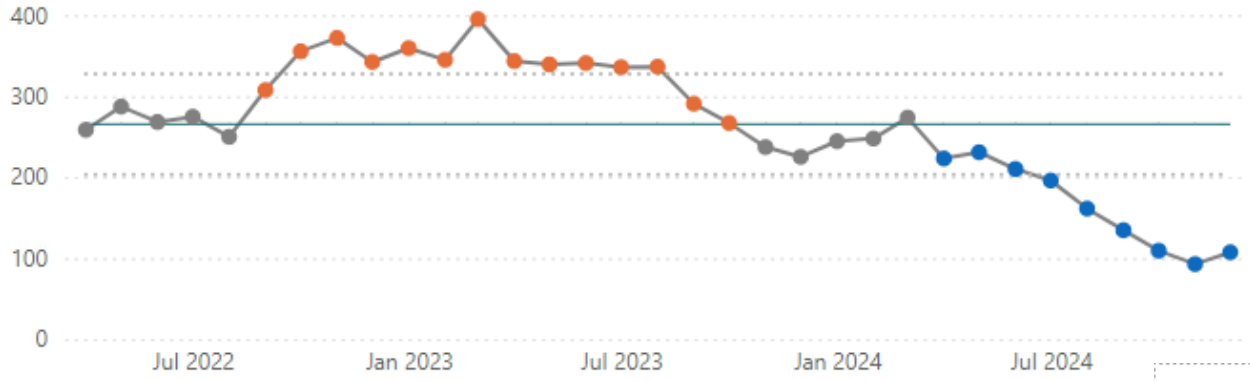
Progress Across the Year

- The Health Board has shown an improving trend across the whole of this financial year thus far. The reported forecast has improved from £49.0m in Month 1 to £28.0m in Month 9 – a change of £21.0m.
- Savings identification of Green and Amber schemes has improved from a shortfall of £24.0m in Month 1, to a shortfall of only £0.2m in Month 9.
- At the Health Board level, core budget performance remains broadly on track, with some non-recurrent underspends supporting the improvements made.
- A key success has been the Nurse Stabilisation programme and focus on reducing reliance on nurse agency with a sustainable workforce development programme. Nurse agency costs have dropped to a three-year low (not adjusted for inflation) with the final intake still to embed with BGH.

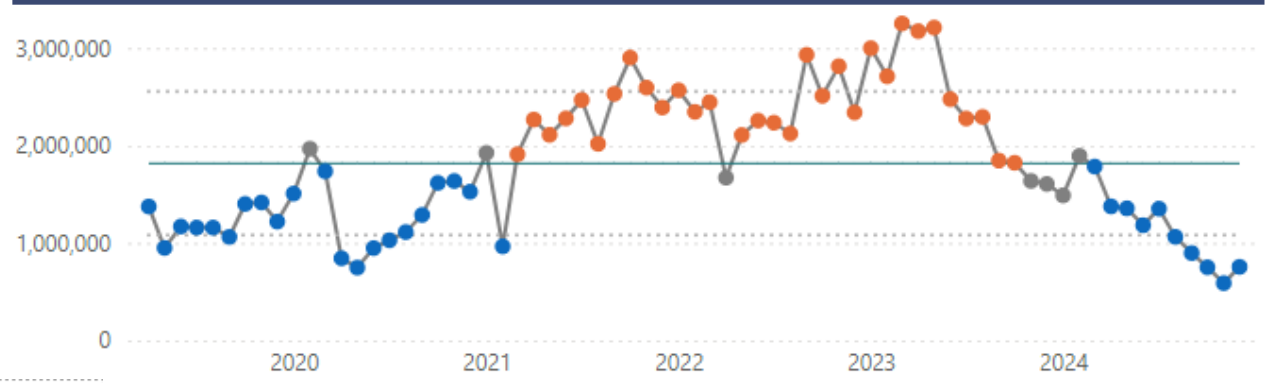
End of Year Gross Forecast Deficit (£'m)



Nurse Agency Resourcing (Whole Time Equivalent)



Nurse Agency Expenditure (£'m)

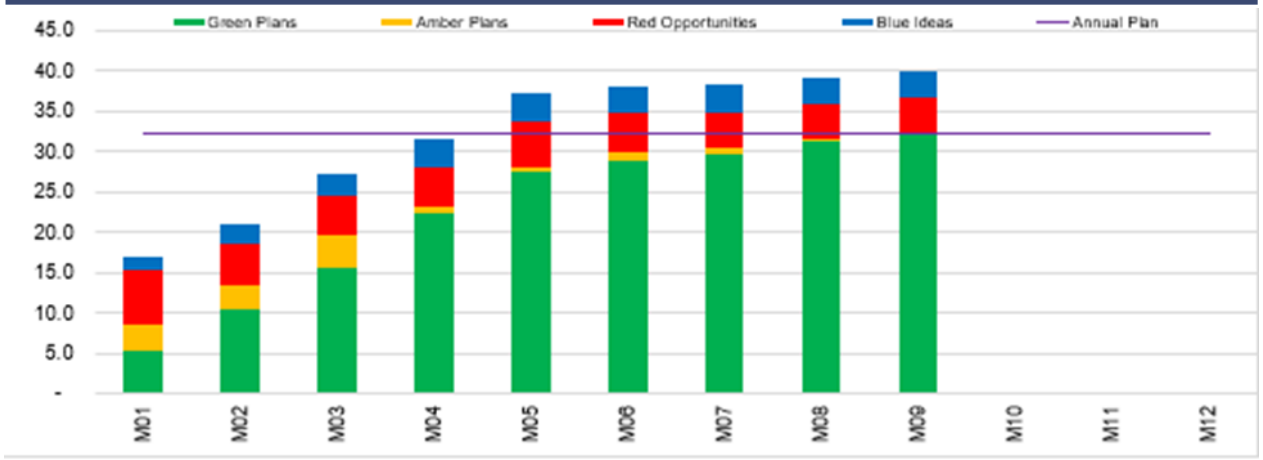


Savings Delivery Performance

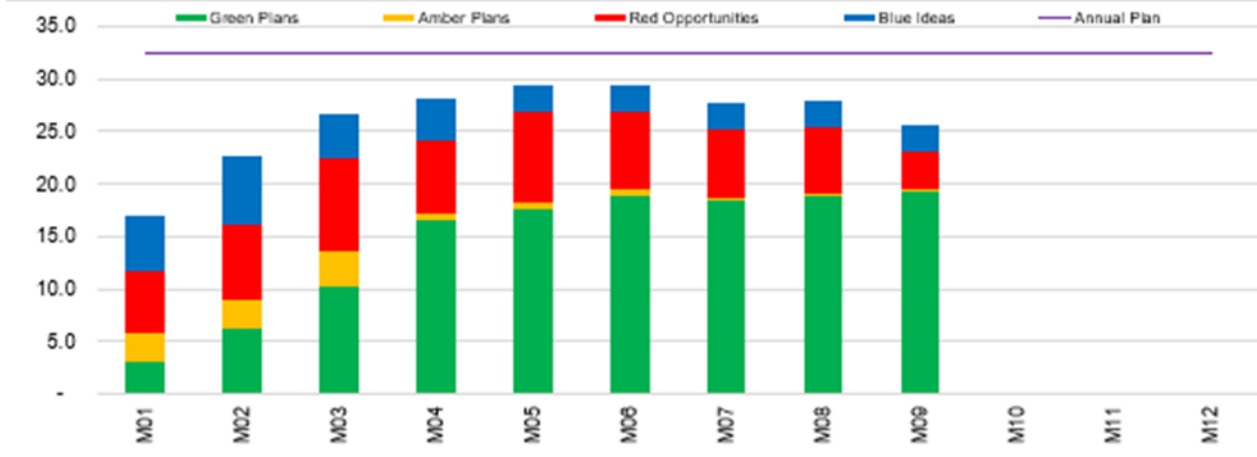
- 2024/25 has experienced a step change, year on year, in the delivery of savings.
- As at Month 9, there is only a £0.2m identification gap remaining – to be closed in Jan/Feb.
- Actual delivery is £1.3m below the planned benefits of the schemes identified to date.
- A slowing trend is experienced, however, for ideas to be accepted from the opportunity's framework.

Annual Savings Movement (£m)	Month 5	Month 9	Change
Savings identification	28.1	32.2	4.1
In-year savings delivery	26.8	30.9	4.1
Unidentified savings gaps	4.3	0.2	4.1
Savings delivery vs identified savings	1.3	1.3	-

Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



Reliance on Non-Recurrent Actions

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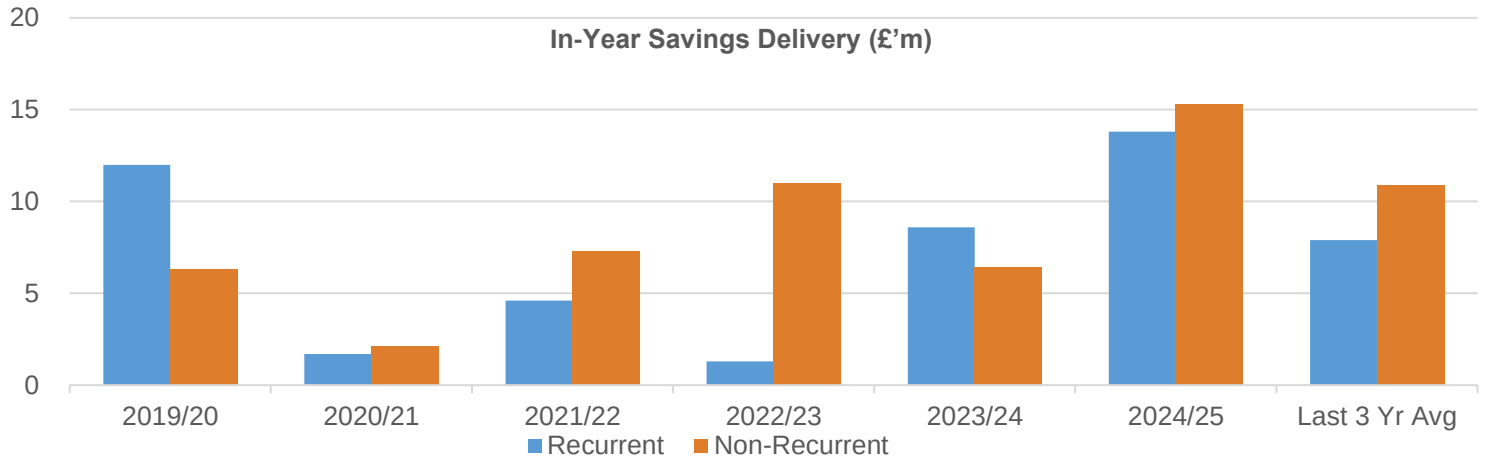
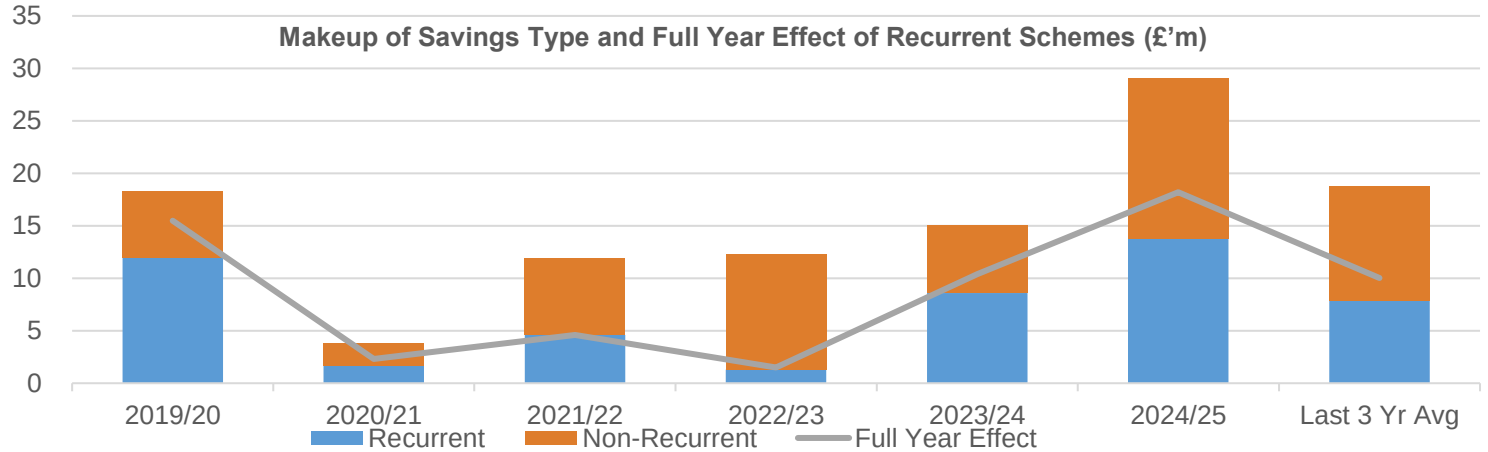
As part of the Annual Plan deliberations the impact on the underlying deficit is being reviewed. Due to the reliance on non-recurrent savings and underspends a significant opening delivery gap exists in next year's financial plan if not addressed. The carried forward impact into the underlying deficit starting point for the 2025/26 financial plan will include, as a minimum, the 2024/25 outturn (currently £28.0m), the recurrent savings gap (currently £13.8m) and directorate underspends that are not signalling an ongoing underspend (currently £8.6m).

Underspending Directorates	£'m
Mental Health and Learning Disabilities	1.3
Director of Operations Management	0.2
Planned Care	0.4
Women and Children	0.1
Carmarthenshire Community	0.6
Pembrokeshire Community	0.7
Ceredigion Community	0.3
Primary Care	3.0
LTAs with other NHS Providers	0.1
Public Health	0.9
Therapies	0.2
Corporate Functions	0.8
Total	**8.6**





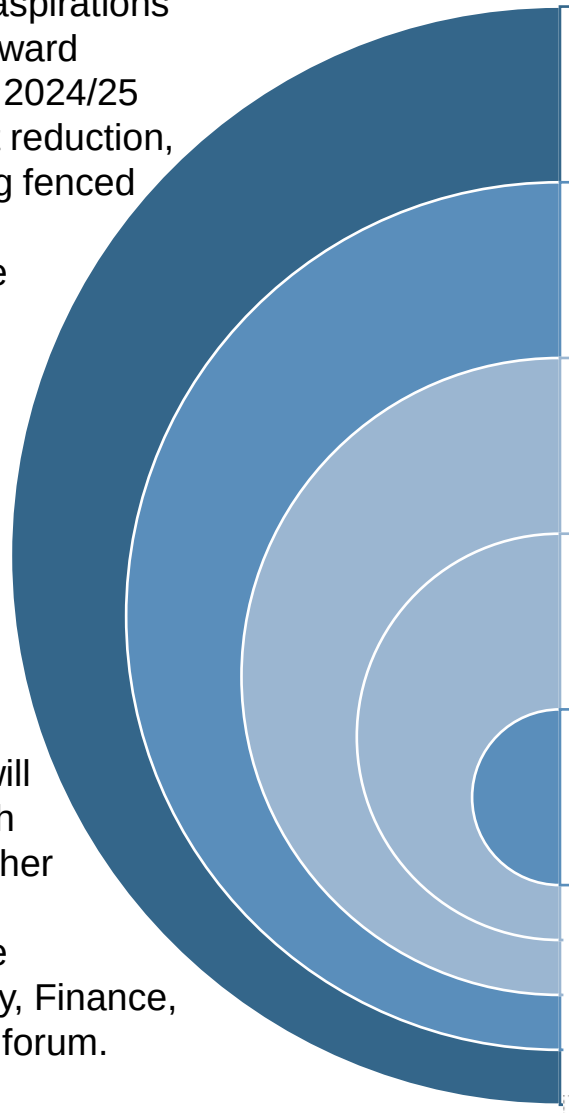
Forward Focus

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Two-year approach to savings aspirations are set based on the carried forward recurrent residual delivery from 2024/25 of a 5% non-ring fenced budget reduction, plus an additional 1.5% non-ring fenced budget reduction adjusted for 2024/25 delivery, to address the underlying deficit concerns.

Allocation of savings targets for technical efficiencies to directorates. Executives will lead on five key efficiency, productivity and value themes aligned to the de-escalation criteria and existing governance arrangements.

Individual Directorate delivery will continue to be overseen through the Directorate Improving Together (DIT) structure and escalation meetings and health board wide delivery at the Integrated Quality, Finance, Planning and Delivery (IQFPD) forum.



Theme 1: Place £3.0m	•Community strategy •Home based care strategy •Acute bed configuration and surge management
Theme 2: People £4.2m	•Nurse and medical rostering •International recruitment for hard to fill roles •Variable pay controls & removal of agency
Theme 3: Enablers £11.0m	•Primary and Secondary care prescribing reviews •Digital transformation •Procurement and cheaper alternatives
Theme 4: Quality, Outcomes and Value £9.4m	•Services embedding prevention & inequalities •Continuing health care packages •Embedding value throughout pathways •MH&LD sustainable model and strategy
Theme 5: Clinical Service Models £7.6m	•Primary Care strategy including access •Out of Hours model to triage appropriately •Clinical Service Plans •Commissioning / Repatriation agreements
Minimum opportunity available totals £35.2m	**Note:** all values are indicative based internal efficiency reviews, benchmarking or other assessments. These figures do not include all technical efficiencies managed locally, which should be brought forward from budget holders.

Domain 3: Fragile services

25/26 Planning Process

October 2024 - Strategic Launch & Parameters

- Comprehensive strategic launch event (10th October) setting Year 2 Targeted Intervention parameters
- Detailed financial framework including 6.5% savings requirement - 5% in 24/25 and 1.5% in 25/26 (6.5% total over 2 years)
- Performance trajectory expectations across all domains
- Quality and safety standards requirements
- Cross-system transformation priorities

Early directorate engagement and planning initiation documents requiring:

- Initial financial modelling and assumptions
- Baseline capacity and demand assessments
- Workforce sustainability requirements
- Service transformation opportunities

November 2024 - System Integration & Dependencies

- Major system-wide workshop (11th November)
- Cross-directorate dependency mapping
- Critical interface identification
- Resource alignment requirements
- Risk identification and mitigation

25/26 Planning Process

Intensive planning development

- Diagnostic capacity modelling
- Therapy resource requirements
- Critical care implications
- Workforce models and movement impacts
- Estate utilisation assessments

December 2024 - Detailed Challenge & Refinement

Comprehensive written feedback to all directorates checking and challenging:

- Assumption validation requirements
- Interdependency resolution needs
- Timeline deliverability assessment
- Resource availability confirmation
- Performance improvement trajectories

Multiple challenge sessions focusing on:

- Financial profiling and phasing including Workforce assumptions and considerations
- Activity delivery assumptions over laid with any Quality impact assessments and Risk mitigation approaches

25/26 Planning Process

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

January 2025 - Final Assurance & Submission

Final plan development (due on 24th January) with the following expectations:

- Full financial profiling and modelling
- Detailed workforce plans
- Clear performance trajectories
- Comprehensive risk mitigation
- System dependency mapping

Systematic assurance process covering:

- **Financial deliverability –** Each directorate needs to demonstrate how they can make their savings and manage within their financial resources
- **Operational sustainability –** activity modelling including capacity planning and workforce alignment
- **Workforce availability** – clear alignment between annual plans and the availability of workforce and/or different workforce models
- **Quality impact –** ensuring all savings and/or proposed changes have or are scheduled to have a QIA before any changes are approved
- **Strategic alignment –** to TI Objectives (year 2) and both the Planning and Performance Frameworks 2025-28
- **Risk management –** using the risk register, how do the directorate annual plans address or potentially create any operational and organisational risks so that any changes can be based on fully informed decisions

Planning
Clinical Services Plan

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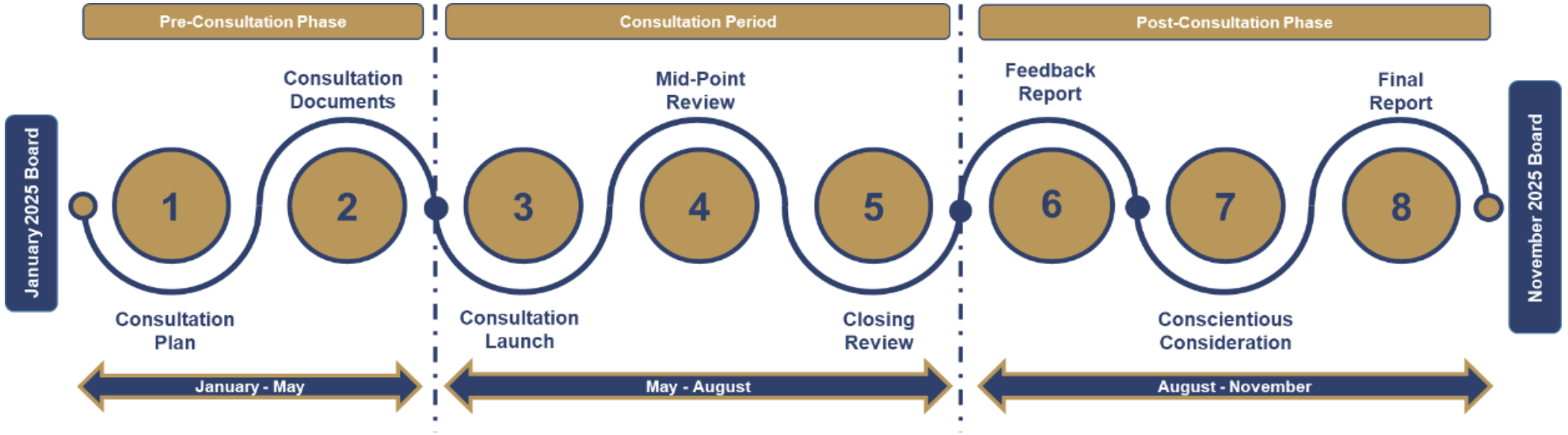
- CSP has moved from Options Development (Phase 2) to Consultation planning ahead of a decision on the future provision of services within the Clinical Services Plan (Phase 3)
- Work is currently being undertaken to develop a consultation plan to support the delivery of Phase 3, with the scope and mandate for consultation to be agreed in January Board.
- The engagement period is expected to run from the end of May following launch of consultation at Board until August.
- The analysis and conscientious consideration of consultation findings will take place between August and November.
- Should there be a large number of consultation responses, the consultation findings may need to go to a later Board date to allow for full analysis of consultation responses.



Fragile Services

Stroke Services

Annual Plan (Short-Term) actions

- Potential *temporary relocation* of acute stroke from Glangwili General Hospital (GGH) to Prince Philip Hospital (PPH) to bolster resilience.
- Aim - Reduce duplication, strengthen out-of-hours cover, and improve stroke outcomes (SSNAP metrics).

Workforce and capacity

- Reviewing critical staff requirements (e.g. medical, nursing, therapy) to ensure safe rotas.
- Funding and organisational change processes (OCP) in early 2025/26 if approved by the Board.

Clinical Services Plan (medium-term) alignment - consultation (May–August 2025)

- Will test longer-term configurations for stroke, reflecting public, clinical, and stakeholder views.
- Ensures that any short-term measures dovetail with final CSP solutions, including potential centralisation or networked models. However, it is recognised that any temporary changes through the annual plan could change again post consultation and engagement.
- Board oversight will incorporate performance monitoring (e.g. door-to-needle times, length of stay) to demonstrate improvement or prompt further adjustment.

Fragile Services

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Diagnostic Services (Radiology)

Annual Plan (Short-Term) Actions -Demand and Capacity Gaps

- Initial plans indicate that there are circa 14,576 **CT** and 7732 **MRI** exams p.a. shortfall, plus significant ultrasound gaps.
- Immediate measures include additional scanning sessions, continued **Everlight** out-of-hours support, and targeted mobile/locum capacity.

Workforce challenges

- Critical radiologist and sonographer shortages; reliance on external reporting services.
- Exploring invest-to-save approaches to recruit permanent staff and reduce outsourcing. However, the issue is around the actual workforce and whether the number of WTEs the Health Board requires is achievable from a recruitment perspective (unlikely to be achieved in 1 year)

Clinical Services Plan (Medium-Term) Alignment

- Service reconfiguration: Possible centralised models or shared regional solutions for advanced diagnostics.
- Longer-Term investment: CSP outcomes will inform capital and workforce planning to address structural gaps.
- Stakeholder engagement: Input from staff, patients, and partner organisations will shape service design, ensuring sustainable capacity for cancer, planned, and urgent pathways.

Fragile Services

Key takeaways/next steps

1. **Immediate priorities** (Annual Plan): Address urgent fragilities in Stroke and Radiology to protect patient safety, manage risk, and optimise existing resources.

2. **Long-term strategy** (CSP): Public consultation in 2025 will refine service models. Interim changes remain flexible, with final decisions subject to formal approval.

3. **Assurance to Welsh Government**: The Health Board is balancing short-term resilience with long-term vision, ensuring all temporary changes align with the overarching strategy and consultation outcomes.

Targeted Intervention and Fragile Services: assurance on current challenges and long-term direction

1. Strategic context

A Healthier Mid and West Wales (AHMWW) – six years of evolution (TI Criteria 6)

Originally agreed in 2018 to address longstanding workforce, financial, and estate fragilities, including an ageing hospital configuration and rising maintenance backlog.

Notable but partial progress has been made (e.g. centralisation of paediatrics at Glangwili Hospital [GGH], ring-fenced elective capacity in Prince Philip Hospital [PPH]); however, fundamental sustainability risks remain.

Infrastructure and capital realities:

Rising construction costs (e.g. +30% in Cross Hands) and urgent fire/RAAC works have constrained transformative investment in acute capacity.

Backlog maintenance has increased from £60m to over £255m (with £42m in high-risk issues), meaning large portions of capital have simply maintained service continuity rather than improved the patient environment or expanded capacity.

2. Fragile Services: medium-term solutions (TI Criteria - 7 and 35)

Clinical Services Plan (CSP) – phase 1 and 2:

Nine services identified as high priority for consolidation or redesign to ensure viability; capital investment could facilitate reconfiguration and address critical risks across the Health Board

Further initial considerations around site-specific approaches could include:

- Glangwili Hospital (GGH) - Evolving as the main acute and emergency centre, requiring targeted investments for capacity and backlog maintenance.
- Prince Philip Hospital (PPH) - Acute medicine, frailty care, and elective surgery; potential to expand as a regional centre for Orthopaedics.
- Withybush Hospital (WGH) - Continues to build on its frailty model and short-stay elective capacity, aligning with the longer-term strategic vision of a phased transition to a community-focused site.
- Bronglais Hospital (BGH) - Provides vital rural services for mid Wales. A networked model utilising digital technology and integrated pathways will underpin its sustainability.

3. Longer-term strategic alignment (TI Criteria 6)

Extended timeline for major infrastructure:

A long-term strategic solution is unlikely to be operational before 2033, potentially stretching to the mid or late 2030s.

This imposes the need for a revised roadmap, balancing the requirement for phased capital investment and urgent service reconfiguration to sustain quality.

Capital feasibility and service transformation:

- Inflation has added £163m to original cost estimates since the 2022 Programme Business Case, raising questions about phasing and scope.
- Interim upgrades (e.g. essential maintenance, site repurposing) will be key to bridging the gap until new infrastructure is delivered.

Primary & Community Strategic Plan:
Emphasises building more robust community hubs (Aberaeron, Cardigan, Cross Hands, Fishguard) and digital-first models of care, reducing unnecessary acute admissions (needed to support long term population health demographics and trends).

4. Assurance of a multi-horizon approach

Current challenges and TI response:
The Board recognises the TI delivery expectations across the 6 domains in order to meet TI de-escalation thresholds, which is being monitored through robust governance structures.

Medium-term service sustainability:
The CSP's focus on consolidation and networked service delivery offers a more resilient model, ensuring that fragile services can continue safely until major capital developments.

Long-term strategy and refresh:
With the new hospital timeline extended, the Health Board will refresh AHMWW, considering post-COVID realities, emerging technologies (AI, robotics), and closer regional collaboration to address shared pressures.

5. Embedding a Population Health approach

Population Health Management (PHM) framework:

We are expanding our lens to prevent ill-health and promote wellness at a population level, not simply treat individuals. This involves tackling the '20-4-7' elements (focusing on the most deprived 20%, four main risk factors - smoking, alcohol, nutrition, physical activity and seven major disease areas such as CVD, Cancer, and Diabetes). An obese patient, for example, can cost the NHS twice as much as a non-obese patient underscoring the economic and clinical imperative of prevention.

Programme-focused prevention:

Discussions are underway across Directorates to shape a Population Health Planning Objective for 2025/26, including the potential for integrated preventive programmes (e.g. tackling alcohol and drug misuse, each £1 invested yielding up to £3–£4 return on investment). We aim to bring this into mainstream planning, aligning performance and quality metrics with population health outcomes—for instance, embedding population health indicators into our IPAR and Directorate 'Improving Together' sessions.

Anchor institution role:

As a major employer and service provider, the Board has the opportunity to influence social determinants of health, reduce local health inequalities, and work with Public Services Boards (PSBs) and Regional Partnership Boards (RPBs). Leveraging this role ensures a far-reaching approach: from shaping local education and workforce initiatives to integrating prevention across health and care pathways.

Driving equity and value:

Improved allocative efficiency means directing resources to where they yield the greatest benefit - both in cost and clinical outcomes. For example, investing in smoking cessation or mental health early interventions can reduce acute admissions and long-term complications. By proactively managing population cohorts rather than waiting for reactive care - our system stands to reduce unwarranted variation, achieve better clinical outcomes, and reduce overall spend.

Domain 6: Quality of care

Hospital-Onset HCAI Performance: C. diff, Staph aureus, and E. coli (TI criteria 50)

Current performance and challenges

C. difficile (C. diff)

Baseline: 8; Target: 6. Recent Average: 5 cases over the last three months, including a low of 4 cases in both August and September—below the threshold.
Key challenge: Sustaining this improvement long-term while continuing to embed the relevant cleaning, antimicrobial stewardship, and competency-based training programmes.

Staph aureus

Baseline: 3; Target: 2. Recent Three-Month Average: 4, though the latest month returned to 3 (baseline).
Key challenge: Fluctuating rates, with occasional peaks (e.g. April, June); consistent three-month compliance has yet to be achieved.

E. coli

Baseline: 7; Target: 5. Recent Average: 5, aligning with the target but not yet consistently below it. July rose briefly to 7, underscoring the need to stabilise performance.
Key challenge: Close to target but requires robust infection prevention measures to ensure no further upward drift.

Overarching challenge

Although recent trends show positive improvement particularly for C. diff and E. coli the service must maintain these gains across all sites, ensuring Staph aureus fluctuations are addressed and actions remain sustainable, to ensure long term solutions.

Quality and Outcomes

Mitigating actions

- **IPC Training, Education, and Oversight** - ANTT (Aseptic Non-Touch Technique) Competency: Mandating 85% or greater compliance via ESR-based training, with ANTT assessors identified for each area. Monitoring at site/directorate levels to track and escalate any shortfalls. Mandatory Training Compliance - Target 85% for IPC Level 1 and 2, ensuring staff can recognise and mitigate infection risks. Reviewing content/delivery methods, especially where repeated themes are identified (e.g. poor hand hygiene). Establishing an IPC champion in each ward or service, providing leadership, local training, and quick escalation of concerns.
- **Root Cause Analysis (RCA) and Learning** - HCAI Assurance Group Meetings - Ensuring each service presents RCA findings/action plans for hospital-onset cases, with monitoring via Datix. Recurring IPC issues (e.g. specific ward-based practices) flagged at quarterly reviews to shape targeted interventions. Involving clinicians in RCA discussions and improvement plans, reinforcing accountability for antimicrobial prescribing, device management, etc.
- **Focused Quality Improvement (QI) Approach** - Establishment of a C. diff Improvement Group chaired by senior clinical leads, developing action plans and reporting to QSEC or the IPSSSG. Antimicrobial Stewardship (AMS) “Start Smart Then Focus” audits championed by the Medical Director and pharmacy teams, with results fed back to prescribers. Regular Grand Rounds/teaching sessions to reinforce prescribing best practices and reduce inappropriate antibiotic use.
- **Targeted Site-by-Site Intervention** - Phased Improvement each acute site has specific training, audit, and environmental review actions designed to stabilise IPC compliance. Environmental & Cleaning Standards to include Implementation of DiffX, UV, and HPV cleaning technologies across all sites, with training records monitored. Annual deep-cleaning programme for wards, ensuring evidence of routine cleaning schedules for both nursing and hotel services.
- **Monitoring & Governance** - Weekly/Monthly IPC Huddles to track new HCAIs, escalate outbreak concerns, and review action plan progress. Utilise surveillance and data such as WPAS bed management and epidemiological data to identify transmission patterns, enabling prompt outbreak responses. Reporting to Board-Level Committees including QSEC (Quality, Safety & Experience Committee) and Board receive regular updates on infection rates, training compliance, and progress against improvement metrics.

Quality and Outcomes

Forward look

- Stabilisation and sustainability - C. diff and E. coli are currently meeting or trending near targets. Ongoing vigilance is needed to keep them there. Staph aureus remains slightly above target; a further sustained focus on hand hygiene, invasive device management, and consistent embedding of ANTT is planned.
- Strengthened ICS collaboration - Greater partnership with Hotel Facilities (cleanliness standards) and Public Health (outbreak management, cross-site learning) to maintain compliance beyond immediate interventions.
- Long-Term QI infrastructure - Dedicated IPC champion network, robust RCA processes, and AMS audits continue, ensuring learning from each case is embedded in practice.

Conclusion

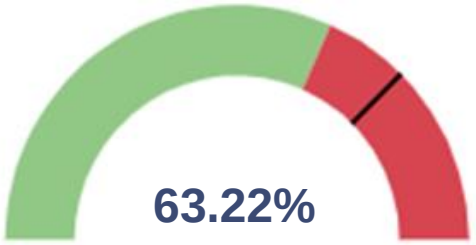
Recent data underscores a positive trajectory for C. diff and E. coli, reflecting successful implementation of training, enhanced auditing, and improved cleaning protocols. Staph aureus remains the main HCAI still exceeding its target. By driving sustained QI efforts, maintaining high compliance with training (ANTT, hand hygiene, antimicrobial stewardship), and expanding oversight at ward/service level, the Health Board is positioned to achieve the required reduction in all three key HCAI metrics and sustain these gains over the longer term.

Quality and Safety: Complaints Response

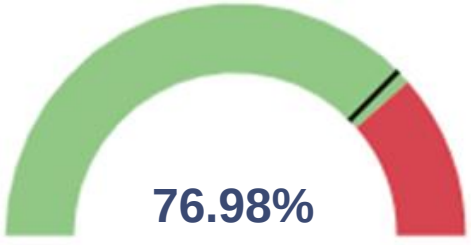
Proportion of complaints settled within 30 days

Improved performance remains on an improvement trajectory with performance above the All-Wales average.

Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2023-24)



Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2024-25)



Data extract from Beacon Dashboard

Proportion of complaints settled through Early Resolution

From 1 November 2024, the Board approved an increase in the time allowed to respond to an early resolution case of 5 working days.

New triage arrangements are having a positive impact and improved patient / complainant experience.

The PTR cases have reduced further in December, as highlighted below and now number are less than half of what they were in Q1 of this year.

Concerns Management/Investigation workshop for senior leaders held on 31 October, in preparation for new PTR implementation 2025 (involving NHSE and WRP).

Received	Managed through PTR
April	200
May	207
June	218
July	226
August	179
September	168
October	205
November	144
December	100
Total	1647

Service user feedback and experience – (TI criteria 36)

Current performance and challenges

Patient Experience Data Integration:

- Recent rollout incorporating CIVICA, Datix, and FFT feedback into escalation and improvement meetings.
- FFT Scores: Consistently above 90%, with a high volume of feedback.
- Positive Assurance: Favourable Ombudsman feedback and 'significant assurance' rating from the Welsh Risk Pool audit.
- Complaints response: 76% of complaints were closed within the 30-working day target timescale advised in the Putting Things Right Regulations.

Learning from the Ombudsman

Three new investigations have been commenced by the Ombudsman in the period October-November 2024. There have been 12 decisions not to investigate. Two final reports were received which were both partly upheld.

Mitigating actions

- Quality Improvement (QI) Integration
- Adding patient experience metrics into directorate packs and the patient safety dashboard.
- Linking Datix/CIVICA insights directly to QI cycles.
- Maintaining high engagement
- Ongoing reporting to the Board and committees.
- Sustaining productive collaboration with the Ombudsman and WRP

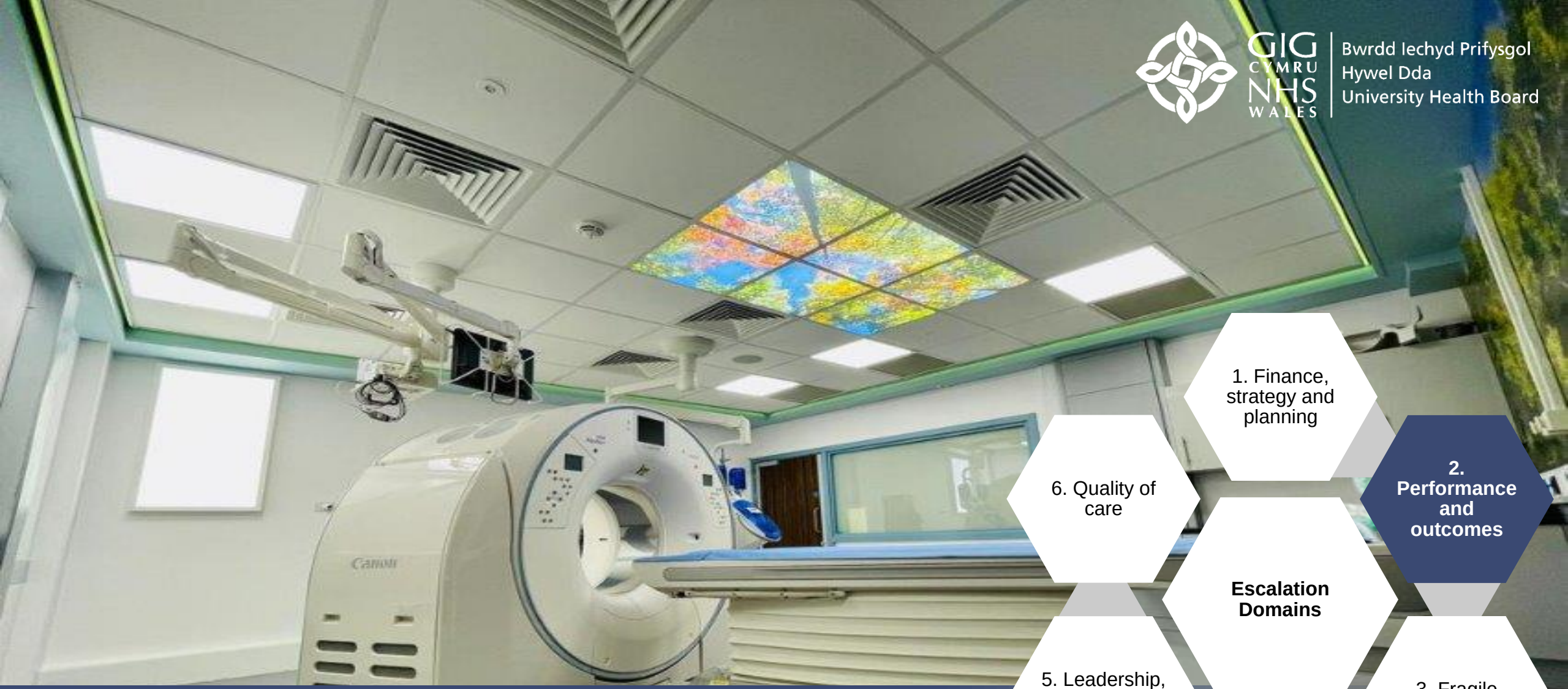
Forward look

Full utilisation of feedback:
As data becomes fully integrated, directorates can better use real-time insights for service improvements.

Strong satisfaction levels:
Continuing the 90%+ FFT rating and high response volume provides in-depth patient perspectives.

Conclusion

Embedding feedback data within daily decision-making and maintaining strong external assurance positions Hywel Dda to improve the quality of services in line with patient needs and expectations.



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Domain 2: Performance and outcomes

Performance and outcomes - exceptions

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Performance de-escalation summary

Latest position key

- Goal achieved
- Making good progress towards goal
- Minimal progress made or decline from previous month
- Same as baseline or worse

	Measure	De-escalation criteria	Baseline	Goal	Latest position																			
					Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Planned Care and Cancer	% single cancer pathway patients starting treatment within 62 days	60% for 3 consecutive months	50%	60%	51%	42%	46%	49%	51%	46%	50%	41%	56%	49%	47%	60%	43%	53%	54%	54%	48.0%	40.0%	44.6%	56%	n/a
	% patients waiting less than 52 weeks for new outpatient appointment	100% for 3 consecutive months	94%	100%	93.6%	94.2%	95.6%	94.8%	94.3%	94.6%	94.0%	93.4%	92.7%	92.8%	93.1%	93.8%	92.5%	91.5%	91.3%	92.9%	93.4%	94.6%	95.0%	95.1%	95.6%
	% patients waiting less than 104 weeks from referral to treatment	100% for 3 consecutive months	97%	100%	96.5%	96.7%	97.1%	97.1%	97.1%	97.1%	97.2%	97.2%	97.4%	97.6%	97.9%	98.5%	98.4%	98.3%	98.2%	98.2%	98.1%	98.1%	97.9%	97.9%	98.1%
	% patients waiting less than 52 weeks from referral to treatment	80% for 3 consecutive months	85%	80%	85.8%	86.1%	87.1%	86.5%	85.7%	85.6%	85.2%	84.7%	84.2%	84.5%	84.9%	85.1%	84.3%	83.7%	83.4%	83.7%	83.7%	84.9%	84.2%	84.6%	84.7%
	Number of patients delayed by 100% for their follow up appointment	15% reduction 3 consecutive months, maintained for 3 months	15,419	9,469	16,181	15,867	15,526	15,377	15,399	15,957	15,571	15,419	15,668	16,310	15,478	15,829	16,028	16,201	16,062	15,714	16,015	16,381	16,481	16,682	16,976
	% R1 ophthalmology patients waiting no longer than 25% of target date	65% for 3 consecutive months	45%	65%	49.1%	49.7%	50.4%	49.6%	47.5%	46.6%	45.2%	44.0%	42.1%	40.5%	40.1%	40.0%	40.1%	38.1%	37.7%	36.1%	36.7%	36.0%	35.0%	34.0%	n/a
	% patients waiting less than 8 weeks for a diagnostic endoscopy	80% for 3 consecutive months	28%	80%	26.8%	27.6%	28.5%	28.9%	24.7%	24.8%	27.8%	26.9%	25.3%	27.0%	31.9%	37.0%	35.8%	34.4%	34.5%	44.0%	36.1%	44.1%	55.3%	57.3%	64.0%
	% patients waiting less than 8 weeks for a Non-obstetric ultrasound (NOUS)	80% for 3 consecutive months	73%	80%	75.8%	70.2%	72.7%	74.1%	67.5%	67.8%	73.3%	68.4%	63.1%	60.6%	70.3%	79.0%	77.5%	81.8%	84.7%	85.9%	77.0%	75.0%	73.4%	67.4%	61.0%
	% patients waiting less than 8 weeks for a non-cardiac MRI	80% for 3 consecutive months	75%	80%	55.1%	63.1%	78.7%	84.3%	70.7%	67.6%	74.6%	69.5%	61.5%	54.4%	65.2%	78.5%	71.7%	66.0%	63.6%	65.2%	57.1%	54.2%	60.9%	49.8%	42.5%
	% patients waiting less than 14 weeks for a specific therapy (excluding Audiology and Weight Management Service)	85% for 3 consecutive months	75%	85%	83.7%	83.3%	85.4%	86.6%	85.3%	84.1%	86.1%	87.4%	86.2%	86.8%	87.8%	86.9%	81.8%	78.9%	78.3%	77.6%	74.6%	78.2%	76.9%	76.1%	77.0%
UEC	Ambulance handovers taking over 1 hour	11% reduction 3 consecutive months, maintained for 3 months	964	680	901	993	863	944	980	854	1,019	915	959	1,245	1,124	1,192	1,103	970	1078	959	721	771	929	986	1,153
	Median time from arrival at ED to assessment by a clinical decision maker (mins) *	60	58	60	57	57	58	71	71	70	65	58	67	64	64	67	65	73	75	74	73	69	73	87	89
	% patients waiting over 12 hours in an emergency department	Continuous improvement towards no more than 7%	9%	7%	8.6%	8.6%	8.2%	8.9%	10.9%	9.2%	9.2%	9.0%	9.7%	11.7%	10.8%	11.3%	10.3%	10.6%	10.7%	10.1%	9.4%	10.6%	10.3%	11.2%	11.7%
	Number of delayed pathways of care	5% reduction 3 consecutive months, maintained for 3 months	203	174	278	230	247	256	238	222	192	227	190	207	212	220	237	249	253	203	194	191	200	204	208
CAMHS	% 0-17 year olds LPMHSS assessments undertaken <28 days	80%	92%	80%	88.2%	86.6%	93.5%	88.5%	76.5%	91.9%	93.8%	86.9%	89.6%	81.3%	92.0%	98.2%	92.2%	95.7%	85.7%	97.0%	90.2%	96.2%	95.3%	87.0%	n/a
	% 0-17 year olds therapeutic interventions started <28 days	65%	59%	65%	45.2%	72.9%	72.2%	48.9%	58.5%	58.5%	65.5%	81.3%	80.0%	78.0%	96.2%	95.8%	91.5%	95.3%	85.1%	81.0%	83.3%	75.0%	84.1%	98.1%	n/a
	% 0-17 year olds having secondary mental health services with valid care treatment plan	80%	95%	80%	100%	100%	100%	97.0%	95.2%	95.5%	93.2%	92.7%	92.9%	91.1%	92.1%	88.4%	93.5%	90.9%	95.0%	91.6%	89.8%	89.9%	90.6%	93.6%	n/a
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	7	6	3	9	8	5	8	10	6	10	7	7	6	8	11	7	4	4	7	8	6
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	3	3	3	3	2	2	4	3	2	4	1	5	7	1	4	3	5	3	0	2	3
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	3					3	5	12	3	2	5	4	4	4	3	7	4	5	4	9	5

Performance and outcomes - exceptions

Single Cancer Pathway (SCP) (TI criteria 13)

Current performance and challenges

Recent performance has risen from a low of 40% (September) to 56% in November. Target: 60% compliance for three consecutive months (currently not achieved).

Key pressure points

- Urology and Lower GI - account for approximately 45% of overall breaches.
- Diagnostic constraints - (e.g., limited endoscopy, MRI capacity) and high referral volumes slow investigations.
- Pathway complexity - Multi-site service delivery, along with workforce and estate issues, creates bottlenecks in some tumour specialties.

Mitigating actions

- Targeted backlog reduction - including additional clinics and theatre sessions: Focused on the highest-pressure tumour sites (Urology, Lower GI) to expedite patient pathways. Outsourcing: Specific outsourcing arrangements to address overflow in diagnostics (endoscopy/imaging) and high-volume treatments (where feasible).
- Diagnostics and pathway optimisation extended Endoscopy sessions - Weekend/evening capacity where staffing allows, aiming to reduce wait times for Lower GI. Radiology Expansion: Exploring mobile MRI or outsourced scanning to relieve bottlenecks.

Performance and outcomes - exceptions

Performance Huddles & Tracking - Weekly or bi-weekly tumour-site huddles to escalate individual cases at risk of breaching.

Alignment with National Optimal Pathways - Earlier Triage & Referral: Ensuring patients are fast-tracked to the right specialty from the outset. Standardised Pathway Review: Working with clinical leads to identify and eliminate non-value-adding steps, reducing overall wait times.

Workforce & Service Development - Recruitment- Boosting specialist staff in oncology, radiology, and endoscopy to increase capacity (where possible). Skill-Mix Expansion: Training and development of advanced nurse practitioners and non-medical endoscopists to offset consultant shortfalls.

Conclusion

The SCP has shown an upward trend from 40% to 56%, demonstrating that action plans are having a positive impact. However, closing the gap to 60% for three consecutive months requires continued focus on the biggest breach contributors (Urology, Lower GI), diagnostic expansion, and systematic pathway reviews to streamline the journey from referral to treatment.

52 Weeks for New Outpatients (TI criteria 14)

Current performance

- 95–96% of patients seen within 52 weeks (baseline: 94%, target: 100%).

Key challenges

Residual backlog in specific specialities (e.g., ENT, T&O) persists. Achieving 100% requires further capacity and efficient scheduling.

Mitigating actions

- Weekend/evening clinics focused on specialty pressures (e.g., ENT, T&O).
- Remote and virtual appointments to increase throughput where clinically appropriate.
- Robust administrative validation to ensure accurate waiting list data and reduce DNAs (Did Not Attends).

Performance and outcomes - exceptions

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104 Weeks RTT (TI Criteria 15)

Current performance

98% of patients within 104 weeks, close to the 100% target.

Key challenges

Remaining 2-year waiters concentrated in **T&O, ENT, and Urology**. Workforce gaps and theatre capacity limit rapid clearance of these complex cases.

Mitigating actions

- Outsourcing packages (e.g., orthopaedic cases) to independent providers.
- Additional theatre sessions - (weekends/evenings) in high-volume areas.
- Daily validation - of near-breach patients to prioritise scheduling.

52 Weeks RTT at 80% (TI Criteria 16)

Current performance

Consistently **84–85%**, surpassing the 80% target.

Key challenges

Occasional dips near 85% do not fundamentally threaten compliance but highlight capacity tightness in certain specialties.

Mitigating actions

Potential de-escalation given consistent over-performance.

Ongoing focus

on-going validation and scheduling to preserve capacity and retain performance above 80%.

Performance and outcomes - exceptions

Delayed Follow-Up >100% (TI Criteria 17)

Current performance

Average **16,000** patients delayed by over 100% (target: 9,469).

Key challenges

Large follow-up backlogs in Ophthalmology, ENT, and other specialties with high demand. Limited clinic capacity and administrative complexities (re-booking, validation) slow improvements.

Mitigating actions

- Focused additional clinics (weekends or evenings) for longest-wait patients.
- Use of virtual follow-ups where safe, freeing up in-person slots.
- Automation/validation drives to ensure accurate follow-up lists and identify any patients who no longer need appointments.

Ophthalmology R1 Patients (TI Criteria 18)

Current performance

36–37%, far below the **65%** target (and 95% national standard).

Key challenges

Fragile service: Nine sites, workforce shortages, ageing equipment. High-volume Glaucoma and Intravitreal caseloads exceeding capacity.

Mitigating actions

Potential centralisation under the Clinical Services Plan (CSP) with options appraisal and stakeholder engagement. Further work with Swansea Bay being scoped.

- Weekend/evening clinics - and recruitment of non-medical injectors to increase IVT throughput.
- Partnership with community optometrists - to manage lower-risk patients and redirect capacity to R1.

Performance and outcomes - exceptions

All Diagnostics (<8 Weeks) (TI Criteria 19)

Current performance

Overall performance still below **80%**, though endoscopy has improved significantly (see TI Criteria 20).

Key challenges

- Staffing shortages in radiology and ultrasound.
- Equipment - constraints limit scanning capacity (MRI, ultrasound).

Mitigating actions

- Extended or weekend scanning sessions for imaging (where staff are available).
- Outsourcing certain diagnostics (MRI, CT) to address peaks in demand.
- Strategic review of diagnostic capacity (including potential service reconfiguration) under the CSP.

Endoscopy (<8 Weeks) (TI Criteria 20)

Current Performance

Improved from **27%** to **64%**, yet under the **80%** target.

Key challenges

Endoscopist shortages and limited suite availability. High GI demand, driven by screening programmes and urgent referrals.

Mitigating actions

- Mobile endoscopy units and additional in-house sessions.
- Outsourcing capacity (where feasible) to reduce the backlog.
- Standardised booking and triage to prioritise urgent/suspicious cases first.

Performance and outcomes - exceptions

NOUS & Non-Cardiac MRI (<8 Weeks) (TI Criteria 21)

Current performance

NOUS down to **61.0%** (Dec-24) from 75.8%. **MRI** at **42.5%** (Dec-24), reflecting a steep fall from 78.7%.

Key challenges

Radiographer/sonographer shortages. Ageing scanners and limited scanning-room capacity, especially at peak times.

Mitigating actions

- Extended scanning hours (evenings/weekends) if staffing available.
- Exploring outsourcing arrangements for MRI scans.
- CSP process to consider radiology options and focus on sustainability with option appraisal and engagement.

Therapy Waiting Times (TI Criteria 22)

Current performance

77% seen within 14 weeks, down from 87%. Target is 85%.

Key challenges

Staffing gaps in physiotherapy, occupational therapy, speech & language.

Mitigating actions

- Weekend/extended sessions to reduce waiting lists.
- Remote or group-based therapy (e.g., virtual physio classes) for appropriate cases.
- Administrative triage to prioritise highest clinical need, discharge non-attenders promptly.

Performance and outcomes - exceptions

Ambulance Handover Delays (>1hr) (TI criteria 24)

Current performance

In December 2024, there were 1,153 over-one-hour ambulance handovers, exceeding the monthly target of 839. Glangwili General Hospital (GGH) showed a minor percentage improvement (from 57.3% to 56.5%), but overall pressures remain high across sites (e.g. Withybush, Prince Philip).

Key challenges

- Front-door bottlenecks - ED overcrowding and limited downstream bed capacity prolong ambulance offloads.
- Demand and Capacity mismatch - demand is exceeding capacity which can impact triage and admissions, causing ambulance queues.
- Variability across sites - each site faces different estate limits, staffing models, and escalation processes.

Mitigating actions

- 50-Day Challenge & Winter Measures - Embedding the Optimal Hospital Flow Framework (Red2Green, D2RA) and extending 7-day working to reduce bed pressures and enable quicker ED admissions from ambulances. Investment of £2.5m in winter resilience for additional staff and discharge capacity.

Local site plans

GGH 12-week plan (fortnightly reviews, weekly ‘Big Room’) targeting front-door processes and SDEC expansions. Boarding protocols refined across sites to relieve ED congestion in high-escalation scenarios.

6 Goals for UEC - Goal 3 (SDEC) Diverts suitable patients from ED, speeding ambulance offloads. Goal 4 Enhanced collaboration with WAST to streamline handover handshakes and offload processes.

Performance and outcomes - exceptions

12-Hour ED Waits (TI criteria 25)

Current performance

December 2024 recorded 1,543 >12-hour breaches (target: 1,137), roughly 10% of attendances, above the 7% goal. GGH remains the most challenged site, although other acute sites also reported high volumes due to winter demand.

Key challenges

- Overcrowding in ED: Inadequate space and slow flow for admissions/discharges.
- Winter surge: Seasonal increases in respiratory and unscheduled care presentations exacerbate crowding.

Mitigating actions

- 50-Day Challenge and Winter Plans - Scheme 1 (Optimal Flow) and Scheme 2 (7-day H&SC) ensure faster weekend discharges, reducing Monday surges that overflow into 12-hour waits. Focus on community falls response and high-risk cohort management (Schemes 6, 10) to prevent avoidable ED attendances.
- Local Site Initiatives - GGH 12-week plan: Expanding SDEC, surgical triage, and Criteria Led Discharge to boost throughput. Other sites improving discharge lounge use and refining escalation protocols (boarding, bed reallocation) to reduce ED backlog.
- 6 Goals for UEC - Goal 5 (Optimal Flow): Embedding daily board rounds, early identification of medically optimised patients, and discharge lounge utilisation to free up ED space. Goal 3 (SDEC): Same Day Emergency Care models in Prince Philip, Withybush, Bronglais to reduce unnecessary ED stays.

Performance and outcomes - exceptions

Median Time to ED Clinical Assessment (≤ 60 Minutes) (TI Criteria 26)

Current performance

Three-month average at 72 minutes, with December 2024 peaking at 89 minutes (highest in the last year). Historically strong performance below 60 minutes now compromised by overcrowding and staffing challenges.

Key challenges

- ED congestion - High ambulance handovers and limited admissions capacity delay triage/assessment.
- Workforce availability – Emergency Medicine shortfalls, inability to expand triage teams at busy periods.
- Peaks in demand - Winter/respiratory surges and rising ED attendances inflate first-assessment wait times.

Mitigating actions

- ED Quality Statement (EDQS) Action Plan - Standardised triage pathways, routine safety huddles, and rapid escalation protocols to expedite initial clinical review. National Six Goals Team ED Improvement Toolkit supporting consistent triage and ‘redirection’ for non-urgent attendances.
- 50-Day Challenge & Winter Measures - Schemes 1 & 2 (Optimal Flow, 7-day working) reducing ED holds by enabling earlier discharges and bed availability. Schemes 6 & 10 tackling out-of-hospital falls and high-risk cohorts, reducing front-door overload.
- Local Site Plans - GGH 12-week plan - Expanding SDEC to shift suitable cases out of ED, and introducing Criteria Led Discharge for faster bed turnover. Adjusted rostering and nurse-led triage expansions in Bronglais, Prince Philip, Withybush to increase capacity for early assessment.

Performance and outcomes - exceptions

Delayed Pathways of Care (DPOC) (TI Criteria 27)

Current performance

Baseline: 203; 5% reduction target: 174. December 2024 recorded 208, with a three-month average of 204, still above target.

Key challenges

- Winter pressures lead to bed shortages and slower discharges for patients needing social care packages or community rehab placements.
- Complex cases - Multi-agency involvement (health, social care, therapy) often prolongs transitions.

Mitigating actions

- Red2Green, Criteria Led Discharge (CLD), D2RA - Aiming to shorten each inpatient journey, focusing on daily board rounds and escalations for any delay. Strengthening 7-day working with local authorities to prevent weekend backlogs.
- Focus on Long Stays - Weekly reviews of top 20 longest stays (>21 days) across sites, removing administrative or supply obstacles (e.g. care packages, home adaptations). Cross-site ‘flow huddles’ to coordinate bed capacity and expedite transfers.
- 50-Day Challenge - Scheme 5 - System-wide review of 21–28-day LOS and top 20 outliers, speeding up approvals and decisions for discharge. Additional winter funds used to secure extra community beds or staff for reablement services.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. Finance, strategy and planning

2. Performance and outcomes

3. Fragile services

4. Governance

5. Leadership, capability and culture

6. Quality of care

Escalation Domains

Domains 4 and 5: Governance and leadership

Leadership

Executive recruitment:

CEO appointed. Recruitment plans being finalised to imminently advertise and appoint to Director of Nursing, Quality & Patient Experience and Medical Director roles

Staff Survey:

- 8% improvement in engagement with 20% response rate.
- Key message to staff from CEO and reminders via ‘Tim Hywel Dda’ Sessions plus engagement threads on Viva Engage.
- Widespread drop-in clinics with staff and share point all contributed to increased engagement.
- Awaiting detailed results of the survey to enable feedback into the organisation.

Leadership development:

- LEAP programme continues with five cohorts completed and 3 in progress. Evaluation from first two show it is exceeding its delivery expectations.
- Three cohorts of New Consultant Programme have been delivered.
- 37 qualified coaches in place with 15 cohorts of the Coach Approach programme delivered

Leadership

Operational Services structure

- 11 key appointments made as part of organisational change process.
- In addition to the 11, following introduction of tailored recruitment programme for all senior leadership roles, a further four senior leader appointments have been made.
- OD development plan being developed for whole team to commence when all appointments made

Staff engagement

- An average of 22% of leavers complete exit interviews
- 73% average engagement score for monthly Board outcome survey
- 1050 staff completed Culture Survey which enables development of localized people culture plans for directorates.
- Speak up – make meaningful change, launched October 2024 with wide array of communications to support our staff.

Governance

Structured Assessment 2024 – key findings

Positive report with only three recommendations issued. Key finding related to corporate governance arrangements include the following:

- Whilst managing a period of significant change, the Board and its committees continue to work well, maintaining a clear focus on public transparency, good governance, continuous improvement and hearing from patients and staff.
- The Health Board has maintained robust arrangements to support the effective conduct of Board and committee business.
- Board and committee meetings continue to be conducted appropriately and effectively, with strengthened arrangements to escalate high-risk matters to the Board.
- The Board and its committees receive good quality, timely papers, which the Health Board is continuing to strengthen as part of ongoing improvement.
- The Board is managing a significant period of change well and is taking positive steps to ensure it remains cohesive and effective through Board development opportunities and arrangements for continuous improvement.
- The Health Board continues to have appropriate arrangements for corporate oversight of risk, performance, tracking recommendations, and the quality and safety of services. The performance management framework however needs to be updated to reflect current performance arrangements, and more frequent updates on the implementation of the Quality Improvement Strategic Framework should be provided.

Further work underway to strengthen operational governance arrangements - scheduled to be implemented by April 2025

Refreshed Board Committee structure to be considered by Board in January 2025 - scheduled to be implemented by April 2025

Board and Committee Effectiveness Programme for 2024/25 currently underway

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

Llywodraeth Cymru
Welsh Government

Dr Philip Kloer
Chief Executive
Hywel Dda University Health Board

Our Ref: JP/GE/SB

29 January 2025

Dear Phil

Targeted Intervention meeting

This letter follows our meeting on 21 January 2025, which is part of the review process linked to your targeted intervention status. Thank you for the slide pack received in advance of the meeting, these form an important part of the record. Apologies were noted from Sue Tranka, Pushpinder Mangat, and Helen Arthur.

Confirmation was received during the meeting that all actions from the previous meeting had been completed.

You started the meeting with a general update on a number of points as follows:

- Recruitment is underway for the Medical Director and Director of Nursing
- Good progress has been made on reducing the financial deficit, supported in part by the reduction in nursing agency usage.
- Challenges remain from a workforce point of view with increases seen in short and long-term sickness rates.
- Organisational development work continues across the health board
- A strategic partner for digital transformation has been appointed
- Pressures within the emergency department and the urgent and emergency care system through the winter period are a real concern.
- You are confident of improving the year-end financial position against the financial control target of £31.5 million and your latest deficit forecast was £28 million.

<u>Finance and Planning</u>

Good progress has been made over the last few months since our last meeting. We discussed the requirement to break even by year three of the three-year planning

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framework in order for the health board to retain the additional conditional recurrent funding issued this year.

I expect you to work closely with Welsh Government and the finance team of the NHS Executive to review your reliance of non-recurrent versus recurrent savings and the conditions associated with additional Welsh Government funding.

You confirmed that there is good progress around the TI action plan with only five actions left to complete from the 17 identified.

You explained that as part of this year's planning cycle a number of workshops have been held across the organisation to drive the planning, development of finance, performance, and quality plans within the individual directorates. Finalised plans from each of the directorates will be submitted by 24 January, with the aim of developing triangulated plans across workforce, finance and quality performance.

Your plan will ensure that the challenges associated with radiology reporting are resolved with appropriate models in place. The plan will also take the appropriate population health focus to prevent ill-health whilst treating patients.

Consultation on the clinical service plan will take place in May 2025. This will include a focus on stroke, critical care and emergency surgery service models.

We would appreciate early notification of any urgent temporary service changes. We discussed the limitations of the urgent service change guidance, and you agreed to provide examples where the guidance is proving problematic so that this can be reviewed.

The joint committee between Hywel Dda and Swansea Bay University Health Boards held its first meeting on 15 January 2025 and is supported by joint working groups for orthopaedics, ophthalmology, diagnostics and some parts of the cancer pathway.

Quality and Safety

Progress had been made against the healthcare acquired infection since the last meeting. C. diff and E. coli had met the de-escalation target, but Staph aureus had not. In support of this you have changed some of the products used for environmental disinfection which has had a positive impact. It is crucial you continue to monitor the standards of cleanliness across all services.

Some improvement has been made related to complaints handling and resolution and you felt that there is room for further improvement.

You have achieved a 50% reduction of your national reported incidents in year along with improvements in your incident management.

Performance and Outcomes

After several disappointing months, progress has been made against your cancer pathway with performance in November being 56% and you anticipate achieving 58% in December. It is important that you focus on the improvements in the cancer pathway to achieve of 70% by the end of March 2025.

You are confident in achieving the 52-week required outpatient position. There are 50-100 orthopaedic patients at risk of not being treated within 104 weeks by the end of March 2025, but you are actively looking for a solution for these patients. Ophthalmology remains an area of concern, both for clinical sustainability and performance.

I am concerned about your diagnostic plan as there does not appear to be a sustainable plan to clear the backlog. Discussions were ongoing internally on how you could secure the required capacity. Plans are in place to address the therapies backlog.

We discussed the challenges facing gynaecology cancer performance which is extremely poor - below 20%, I expect this position to improve urgently over the coming months. *(Post meeting note: an update was provided to the Welsh Government on steps being taken to improve performance).*

Urgent and Emergency Care

We noted that ambulance handover times and long waits at emergency departments were deteriorating again, even though you have a comprehensive improvement plan, including various levels of support and programmes in place – this is a real concern.

You highlighted that the streaming hub at Bronglais hospital seems to be having a positive impact in terms of conveyance and admission avoidance. The Cardigan SDEC is also having a positive impact and will continue to be open until the end of March 2025. Feedback has been very positive with approx. 70 – 80% of patients being diverted from attending Glangwili emergency department. Pathways of care delays are static and bed day utilisation was reducing – there needs to be a real focus in these areas.

Governance and Leadership

The Organisational Change Programme and structure is progressing well, and the majority of the service directors will be in post by 3 February, with the final two vacancies filled by the end of March 2025. I look forward to receiving an up-to-date structure when all posts have been filled.

Summary

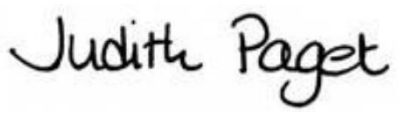
This had been a helpful discussion around the processes and systems in place to support improvement within the health board. I expect to see performance improved for cancer, planned care, urgent and emergency care and healthcare acquired infections.

You have made progress against your financial position; the health board will need to continue its efforts in reducing its forecast deficit both in-year and on a recurrent basis. I expect you to have a clear route map to financial balance which reverses the deteriorating trajectory of the financial position. We agreed the following actions:

- Health board to provide early warning advice on any urgent service changes
- Welsh Government officials to review the urgent service changes guidance following the examples to be shared by the health board.
- The health board to share a copy of an up-to-date structure
- Health board to provide an update on improvements to the gynae-oncology pathway (received)

Please thank your team for the discussion and information provided. I look forward to seeing progress at the next meeting.

Yours sincerely



Judith Paget CBE

Attendance

List of attendees and noted apologies	
Health Board	**Welsh Government**
Dr Philip Kloer	Judith Paget - Chair
Andrew Carruthers	Nick Wood
Joanne Wilson	Jeremy Griffith
Shaun Ayres	Hywel Jones
Huw Thomas	Olivia Shorrocks
Lee Davies	Samia Edmonds
Lisa Gostling	Richard Desir
Sharon Daniel	Heather Payne
Helen Mitchell	Gaynor Evans - Secretariat
Apologies	
	Pushpinder Mangat
	Helen Arthur
	Sue Tranka

8

12:45, 0 Mins

8 - NWSSP – Audit and Assurance Services - Internal Audit (Part 3)

8.1

12:45, 10 Mins

8.1 - Targeted Intervention Governance (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Philip Kloer (Hywel Dda UHB - Chief Executive), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Deputy Director of Operational Planning and Commissioning)

For assurance

Attachments

8.1 TI Governance Final IA Report.pdf

Targeted Intervention Governance

Final Internal Audit Report

2024/25

Hywel Dda University Health Board

Reasonable Assurance

Contents

Review Reference	HDU-2425-02
Fieldwork	July 2024 – January 2025
Executive Sign Off	28th January 2025
Audit Committee	February 2025
Executive Lead	Phil Kloer, Chief Executive Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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

Executive Summary

Purpose

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 Targeted Intervention (TI) actions.

Overview

A new governance structure to aid in addressing TI actions has been embedded with the Executive Team is supported by formal reporting groups and sub-groups with roles and responsibilities outlined in terms of references. Formal reporting groups and statutory committees of the Health Board receive regular progress update reports during 2024 that align to a newly defined assurance level approach providing clear visual rating on the progress and implementation of each TI action.

The reporting groups and statutory committees are responsible for reviewing the progress and performance levels of allocated TI actions with the aim of de-escalation, whilst the Audit and Risk Assurance Committee (ARAC) provides overarching scrutiny in the progress of TI actions. 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 de-escalation.

Two matters requiring management attention regarding:

- The reporting of summary information from reporting groups and other statutory committees into ARAC in order to provide assurance for independent members and a review of TI governance arrangements of the Quality, Safety and Experience Committee [Medium Priority]
- The lack of detail and engagement from some directorates and services in delivering service change plans as part of the recent 100-day planning and delivery programme [Medium Priority]

Whilst positive actions to establish and embed clear governance structures have been identified; challenges still face the Health Board in the delivery of the TI actions. We have therefore concluded **reasonable** assurance on this area.

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

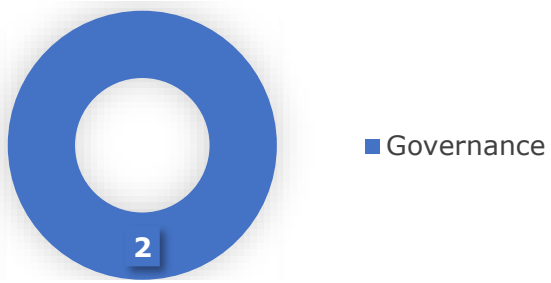
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Appropriate governance arrangements have been established to manage the six domains of the *NHS Wales Escalation and Oversight Framework*	1 & 2	**Reasonable**
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**

Management Actions

0	2
High Priority	Medium Priority

Themes

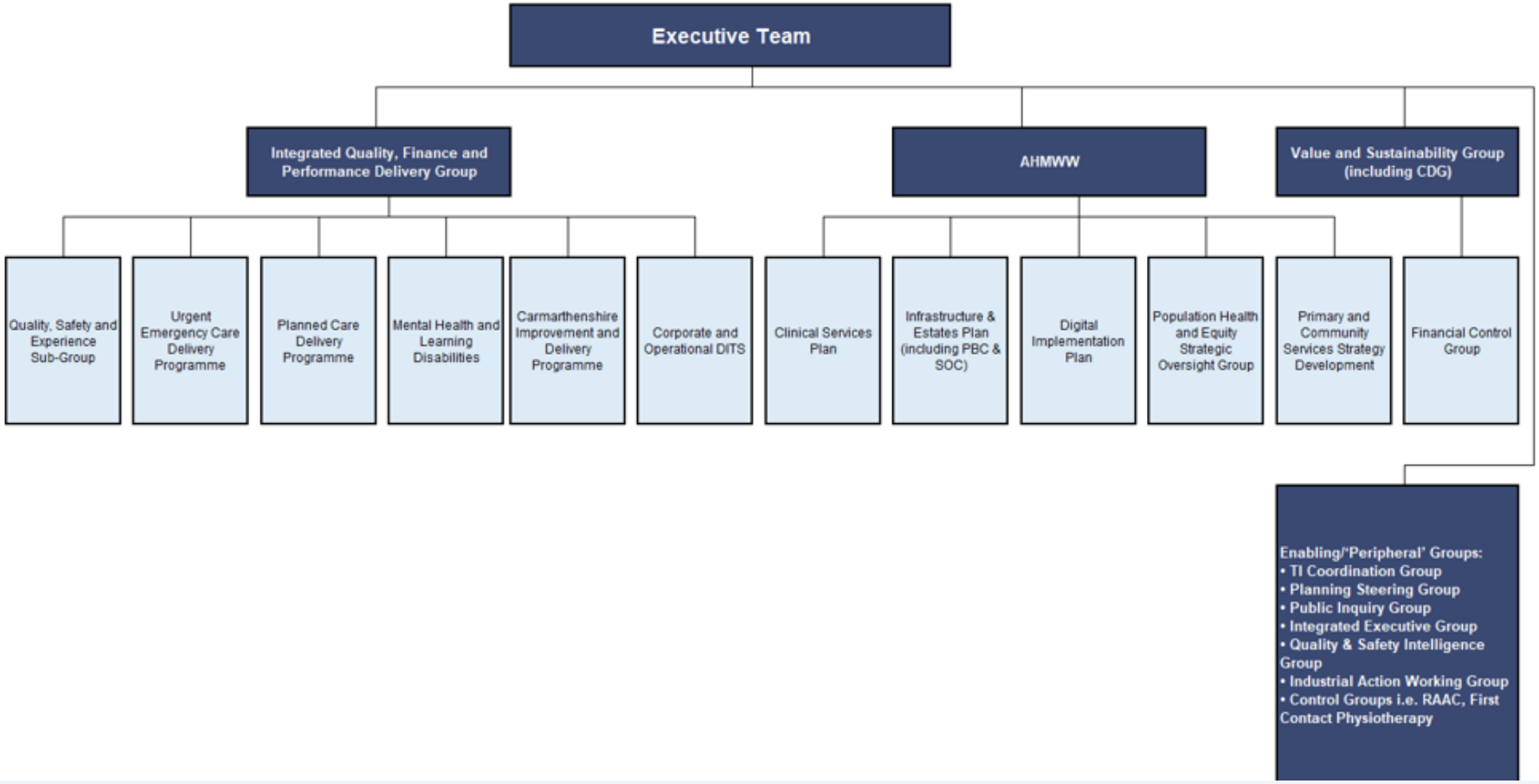


Risk Types

Quality or Safety Issues

New Executive Team Governance Arrangements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



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*	**Reasonable**

Overview / Summary of Observations

A new governance structure was established in June 2024 to manage the TI actions (see page 2 above). The Executive Team is supported by three formal reporting groups, in addition to an overarching TI Coordination Group, that are supported by sub-groups and meetings. Each reporting group has terms of reference in place with outlined roles, responsibilities and objectives. TI actions have also been mapped to dedicated sub-committees of the Health Board, whilst a Lead Executive Director has assigned responsibility for each of the six escalation domains.

The Deputy Director of Planning and Commissioning (in his additional role as Programme Director for Targeted Intervention) plays a key role within the TI 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 Welsh Government.

A newly defined assurance level approach was also introduced to provide clear visual rating on the progress and implementation of each TI action within reports provided to the reporting groups and sub-committees.

At the Audit and Risk Assurance Committee (ARAC) meeting in October 2024, feedback from independent members highlighted the role and remit of ARAC in evaluating how other committees are managing, scrutinising and monitoring TI actions. To address the members comments, a review of the format and content of the escalation status reports was undertaken with a new streamlined escalation/update report introduced in December 2024. However, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC require addressing.

We can confirm the clear reporting of progress reports from the sub-groups and meetings to the reporting groups and sub-committees of the Health Board, apart from the Quality, Safety and Experience Group (QSEC) that provided updates of TI actions within separate individual reports. At the ARAC meeting in December 2024, it was recognised that further work is required surrounding the TI governance arrangement of QSEC.

A 100-day planning and delivery cycle of key programmes was introduced to aid in the planning, execution and oversight of critical change initiatives by 1st October 2024. The delivery cycle was supported by a documented enhanced scrutiny and rapid escalation process. Of the six programmes identified, a post-programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes, whilst there was little engagement from some directorates and services that resulted in no plan being presented or developed.

Whilst positive actions to establish and embed clear governance structures have been identified, challenges still face the Health Board (that have been reported to groups and committees) in the delivery of the TI actions.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance and Reporting Arrangements** Following feedback from independent members at ARAC meetings, further actions regarding summary information on the	Poor governance and reporting arrangements	**Agreed Action:** Structuring reports by the six specific TI actions under ARAC's remit, ensuring that each action is clearly tracked, monitored,

	assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing.	impacts on the Health Board's ability to address TI actions.	and reported. In addition, summary assurance from other committees will also to be provided. Highlighting any variance or potential non-compliance promptly. Where there is any indication that performance, quality, or governance arrangements do not align with TI criteria, ARAC will be duly notified so that corrective measures can be enacted swiftly and robust oversight can be maintained The approach to QESC follows the same reporting and assurance framework as other committees. Where criteria fall within QESC's remit, regular updates will be submitted, detailing progress, evidence-based outcomes, assurance ratings, and any further actions required. This consistent process ensures that each committee, QESC included, receives transparent and comprehensive updates on the organisation's performance against TI requirements.
			Expected Evidence of Implementation: 1) Restructured TI update reports highlighting any variances or non-compliance, and any other concerns
		Medium Priority	**Officer:** Programme Director of Targeted Intervention **Target Implementation Date:** 23rd January 2025
	Theme: Governance	Control Design	
2	**Directorate and Service Engagement** The post 100-day planning and delivery programme review (undertaken by the Programme Director of Targeted Intervention) identified missing key information within three of the programmes and little engagement from some directorates and services that resulted in no plan being presented or developed, impacting on the Health Board's ability to delivery TI actions.	Lack of engagement resulting in TI actions not being addressed.	**Agreed Action:** An escalation process between the Programme Director of Targeted Intervention and the Chief Executive Officer/ Deputy Chief Executive Officer for the non-engaged directorates and service to be agreed
			Expected Evidence of Implementation: 1) Agreement of an escalation process for directorates and services not engaging in the TI process
		Medium Priority	**Officer:** Programme Director of Targeted Intervention **Target Implementation Date:** 28th February 2025
	Theme: Governance	Control Operation	

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

Every TI action is allocated a reporting group and committee that are responsible for reviewing the progress and performance levels with the aim of de-escalation. ARAC, as part of its role as responsibility, receives regular update reports on the de-escalation progress of TI actions by the reporting groups and committees.

The update report submitted to ARAC in October 2024, highlighted five performance figures that had met their target for a minimum of three consecutive months that led to their de-escalation, including:

- % patients waiting less than 52 weeks from referral to treatment
- % 0-17 year olds LPMHSS assessments undertaken <28 days
- % 0-17 year olds therapeutic interventions started <28 days
- % 0-17 year olds having secondary mental health services with valid care treatment plan
- Number of hospital onset E.coli infections

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 Welsh Government to support their de-escalation.

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.

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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 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.

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

9

12:55, 0 Mins

9 - For Information

9.1 **12:55, 0 Mins**

9.1 - ARAC Workplan 2024/25

For information

Attachments

9.1 Audit Work Programme 2024-25.pdf

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2024/25

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	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
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**					✓		✓		
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**		✓							✓
Escalation Status Update	**PK/LD**	✓		✓		✓	✓	✓	✓	✓
Compliance with Ministerial Directions	**JW**		✓							
Compliance with Welsh Health Circulars (WHCs)	**JW**		✓							
Review Draft/Final ARAC Annual Report	**Chair**		✓							
Review Draft/Final Board Effectiveness Report	**JW**		✓							
Review Draft/Final Accountability Report, including Annual Governance Statement	**JW**		✓ (Draft)		✓ (Final)					
Review Annual Head of Internal Audit Report and assoc op (incl Capital/PFI)	**JJ**		✓ (Draft)	✓ (Final)						

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Review, agree and recommend to the Board the audited accounts & financial statements	**HT**		✓ (Draft)		✓ (Final)					
Audit Enquiries to those charged with Governance and Management	**HT**		✓							
Internal Audit: Annual Governance Statement Review	**JJ**				✓					
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**									✓
Annual Review of Standing Orders and Standing Financial Instructions	**JW**		✓							✓
Scheme of Delegation	**JW**						✓			
All Wales NHS Audit Committee Chairs' Meeting Update	**Chair**					✓	✓	✓		✓
Contract and Procurement Processes – Governance	**JW**	✓								
Annual Review of Terms of Reference/membership	**Chair/JW**			✓						
Procedure 175: Management of Board and Committees SOP	**JW**						✓			
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 through where a significant activity is shared with another organisation (eg NWSSP, JCC)	**HT/SM**	✓	✓	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
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**	✓	✓	✓	✓	✓	✓	✓	✓	✓
FINANCIAL FOCUS										
Review risks and controls around financial management (via Financial Assurance Report)	**HT**	✓		✓		✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	**HT**			✓						
Receive Post Payment Verification (PPV) report	**HT**			✓				✓		
Receive PPV annual report	**HT**			✓						
Receive Primary Care PPV report	**JP**			✓				✓		
Annual statement of financial procedures	**HT**								✓	
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**									
Non-Clinical Temporary Staff/Agency Spend and Numbers	**HT/LG**	✓								
NuroKor Write-Off	**HT**	✓								
Industrial Action Payments	**HT/AG**	✓								

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
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 2023 Management Response Update	**Audit Wales/JW**					✓			✓	
Structured Assessment 2024	**Audit Wales**							✓	✓	
Follow-up Review of Primary Care	**Audit Wales/JP**	✓								
Review of Operational Governance Arrangements across Service Directorates	**Audit Wales/AC**	D		✓					✓	
Review of Cost Savings Arrangements Report and HDdUHB Management Response	**Audit Wales/HT**					✓				
Review of Urgent and Emergency Care	**Audit Wales/AC**	D				D	D	D	D	✓
Planned Care Review	**Audit Wales/AC**								D	✓
Review of Arrangements for Capital Programme Prioritisation	**Audit Wales/LD**								D	D

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	**Audit Wales/AC**									✓
NWSSP – AUDIT AND ASSURANCE SERVICES – 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**	✓								
WGH RAAC Internal Major Incident (Reasonable Assurance)	**JJ/AC**	✓								
Transforming Urgent & Emergency Care (Reasonable Assurance) and update	**JJ/AC**	✓				✓	✓			
Cleanliness/Cleaning Standards (Limited Assurance)	**JJ/AC**	D	✓							
Elective Waiting List Management – SCP (Reasonable Assurance)	**JJ/AC**	✓								
GGH Fire Enforcement (BJC1) (Limited Assurance)	**JJ/AC**	D	✓							
Records Digitisation Follow-up (Reasonable Assurance)	**JJ/AC**	✓								
Discharge Management (Limited Assurance) and update	**JJ/AC**	✓				✓				
Agency/Rostering (Reasonable Assurance)	**JJ/LG**	✓								

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Cross Hands Health & Wellbeing Centre Capital Scheme (Reasonable Assurance)	**JJ/LD**	✓								
Consultant Job Planning Follow-up (Limited Assurance) and update	**JJ/MH**	✓				✓				
BGH Chemotherapy Day Unit Review (Final Briefing Paper) and update	**JJ/AC**			✓		✓				
RAAC Programme WGH (Substantial Assurance)	**JJ/LD**			✓						
Planning Maturity Matrix (Reasonable Assurance)	**JJ/LD**			✓						
Accelerated Cluster Development (Reasonable Assurance)	**JJ/JP**			✓						
Emergency Response Planning – Industrial Action (Reasonable Assurance)	**JJ/AG**			✓						
Health & Care Quality Standards/Duty of Quality (Reasonable Assurance)	**JJ/SD**			✓						
Nurse Staffing Levels (Wales) Act 2016 (Reasonable Assurance)	**JJ/SD**					✓				
Falls Management (Reasonable Assurance)	**JJ/SD**						✓			
Emergency and Business Continuity Planning (Reasonable Assurance)	**JJ/AG**						✓			
Digital Benefits Realisation (Substantial Assurance)	**JJ/HT**						✓			
Ultrasound Services (Reasonable Assurance)	**JJ/AC**					D	✓			
Speaking Up Safely (Reasonable Assurance)	**JJ/LG**						D	✓		
Nursing Management (Limited Assurance)	**JJ/SD**						D	✓		
Discharge Management Follow-up (Limited Assurance)	**JJ/AC**							✓		

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Energy Management (Reasonable Assurance)	**JJ/AC**							✓		
Capital Systems (Reasonable Assurance)	**JJ/AC**							✓		
Cash Management (Substantial Assurance)	**JJ/HT**						D	✓		
Management of Bed Capacity (Limited Assurance)	**JJ/AC**							D	✓	
Mortuary Services (Limited Assurance)	**JJ/AC**							D	✓	
Health and Safety (Limited Assurance)	**JJ/JS**						D	D	✓	
Data Quality (Limited Assurance)	**JJ/HT**								✓	
Targeted Intervention Governance (Reasonable Assurance)	**JJ/PK/JW**								✓	
Financial Management	**JJ/HT**							D	D	✓
Performance Management Arrangements	**JJ/HT**								D	✓
Executive Team Working	**JJ/PK/JW**								D	✓
Elective Waiting List Management	**JJ/AC**								D	✓
Learning Lessons	**JJ/SD**								D	✓
Medical Workforce (Medical Locums Planned Care)	**JJ/MH**								D	✓
Digital Strategy Partner (IC)	**JJ/HT**									✓
Consultant Job Planning Follow-up (2)	**JJ/MH**									✓
Primary Care Strategy including Managed Practices	**JJ/JP**									✓
UHB Procurement - Contract Management	**JJ/HT**									✓
Annual Planning	**JJ/LD**									✓
Cleanliness/Cleaning Standards Follow-up	**JJ/AC**									✓
Withybush Hospital (WGH) RAAC	**JJ/AC**									✓

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Continuing Health Care	**JJ/JP**									✓
Revised Operational Governance arrangements	**JJ/AC**									D
Estates Facilities Directorate	**JJ/AC**									D
CLINICAL AUDIT										
Review annual forward clinical audit plan and terms of reference	**SD**			✓				✓		
Review the effectiveness of clinical audit – consider recommendations from the Effective Clinical Practice Group on suggested areas of activity for review by internal audit	**SD**							✓		✓
DEEP DIVE										
TBC *										
ASSURANCE AND RISK										
Audit Tracker	**JW/CW**	✓		✓		✓	✓		✓	
Risk Assurance Report	**JW/CW**					✓		✓		✓
Risk Assessment Procedure	**JW**			✓						
Scrutiny of Outstanding Improvement Plans *	**JW/CW**									
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**	✓								✓
Guidance on Offence of Failure to Prevent Fraud	**HT**							✓		
Annual Review of Requisitions	**CFO**							✓		

AGENDA ITEM/ISSUE	LEAD	16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**									
FOR INFORMATION										
ARAC Work Programme 2024/25	**Chair**	✓		✓		✓	✓	✓	✓	✓
National Internal Audit Reports *										
REVIEW OF THE MEETING										
Matters & Risks for Escalation to the Board	**Chair/JW**	✓		✓		✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

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

Audit Committee Tasks		16 April 2024	9 May 2024	18 June 2024	9 July 2024	13 Aug 2024	15 Oct 2024	10 Dec 2024	11 Feb 2025	April 2025
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**					✓				
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

12:55, 0 Mins

10 - Any Other Business

11

12:55, 0 Mins

11 - Review of Meeting

11.1

12:55, 0 Mins

11.1 - Matters and Risks for Escalation to the Board

For discussion

12

12:55, 0 Mins

12 - Date and Time of Next Meeting

9.30am, 15 April 2025